World Council of Churches

Faith Sector Implementation of the Global AIDS Strategy

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WCC Publications is the book publishing programme of the World Council of Churches. The WCC is a worldwide fellowship of 352 member churches which represents more than half a billion Christians around the world. The WCC calls its member churches to seek unity, a common public witness and service to others in a world where hope and solidarity are the seeds for justice and peace. The WCC works with people of all faiths seeking reconciliation with the goal of justice, peace, and a more equitable world.

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Foreword

The global HIV response today is guided by local and global actors, who develop key strategic resources to orient and align the global response. However, the HIV response cannot be driven only by these agencies. The crucial role of communities, and particularly of faith communities, has long been emphasized. It is important to ensure that faith responses are aligned with international strategies.

This World Council of Churches publication presents a summary of three key documents: the UNAIDS (the Joint United Nations HIV/AIDS Program) *Global AIDS Strategy 2021-2026, End Inequalities. End AIDS*; the USA President's Emergency Plan for AIDS Relief (PEPFAR) strategy *Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030*, produced in 2022; and the Global Fund to Fight HIV, Tuberculosis and Malaria strategy, *Fighting Pandemics and Building a Healthier and More Equitable World*.

The authors analyse the strategies and provide guidance for the unique role of the faith sector in HIV response while implementing these strategies. Discussions include what the faith sector can do at global, regional, and local levels; what actions should be led by the faith sector, how, by whom, and with whom?

This resource is the result of the experience of WCC staff working on HIV and AIDS for many decades, with the support of international experts. I recommend the reading and revision of this document in every faith community. There is a role for all actors in the faith community, including local, national, and international faith communities and congregations, national and international interfaith coalitions, faith-based hospitals, clinics and relief and development organizations, as well as the diversity of interfaith religious leaders.

The HIV epidemic continues to be a challenge for the world and demands the engagement of faith communities who respond with sound and relevant actions. It is our responsibility to participate in the HIV response; it is our calling to care for the most vulnerable.

Rev Dr Kenneth Mtata
Director Public Witness and Diakonia
World Council of Churches

31 August 2023
Geneva-Switzerland

Overview

The goal of all partners in the global response to HIV is to end HIV and AIDS as a public health threat by 2030. The global strategy to achieve that is articulated in *End Inequalities. End AIDS. Global AIDS Strategy 2021–2026* of UNAIDS (the Joint United Nations HIV/AIDS Program) was approved by the United Nations in 2021.[1] A related document, *Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030*, produced in 2022, articulates the USA President's Emergency Plan for AIDS Relief (PEPFAR)'s strategy as a leading partner in the global response.[2] Similarly, in 2021, the Global Fund released its strategy document, *Fighting Pandemics and Building a Healthier and More Equitable World*.[3] Although organized slightly differently, the three strategy documents articulate a clear and consistent vision of what the world must do to end HIV and AIDS as public health threats by 2030.

The UNAIDS, PEPFAR, and Global Fund strategy documents all emphasize the importance of the faith sector in their strategies. Faith sector contributions are significant in three areas:

- Integration of faith communities into public health systems
- Reduction of stigma, discrimination, and inequalities in HIV services and outcomes
- Reliance on data and evidence to guide HIV programmes and interventions

1. UNAIDS, End Inequalities. End AIDS. Global AIDS Strategy 2021-2026. https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026.

2. PEPFAR, Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030, https://www.state.gov/wp-content/uploads/2022/11/PEPFARs-5-Year-Strategy_WAD2022_FINAL_COMPLIANT_3.0.pdf.

3. The Global Fund, Fighting Pandemics and Building a Healthier and More Equitable World, https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf.

Different faith actors have different roles to play in three areas, advocacy, implementation, and capacity building.

Advocacy at the local level is focused on ensuring equitable access to HIV services, reducing societal stigma, and addressing social issues such as gender-based violence. Advocacy at the national level promotes strong HIV programmes with sustainable funding and focuses on eliminating laws and policies that create inequalities in HIV service delivery. Advocacy at the international level works toward reducing global healthcare inequalities, demanding human rights for all—including marginalized and key populations, sustainable financing, and holding global institutions accountable for their commitments.

Faith sector implementation of other elements of the Global AIDS Strategy is primarily at the local and national levels. Local faith communities can contribute by ensuring the health of their members, reducing stigma toward marginalized and vulnerable populations, and gathering data to help guide the global response. Faith-based hospitals and clinics can contribute by ensuring that their HIV services are delivered without stigma, discrimination, or risk of criminal prosecution. National faith communities and interfaith coalitions can contribute through involvement in planning and monitoring national HIV strategies and building the capacity of their affiliated local communities, hospitals, and clinics through the widespread adoption of good practices.

Important next steps for the faith sector include:

- Integrating national interfaith coalitions into the planning, implementation, and monitoring of more national HIV programmes
- Articulating HIV good practices for local faith communities and faith-based hospitals and clinics
- Developing a monitoring and evaluation framework for faith-based HIV initiatives and associated quantitative targets
- Strengthened HIV advocacy at the international and national levels

The World Council of Churches (WCC) and its member churches are well-positioned to be a significant leader and partner in the faith sector support of the Global AIDS Strategy. In particular, we suggest that the WCC, in partnership with other interfaith coalitions and with people living with HIV, act to:

- Articulate HIV good practices for local congregations and faith-based hospitals and clinics
- Develop a programme promoting HIV voluntary testing and counselling among congregation members
- Establish overall targets for voluntary HIV testing and counselling among church and congregation members and for the adoption of good practices by local congregations, hospitals, and clinics
- Advocate for sustainable resources for the HIV response and for reducing health system inequalities at the global and regional levels

We suggest that WCC member churches undertake the following actions:

- Work closely with governmental agencies, secular organizations, and other interfaith coalitions on the development and implementation of national HIV plans
- Adapt HIV good practices to different religious traditions, languages, cultures, and legal contexts to implement capacity-building programmes for affiliated local congregations, hospitals, and clinics
- Implement programmes for voluntary HIV testing and counselling among congregants
- Establish targets for HIV voluntary testing and counselling and for adopting HIV good practices
- Implement mechanisms for monitoring, evaluation, and tracking of progress toward the targets
- Advocate for the repeal of punitive laws and policies that are barriers to effective HIV service delivery

We recommend that local congregations affiliated with WCC member churches:

- Work closely with local government agencies and other community-based initiatives to coordinate the delivery of HIV prevention and treatment services
- Adopt HIV good practices, including programmes to reduce stigma and address social drivers such as gender-based violence
- Provide information about good practices to affiliated churches

Global AIDS Strategies

UNAIDS

In 2021, the United Nations adopted a new five-year strategy for ending the HIV and AIDS epidemic. *End Inequalities. End AIDS. Global AIDS Strategy 2021–2026* describes actions and targets designed to end HIV and AIDS as a public health threat by 2030.[1] The strategy is organized around three strategic priorities:

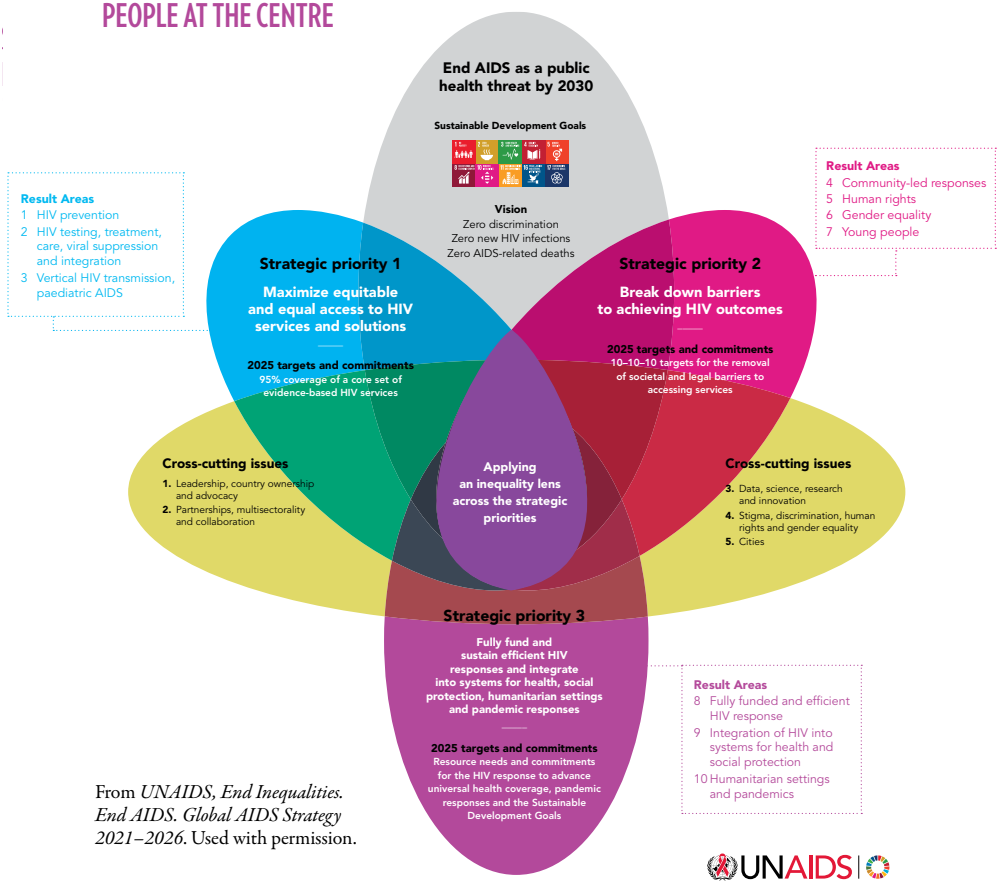
- Maximize equitable and equal access to HIV services and solutions
- Break down barriers to achieve HIV outcomes
- Fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings, and pandemic responses

1. UNAIDS, End Inequalities. End AIDS. Global AIDS Strategy 2021-2026. https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026

The strategy also identified five cross-cutting issues that affect all three of the priorities:

- Leadership, country ownership and advocacy
- Partnerships, multisectorality, and collaboration
- Data, science, research, and innovation
- Human rights, gender equality, and reduction of stigma and discrimination
- Cities, urbanization, and human settlements.

GLOBAL AIDS STRATEGY 2021–2026: AN INEQUALITIES FRAMEWORK THAT PUTS PEOPLE AT THE CENTRE



From *UNAIDS, End Inequalities. End AIDS. Global AIDS Strategy 2021–2026.* Used with permission.

PEPFAR

On World AIDS Day in 2022, PEPFAR released its five-year strategy for ending HIV and AIDS as a public threat by 2030. *Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030* defines a set of priorities organized around five strategic pillars:[2]

- Health Equity for Priority Populations
- Sustaining the Response
- Public Health Systems and Security
- Transformative Partnerships
- Follow the Science

The PEPFAR strategy includes three enablers that affect all five pillars:

- Community Leadership
- Innovation
- Data

From *PEPFAR, Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030.*

2. PEPFAR, Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030, https://www.state.gov/wp-content/uploads/2022/11/PEPFARs-5-Year-Strategy_WAD2022_FINAL_COMPLIANT_3.0.pdf.

Global Fund

In July 2021, the Global Fund adopted its five-year (2023–2028) strategy for ending AIDS, Tuberculosis and Malaria by 2030. *Fighting Pandemics and Building a Healthier and More Equitable World* defines a primary goal and a set of four mutually reinforcing contributory objectives:[3]

- **End AIDS, TB, and Malaria**
- Maximizing people-centred integrated systems
- Maximizing the engagement of most affected communities
- Maximizing health equity, gender equality, and human rights
- Maximizing increased resources

In addition, the strategy includes an evolving objective that goes beyond the three diseases:

- Contribute to pandemic preparedness and response

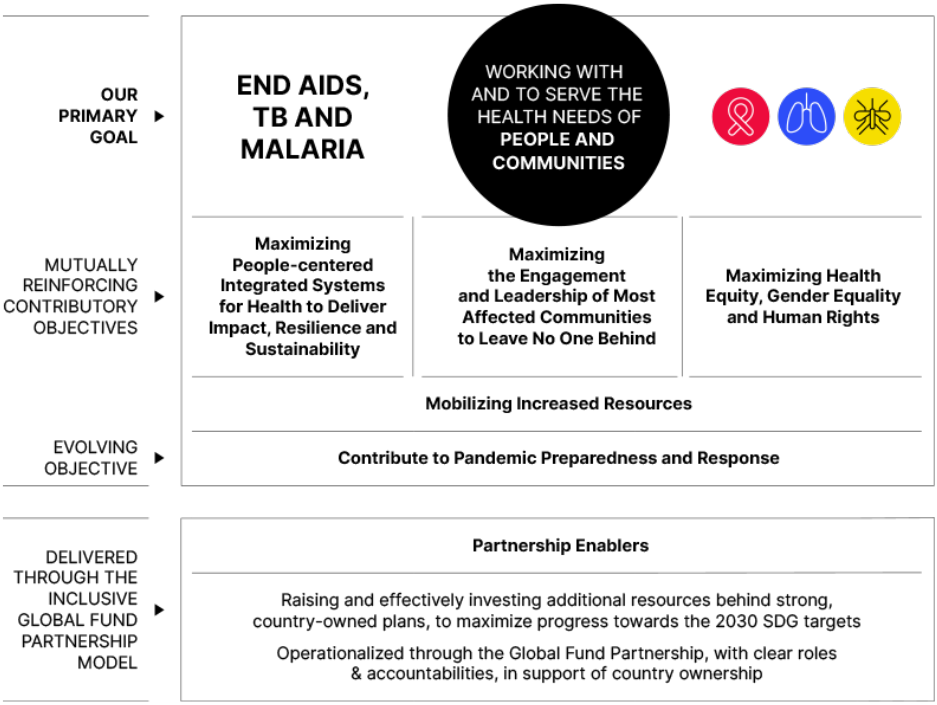
The strategy also includes a description of the Global Fund partnership model, including specific roles for different groups of partners.

When analyzed, the three strategy documents clearly show what the world must do to end HIV and AIDS as a public health threat by 2030:

- Despite setbacks in the global HIV response caused by the COVID-19 pandemic, we have had significant successes in addressing HIV, and it is still possible to end HIV and AIDS as public health threats by 2030.
- Inequalities in the availability and delivery of health services at the global, national, and local levels must be substantially reduced if we are to end HIV and other current epidemics and successfully defend against future epidemics.
- Progress on HIV prevention has been slower than progress on HIV treatment. Strengthened combination strategies will be required to achieve prevention targets.

3. The Global Fund, Fighting Pandemics and Building a Healthier and More Equitable World, https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf.

- Social drivers, especially stigma, continue to be significant barriers to the effective delivery of HIV prevention and treatment services. Actions and programmes to reduce stigma must be strengthened.
- Service delivery is most effective if guided by country-level planning with significant community-level participation.
- Different demographic groups and vulnerable populations have different needs and require different approaches to ensure that no one is left behind.



From *The Global Fund, Fighting Pandemics and Building a Healthier and More Equitable World*, under Creative Commons Attribution 3.0 Unported License. (https://creativecommons.org/licenses/by/3.0/)

Faith Sector Contributions

The UNAIDS, PEPFAR, and Global Fund strategy documents all emphasize the importance of the faith sector in their strategies. In particular, there are three areas in which faith sector contributions are especially important:

Integration of faith communities into the public health system. At the local level, faith communities can be significant partners in providing HIV health services both to their members and to the broader community. These services can include guidance about preventing HIV transmission, promoting HIV voluntary testing and counselling, supporting people living with HIV and directly providing treatment services that are not otherwise available. At the national level, faith communities and interfaith coalitions must be integral partners in planning, implementing, and monitoring national HIV programmes.

Reduction of stigma, discrimination, and inequalities in HIV services and outcomes. There are severe inequalities in health care delivery globally, regionally, and nationally. Concerning HIV services and outcomes, the inequalities are exacerbated by stigma and discrimination. Faith actors at all levels must continue to be strong advocates for reducing these inequalities and for ensuring that all people have access to HIV services, particularly adolescent girls and young women, children, and key populations that are marginalized and vulnerable.

Reliance on data and evidence to guide HIV programmes and interventions. Local faith communities and faith-based hospitals and clinics can help track progress in the HIV response by gathering HIV informa-

tion about their members and clients, as well as data about interventions that they are using. National faith communities and interfaith coalitions can be instrumental in collecting, organizing, and analysing the data to guide national HIV programmes to support scientific research and to ensure transparency and accountability.

Different faith actors have different roles to play in these three areas.[1] Some of these roles involve advocacy, others involve implementation, and several involve capacity building.[2]

Faith Sector Advocacy

Advocacy has always played an important role for the entire faith sector response to HIV. Advocacy remains an important role. It comes in many forms, including activism, lobbying, and exercising political influence. In support of the Global AIDS Strategy, different faith actors may emphasize different aspects of advocacy.

Local Faith Communities

At the community level, reducing stigma is obviously an important element in providing HIV education and services to faith community members, as well as reaching out to marginalized and key populations. In addition, local faith leaders can use their community influence to raise awareness about HIV and health inequalities, as well as social drivers such as gender-based violence.

Faith-Based Hospitals and Clinics

At the community level, it is very important for faith-based hospitals and clinics to ensure that their HIV prevention and treatment services are available to all who need them—including marginalized and key populations—free of stigma and discrimination. In addition, faith-based hospitals and clinics can be instrumental in finding ways to deliver services in the context of punitive laws and policies.

1. For descriptions of the different faith sector actors, see Appendix 1.

2. For a more detailed analysis for each actor in the faith sector, for each of the three strategy documents, see Appendices 2, 3, and 4.

National Faith Communities and Interfaith Coalitions

At the national level, advocacy by faith communities and interfaith coalitions is especially important in raising awareness, reducing inequalities in health services, mobilizing sustainable funding for the HIV response, and arguing for the elimination of punitive laws and policies.

Faith-Based Relief and Development Organizations

Faith-based organizations can be strong advocates in regions where they operate and can be strong voices on the international level.

International Faith Communities and Interfaith Coalitions

At the international level, advocacy by faith communities and interfaith coalitions is especially important in mobilizing sustainable funding for the HIV response, holding global institutions accountable for their commitments, reducing global inequalities in public health systems, and demanding human rights for all—including marginalized and key populations. It is also crucial for international faith institutions to promote "following the science" in strengthening the HIV response by other actors in the faith sector.

Prominent Religious Leaders

Advocacy by prominent religious leaders, especially at the national and international levels, is vital in raising awareness, challenging stigma, reducing inequalities in health services, arguing for the elimination of punitive laws and policies, and ensuring that HIV remains a priority in global development on the health and financing agenda.

Faith Sector Implementation

Faith communities have been on the front lines since the beginning of the AIDS epidemic, providing care and support before there were viable treatments. Faith communities must continue to be on the front lines in implementing elements of the Global AIDS Strategy, with different faith actors playing different roles.

Local Faith Communities can contribute by:

- Ensuring the health of their members, including guidance about HIV prevention, holistic support for members living with HIV, and direct provision of HIV services when appropriate, as well as addressing social issues such as gender-based violence
- Reducing stigma toward marginalized and vulnerable populations, both directly by reducing the stigmatizing attitudes of their members and indirectly through their influence in the wider community
- Collaborating actively with other community organizations and groups to ensure a coordinated community-level response to HIV
- Helping to track progress by gathering data about the health status of their members and about the HIV interventions they have adopted

Faith-based Hospitals and Clinics can contribute by:

- Ensuring that their HIV services are grounded in scientific evidence and reflective of good practices without stigma, discrimination, or risk of criminal prosecution
- Helping to track progress by gathering data about the health status of their clients and about the HIV interventions they have adopted

National Faith Communities can contribute by:

- Participating in the planning, implementation, and monitoring of national HIV strategies, ideally working with other faith actors through national interfaith coalitions
- Building the capacity of their affiliated local faith communities and hospitals, and clinics
- Collecting and analyzing data from affiliated local faith communities and hospitals and clinics

National Interfaith Coalitions can contribute by:

- Coordinating faith-based activities in the planning, implementation, and monitoring of national HIV strategies
- Ensuring that data are gathered and analyzed consistently across different faith-oriented organizations and faith traditions

Faith Sector Good Practices

Through years of experience, actors in the faith sector have developed a strong understanding of what HIV interventions are essential and effective. It is strategically important to articulate these good practices and to ensure widespread adoption, particularly by local faith communities and faith-based hospitals and clinics.

Good practices for **local faith communities** address many contributions to the Global AIDS Strategy,[3] including (a) providing care and support for members and their families; (b) providing information and guidance about prevention; (c) engaging with marginalized and key populations; (d) eliminating HIV-related stigma; and (e) reducing gender-based violence.

Good practices for **faith-based hospitals and clinics** address many contributions to the Global AIDS Strategy, including (a) providing access to HIV prevention and treatment services to all; (b) following scientific and medical evidence for services; (c) eliminating stigma or discrimination when providing services; (d) providing holistic services, addressing medical, psychological, social, and spiritual needs; and (e) providing HIV services in the context of legal and policy barriers.

Many local faith communities, hospitals, and clinics already do these activities well; many more must adopt good practices if we are to end HIV and AIDS as a public health threat by 2030.

Other faith actors have different roles to play in articulating and promoting good practices.

International interfaith coalitions, in consultation with other international institutions, have a leadership role to play in articulating interfaith good practices.

National interfaith coalitions are well positioned to adapt good practices to local contexts, including language, culture, and legal or policy barriers.

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3. A list of recommended practices for local faith communities based on training materials and case studies is available in David Barstow, Gracia Violeta Ross, and Manoj Kurian, *Recommended Practices to Combat HIV-Related Stigma: A Guidebook for Local Faith Communities* (Geneva: WCC, 2023) https://www.oikoumene.org/resources/publications/recommended-practices-to-combat-hiv-related-stigma.

International faith communities have several roles to play, including (a) adapting the interfaith good practices to their respective faith traditions; (b) providing resources, such as training materials and theological reflections, for their affiliated local faith communities; (c) providing resources, such as policy guidelines, for their affiliated hospitals and clinics.

National faith communities are in the best position to ensure the widespread adoption of good practices by (a) adapting good practices to their local contexts, including language, culture and legal or policy barriers; (b) organizing and operating training programmes for national and local religious leaders; (c) tracking progress in the adoption of good practices by affiliated local faith communities, hospitals, and clinics.

Faith-based relief and development organizations can also be instrumental in building the capacity of religious leaders as well as of faith-based hospitals and clinics.

Faith Sector Targets

The Global AIDS Strategy identifies several quantitative targets to achieve by 2025. These include 95-95-95 on the treatment cascade and several 10% targets related to social drivers like stigma. In addition, the strategy includes a 30-80-60 target for community involvement: communities will deliver 30% of testing and treatment services, 80% of prevention services, and 60% of programmes related to social drivers.

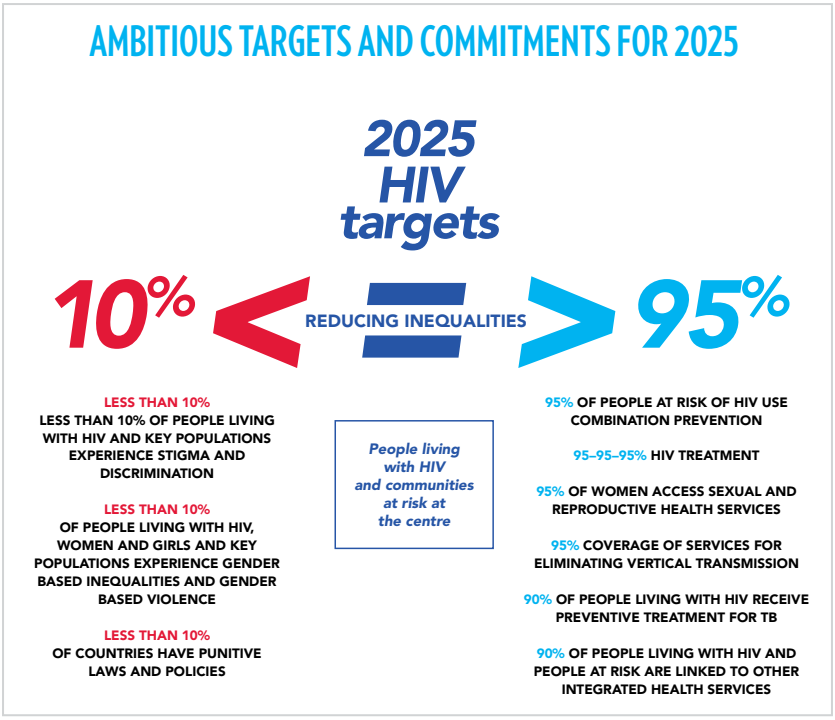
Similarly, the faith sector could also set ambitious targets for its contributions. The global targets should be set by international faith communities and interfaith coalitions in consultation with UNAIDS. Corresponding national targets should be set by national interfaith coalitions in collaboration with other national HIV actors to reflect local and national conditions. The targets should be primarily related to the contributions of faith actors, incorporating the Global AIDS Strategy targets where appropriate.

For example, targets for the faith sector might include:

People who actively participate in faith communities meet or exceed the HIV epidemiological targets for the general population. The epidemiological targets involve both prevention and treatment services and would incorporate several of the 95% targets in the Global AIDS Strategy as well as some of the 10% targets.

In regions of high HIV prevalence, more than half of the local faith communities have adopted stigma-reduction good practices. With limited scientific analysis, it is not possible to say whether "more than half" is the right target, but the target must be high enough to have a statistically significant effect on stigma in the entire community beyond the walls of the local faith communities.

All faith-based HIV prevention and treatment centres provide services grounded in scientific evidence and reflective of good practices without stigma, discrimination, or risk of criminal prosecution. This may be a high



From *UNAIDS, End Inequalities. End AIDS. Global AIDS Strategy 2021–2026.* Used with permission.

bar to reach, but if the world is to end HIV and AIDS as public health threats by 2030, we must come close to this target.

Local communities have many significant differences, so it is not realistic to establish targets for the contribution of local faith communities to the Global AIDS Strategy 30-80-60 community involvement targets. However, if the faith sector makes substantial progress toward the three targets listed above, there will certainly also be significant contributions to the targets related to community involvement.

As targets are established, it will be essential to develop monitoring and evaluation mechanisms to track progress toward achieving them, as well as progress on adopting good practices and capacity-building initiatives. The mechanisms are best developed at the international level to ensure consistency but will require implementation at national and local levels.

Next Steps

Several focused near-term initiatives will strengthen future contributions of the faith sector to the Global AIDS Strategy:

Integrating national interfaith coalitions into the planning, implementing, and monitoring of more national HIV programmes. In some countries, the faith sector is already well integrated into national HIV programmes. In other countries, the integration of the faith sector is still relatively weak. National interfaith coalitions, working with national faith communities, are best positioned to take the lead in achieving greater integration.

Articulation of HIV good practices for local faith communities and faith-based hospitals and clinics. Local faith communities, as well as faith-based hospitals and clinics, have critical contributions to make in implementing several elements of the Global AIDS Strategy. The contributions of local faith communities, as well as faith-based hospitals and clinics, would be greatly facilitated by a consensus set of good practices. These good practices should be developed and endorsed by a broad range of religious traditions in collaboration with secular partners in the HIV response, including networks of people living with HIV and populations at greater risk of HIV. International interfaith coalitions are best positioned to take the lead in articulating good practices.

Development of a monitoring and evaluation framework for faith-based HIV initiatives. Future contributions of the faith sector to the Global AIDS Strategy depend critically on gathering and analysing objective data. A monitoring and evaluation framework for faith-based initiatives would (a) be convenient for use by faith-based organizations; (b) clarify the impact in medical, social, and spiritual terms; (c) provide reliable data to guide future faith-based initiatives; and (d) support independent validation of epidemic impact by

third parties. International interfaith coalitions are best positioned to take the lead in developing a monitoring and evaluation framework in collaboration with organizations like UNAIDS, PEPFAR, and the Global Fund, as well as to identify specific targets for contributions by the faith sector.

Strengthened HIV advocacy at the international and national levels. International advocacy is vital to ensure the global HIV response is re-invigorated in the aftermath of the COVID-19 pandemic. National advocacy is especially important to eliminate laws and policies that are barriers to universal access to HIV prevention and treatment services.

A Role for the World Council of Churches

The World Council of Churches, together with its member churches, has long been a major leader and partner in the faith response to AIDS and HIV. The WCC is well positioned to continue and strengthen that role in support of the Global AIDS Strategy described by UNAIDS, PEPFAR and the Global Fund.

In particular, we suggest that the World Council of Churches, as a prominent international faith coalition, undertake the following actions through its HIV programme and the newly created Commission of the Churches on Health and Healing:

- Articulate and recommend HIV good practices for local faith communities and faith-based hospitals and clinics and develop training materials, as well as other resources to support the adoption of these practices
- Establish overall targets for the health status of congregation members and the adoption of good practices by local congregations, hospitals, and clinics. Develop mechanisms for monitoring, evaluation, and tracking progress toward the targets.
- Develop technical partnerships to support the faith-based elements of international HIV organizations, such as UNAIDS, PEPFAR, and the Global Fund
- Advocate for sustainable resources for the HIV response and the reduction of health system inequalities at the global and regional levels

These WCC actions should be undertaken in partnership with people living with HIV and with at-risk and marginalized populations and in collaboration with other international interfaith coalitions.

At the international level, we recommend that **WCC member churches** undertake the following actions:

- Adapt HIV good practices to different religious traditions
- Establish targets for the health status of members and the adoption of HIV good practices by affiliated local congregations, hospitals, and clinics. Implement mechanisms for monitoring, evaluation, and tracking of progress toward the targets
- Develop technical partnerships to support international HIV organizations, such as UNAIDS, PEPFAR, and the Global Fund

At the national level, we suggest that **WCC member churches** undertake the following actions:

- Work closely with governmental agencies and secular organizations on the development and implementation of national HIV plans and the integration of faith-based health services into National Health Service delivery systems
- Work closely with national interfaith coalitions and other faith actors to coordinate HIV activities and to ensure as much interfaith consistency as possible
- Adapt HIV good practices, training materials, and other resources to different languages, cultures, and legal contexts
- Build the capacity of local congregations, hospitals, and clinics through training programmes aimed at the adoption of HIV good practices
- Implement mechanisms for the promotion of health among the congregation members, including the psychological, social, and spiritual dimensions of health
- Establish targets for the implementation of HIV good practices by affiliated local congregations, hospitals, and clinics and implement mechanisms for monitoring, evaluation, and tracking of progress toward the targets
- Advocate for the repeal of punitive laws and policies that are barriers to effective HIV service delivery

At the local level, we suggest that **local congregations** affiliated with WCC member churches can:

- Work closely with local government agencies and other community-based initiatives to coordinate the delivery of HIV prevention and treatment services
- Adopt HIV good practices for local faith communities, including programmes to reduce stigma and address social drivers such as gender-based violence
- Monitor the health status of their members, including the psychological, social, and spiritual dimensions of health
- Provide data about the health status of members and adoption of good practices to affiliated WCC member churches

We suggest that **hospitals and clinics** affiliated with WCC member churches:

- Work closely with local government agencies and other community-based initiatives to coordinate the delivery of HIV prevention and treatment services
- Adopt HIV good practices for faith-based hospitals and clinics, including the provision of HIV services to all who need them, free of stigma, discrimination, and fear of criminal prosecution
- Provide data about the health status of church congregants and adoption of good practices to affiliated WCC member churches

The following are suggested actions for **relief and development organizations** affiliated with WCC member churches:

- Work closely with affiliated WCC member churches to help build the capacity of local congregations, hospitals, and clinics
- Work closely with national governmental and non-governmental organizations to provide HIV services in humanitarian settings

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Appendix I: Faith Sector Actors

The faith sector includes a vast range of individuals, organizations, institutions, and traditions. The diversity of these faith actors prevents a simple classification. Nonetheless, for this analysis, it is helpful to identify broad categories that play different roles in implementing the Global AIDS Strategy.

Local Faith Communities

Local faith communities include informal and formal communities that encourage and support worship and spirituality for their members. Studies have shown that, in many high-burden countries, a substantial fraction of the population regularly worships in such communities, giving organized faith communities and institutions an especially influential role.

National and International Faith Communities

National and international faith communities are the hierarchical levels of organizations that include many local faith communities. Faith communities might be organized at various levels with varying degrees of control, influence, or autonomy.

National and International Interfaith Coalitions

Interfaith coalitions bring together representatives of different religious traditions for dialogue and joint action. Different coalitions have different scope and reach, both theologically and geographically. Some interfaith coalitions were initially organized for other purposes and have adapted to include the HIV response; other coalitions have been founded more recently to address HIV and AIDS specifically.

Faith-Based Hospitals and Clinics

Hospitals and clinics are often the key providers of HIV prevention and treatment services. Many of these hospitals and clinics have a long history of affiliation with specific faith traditions and faith-based institutions. Other clinics and organized providers of HIV services have come into being more recently by people with a strong faith motivation.

Faith-Based Relief and Development Organizations

Faith-based organizations are defined as faith-influenced non-governmental organizations. They are often structured around development and/or relief service delivery programmes and are sometimes run simultaneously at the national, regional, and international levels.

Prominent Religious Leaders

Some religious leaders have gained public prominence; therefore, their advocacy and pronouncements have significant influence beyond their local context.

Appendix II: UNAIDS Global AIDS Strategy Priorities

The UNAIDS *End Inequalities. End AIDS. Global AIDS Strategy 2021–2026* described on page 8 identifies three strategic priorities, each with associated result areas (RA) and five cross-cutting issues. Different faith actors have different roles to play in these priorities and result areas.

Strategic Priority 1: Maximize equitable and equal access to HIV services and solutions

RA 1 HIV prevention for key populations, adolescents, and other priority populations, including adolescents and young women and men in locations with high HIV incidence.

RA 2 Adolescents, youth and adults living with HIV—especially key and other priority populations—know their status and are immediately offered and retained in quality, integrated HIV treatment and care that optimize health and well-being.

RA 3 Tailored integrated and differentiated vertical transmission and pediatric service delivery for women and children, particularly for adolescent girls and young women in locations with high HIV incidence.

Local faith communities are vital to achieving results in all three result-areas, both through care and support for members and their families and through outreach to marginalized and key populations.

Faith-based hospitals and clinics are primary providers of HIV prevention and treatment services and must ensure that their services are available to all without stigma, discrimination, or risk of criminal prosecution.

National and international faith communities and **faith-based relief and development organizations can** be instrumental in building the capacity of their affiliated local faith communities, hospitals, and clinics to achieve results in all three result areas.

Strategic Priority 2: Break down barriers to achieving HIV outcomes

RA 4 Fully recognized, empowered, resourced, and integrated community-led HIV responses for a transformative and sustainable HIV response.

RA 5 People living with HIV, key populations, and people at risk of HIV enjoy human rights, equality, and dignity free of stigma and discrimination.

RA 6 Women and girls, men, and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality and work together to end gender-based violence and to mitigate the risk and impact of HIV.

RA 7 Young people are fully empowered and resourced to set new directions for the HIV response and unlock the progress needed to end inequalities and end AIDS.

Local faith communities and **faith-based hospitals and clinics** can help achieve RA4 by ensuring they are fully integrated into the HIV response of the communities where they are located.

Local faith communities can play a significant role in achieving RA5 and RA6 through outreach to marginalized and key populations and through their influence on the attitudes of their members, which indirectly influence the attitudes of the broader society. Local faith communities can also play a significant role in achieving RA7 by empowering their young people through developing their leadership skills.

National and international faith communities and **faith-based relief and development organizations** can be instrumental in building the capacity of their affiliated local faith communities to achieve results in all four result-areas.

All faith actors, especially **national and international faith communities**, **national and international interfaith coalitions** and **prominent religious leaders**, can play vital advocacy roles to help achieve RA5, RA6 and RA7.

Strategic Priority 3: Fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings and pandemic responses

RA 8 A fully funded and efficient HIV response implemented to achieve the 2025 targets.

RA 9 Systems for health and social protection schemes that support wellness, livelihood, and enabling environments for people living with, at risk of, or affected by HIV to reduce inequalities and allow them to live and thrive.

RA 10 A fully prepared and resilient HIV response that protects people living with, at risk of, and affected by HIV in humanitarian settings and from the adverse impacts of current and future pandemics and other shocks.

National and international faith communities and **faith-based relief and development** organizations **can** help achieve RA8 by providing resources to their affiliated local faith communities, hospitals, and clinics.

Local and national faith communities and **faith-based hospitals and clinics** can be integral parts of the systems envisioned in RA9, especially by emphasizing a holistic approach to health, including medical, psychological, social, and spiritual components.

International faith communities and **faith-based relief and development organizations** often play a central role in providing assistance in the humanitarian settings identified in RA10.

International interfaith coalitions and **prominent religious leaders** can play an important advocacy role in all three-result areas.

Cross-Cutting Issue 1: Leadership, country ownership, and advocacy

Leaders at all levels must renew political commitment to ensure sustained engagement with and catalyse action from key and diverse stakeholders.

National faith communities and **interfaith coalitions** should be important partners in planning and implementing national HIV programmes and, along with **prominent religious leaders**, must be important advocates for reducing inequalities in health care services, including those related to HIV and AIDS.

Cross-Cutting Issue 2: Partnerships, multisectorality, and collaboration

Partners at all levels must align strategic processes and enhance strategic collaboration to fully leverage and synergize the contributions to ending AIDS.

As noted in the Global AIDS Strategy, **local faith communities** have unique contributions to make, especially in providing "services and support beyond the reach of many conventional services and systems." Close collaboration among local faith communities, as well as with **faith-based hospitals and clinics** and secular community organizations, will be essential. **National faith communities** and **interfaith coalitions** can be instrumental in facilitating these partnerships.

Cross-Cutting Issue 3: Data, science, research, and innovation

Data, science, research, and innovation are important across all areas of the strategy to inform, guide and reduce HIV-related inequalities and accelerate the development.

Local faith communities and **faith-based hospitals and clinics** can be vital sources of data and information about the HIV response, including gathering health data about their members and clients and providing information that will support research about the effectiveness of faith-based interventions. **National faith communities** and **interfaith coalitions** play a crucial role in collecting and organizing the data at a national level in a consistent fashion. **Faith-based relief and development organizations** are also well-positioned to gather and analyze data about their HIV initiatives.

Cross-Cutting Issue 4: Human rights, gender equality and reduction of stigma and discrimination

> **Human rights and gender inequality barriers that slow progress in the HIV response and leave key populations and priority populations behind must be addressed and overcome.**

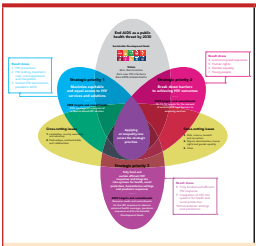
At all levels, faith actors can play substantial roles in advocacy concerning stigma, discrimination, human rights, and gender inequality. In particular, **local faith communities** can use their influence to reduce stigmatizing attitudes among their members, thereby indirectly reducing stigma in society as a whole. **Faith-based hospitals and clinics** must ensure that their services are grounded in scientific evidence and reflective of good practices without stigma, discrimination, or risk of criminal prosecution.

Cross-Cutting Issue 5: Cities, urbanization, and human settlements

> **Cities and human settlements as centres for economic growth, education, innovation, positive social change, and sustainable development to close programmatic gaps in the HIV response.**

Local faith communities are present and influential in all cities and human settlements, with the potential for significant influence on complex human interactions, especially education and positive social change.

This analysis is summarized in the chart below.

	Local Faith Communities	National Faith Communities	International Faith Communities	National Interfaith Coalitions	International Interfaith Coalition	Faith-Based Hospitals and Clinics	FB RelFBf and Development Orgs	Prominent Religious Leaders
Priority 1: Maximize equitable and equal access to HIV services and solutions								
RA1	I	C	C			I	C	
RA2	I	C	C			I	C	
RA3	I	C	C			I	C	
Priority 2: Break down barriers to achieving HIV outcomes								
RA4	I	C	C			I	C	
RA5	I	C, A	C, A	A	A		C	A
RA6	I	C, A	C, A	A	A		C	A
RA7	I	C, A	C, A	A	A		C	A
Priority 3: Fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings, and pandemic responses								
RA8		I	I		A			A
RA9	I	I			A	I		A
RA10			I		A		I	A
Cross-Cutting Issue 1: Leadership, country ownership and advocacy								
		I, A		I, A				A
Cross-Cutting Issue 2: Partnerships, multisectorality, and collaboration								
	I			I		I	I	
Cross-Cutting Issue 3: Data, science, research, and innovation								
	I	I		I		I	I	
Cross-Cutting Issue 4: Human rights, gender equality, and reduction of stigma and discrimination								
	I, A	A	A	A	A	I	A	A
Cross-Cutting Issue 5: Cities, urbanization, and human settlements								
	A						I	A

I = Implementation, C = Capacity Building, A = Advocacy

Appendix III: PEPFAR Strategic Pillars and Enablers

The PEPFAR five year strategy described on page 9, *Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030*, identifies five strategic pillars, each with associated focus areas and three strategic enablers. Different faith actors have different roles to play in these priorities, focus areas (FA), and enablers.

Strategic Pillar 1: Health Equity for Priority Populations

FA1 Advancing gender-equitable programming

FA2 Launching a youth-focused movement to prevent HIV acquisition for the next generation

FA3 Leading the global movement to end AIDS in children

FA4 Transforming key population service delivery through key population leadership

FA5 Doubling down on a holistic combination prevention approach

FA6 Dismantling structural barriers to HIV/AIDS care

Local faith communities are vital to achieving results in FA1, FA2, FA3, and FA5 through care and support for members and their families and in FA4 through outreach to marginalized and key populations.

Faith-based hospitals and clinics are primary providers of HIV prevention and treatment services and must ensure that their services are available to all without stigma, discrimination, or risk of criminal prosecution, especially in FA4 and FA5.

National and **international faith communities** and **faith-based relief and development organisations** can be instrumental in building the capacity of their affiliated local faith communities, hospitals, and clinics to achieve results in all focus areas.

All faith actors—especially **national** and **international faith communities**, **national** and **international interfaith coalitions,** and **prominent religious leaders**—can play vital advocacy roles in all focus areas, particularly FA3, FA4, and FA6.

Strategic Pillar 2: Sustaining the Response

FA1 Developing a country-led sustainability roadmap

FA2 Accelerating integration

FA3 Sustaining impact through local and regional organization implementation

FA4 Engaging in integrated national planning

Faith-based hospitals and clinics are already key actors in delivering HIV services, and **local faith communities** must become key actors to help, especially in areas where the public health infrastructure is weak (FA2 and FA3).

National faith communities and **interfaith coalitions** must be closely involved in activities at the national level in FA1, FA2 and FA4.

Strategic Pillar 3: Public Health Systems and Security

FA1 Strengthening national public health institutions

FA2 Strengthening the health workforce

FA3 Catalyzing regional manufacturing

FA4 Modernizing the downstream supply chain

FA5 Improving patient-centred care for PLHIV

FA6 Strengthening pandemic preparedness and response capabilities

By becoming first-line service providers to their members, **local faith communities** can "bring medicine to the clients" (FA4) and provide improved patient-centred care (FA5). In addition, local faith communities can be vital communication channels to support FA6.

National faith communities can contribute directly to FA1 by coordinating the activities of their affiliated local faith communities. They can be instrumental in raising the capacity of their local faith communities for FA2, FA4, and FA5.

Strategic Pillar 4: Transformative Partnerships

FA1 Elevating the role of regional institutions

FA2 Activating philanthropic partnerships

FA3 Integrating the private sector across the supply chain

FA4 Collaborating with USA institutions

Regional **international faith communities** and **interfaith coalitions,** as well as **faith-based relief and development organizations,** have long been and will continue to be active partners in the response to HIV and AIDS (FA1).

Strategic Pillar 5: Follow the Science

FA1 Mainstreaming behavioural and social science into HIV programming

FA2 Leveraging targeted implementation science for programme improvement

FA3 Developing and deploying the next-generation surveillance methods

Local faith communities significantly influence the attitudes and behaviours of their members and even the wider community. Therefore, they are well-positioned to help local behavioural and social science initiatives in FA1. Local faith communities can also be instrumental in gathering health data about their members (FA3).

National and **international faith communities** can support FA1 by emphasizing the importance of following science as they develop and implement their HIV strategies.

Faith-based hospitals and clinics can also be instrumental in gathering health data about their clients (FA3).

National faith communities and **interfaith coalitions** can play a central role in FA3 by gathering and organizing data from affiliated local faith communities and faith-based hospitals and clinics (FA3).

Strategic Enabler 1: Community Leadership

FA1 Increasing role for community leadership within PEPFAR

FA2 Sustaining community leadership in partner government programmes

FA3 Elevating the next generation of community leadership

As noted in PEPFAR's strategy document, **local faith communities** and **faith-based hospitals and clinics** are central to achieving sustainable results in FA1. They can support FA2 and FA3 through active partnerships with other community organizations and leaders.

National faith communities and interfaith **coalitions** must be active partners in the planning and execution of government programmes (FA2).

Local faith communities, as well as **national faith communities**, can be instrumental in raising the next generation of community leaders (FA3).

All the faith actors, especially **national faith communities**, **national interfaith coalitions,** and **prominent religious leaders**, can play vital advocacy roles in all focus areas, especially FA1 at the local level and FA3 at the national level.

Strategic Enabler 2: Innovation

FA1 Accelerating country-led innovation

FA2 Proactive market shaping for new product introductions

FA3 Leveraging innovative finance models to drive programming scale

National faith communities and **interfaith coalitions** can be instrumental in identifying innovative ways to capitalize on the unique reach, resources, and positions of trust of **local faith communities** and **faith-based hospitals and clinics** within their communities (FA1).

Local faith communities and **faith-based hospitals and clinics** can also be instrumental in facilitating the adoption of scientific and medical innovations, especially by shaping the attitudes of their members and clients (FA2).

Strategic Enabler 3: Data

FA1 Collecting and using "smart data"

FA2 Accelerating data integration at country level

FA3 Setting the pathway to 2030

Local faith communities can play a central role in gathering data about the health of their members, just as **faith-based hospitals and clinics** collect health data about their clients (FA1). In addition, it would be valuable for both to gather data about the implementation and effectiveness of good practices.

National faith communities and **national interfaith coalitions** will play vital roles in integrating data from their local affiliates and providing data to other entities at the national level (FA2).

National and **international faith communities** could set specific targets for their faith traditions, such as targets for the health conditions of their members, including the HIV treatment cascade, as well as the adoption of good practices by affiliated **local faith communities** and **faith-based hospitals and clinics** (F3).

This analysis is summarized in the chart below.

	Local Faith Communities	National Faith Communities	International Faith Communities	National Interfaith Coalitions	International Interfaith Coalition	Faith-Based Hospitals and Clinics	FB RelieFBand Development Orgs	Prominent Religious Leaders
Pillar 1: Health equity for priority populations								
FA1	I	C	C				C	
FA2	I	C	C				C	
FA3	I	C, A	C, A	A	A		C	A
FA4	I	C, A	C, A	A	A	I	C	A
FA5	I	C	C			I	C	
FA6		A	A	A	A			A
Pillar 2: Sustaining the response								
FA1		I		I				
FA2	I					I		
FA3	I	I		I		I		
FA4		I		I				
Pillar 3: Public health systems and security								
FA1		I		I				
FA2		C		C				
FA3								
FA4	I	C		C				
FA5	I	C		C				
FA6	I							
Pillar 4: Transformative partnerships								
FA1			I		I		I	
FA2								
FA3								
FA4								

Pillar 5: Follow the science								
FA1	I							
FA2								
FA3	I	I		I		I		
	Local Faith Communities	National Faith Communities	International Faith Communities	National Interfaith Coalitions	International Interfaith Coalition	Faith-Based Hospitals and Clinics	FB ReliefBand Development Orgs	Prominent Religious Leaders
Enabler 1: Community Leadership								
FA1	I					I		A
FA2		I	I					A
FA3	I	I						
Enabler 2: Innovation								
FA1	I	I		I		I		
FA2	I					I		
FA3								
Enabler 3: Data								
FA1	I					I		
FA2		I		I				
FA3		I	I					

I = Implementation, C = Capacity Building, A = Advocacy

Appendix IV: Global Fund Strategy

The Global Fund strategy for 2023–2028, *Fighting Pandemics and Building a Healthier and More Equitable World* (p. 10), describes the primary objective, four mutually reinforcing contributory objectives, and one evolving objective, each with specific sub-objectives (SO). The strategy also includes a partnership model with partnership enablers and an associated framework for monitoring and evaluation.

Primary Objective: End AIDS, TB, and Malaria

The Primary Objective includes three sub-objectives related explicitly to the HIV epidemic:

SO1 Accelerate access to and effective use of precision combination prevention with behavioural, biomedical, and structural components tailored to the needs of populations at high risk of HIV infection, especially key and vulnerable populations

SO2 Provide quality, people-centred diagnosis, treatment, and care, to improve well-being for people living with HIV, prevent premature mortality, and eliminate HIV transmission

SO3 Advocate for and promote legislative, practice, programme and policy changes to reduce HIV-related stigma, discrimination, criminalization, and other barriers and inequities, and uphold the rights of people living with HIV and key and vulnerable populations.

Local faith communities are vital to achieving results in SO1 and SO2 through HIV prevention guidance as well as care and support for members and their families. In SO3, through programmes to reduce stigmatizing attitudes among their members.

Faith-based hospitals and clinics are primary providers of HIV prevention and treatment services (SO1 and SO2) and must ensure that their services are available to all without stigma, discrimination, or risk of criminal prosecution (SO3)

National and international faith communities and **faith-based relief and development organizations** can be instrumental in building the capacity of their affiliated local faith communities, hospitals, and clinics to achieve results in all sub-objectives.

All faith actors, especially **national** and **international faith communities**, **national** and **international interfaith coalitions,** and **prominent religious leaders**, can play vital advocacy roles in support of SO3.

Contributory Objective 1: Maximizing People-centred Integrated Systems for Health to Deliver Impact, Resilience and Sustainability

SO1 Deliver integrated, people-centred, quality services

SO2 Strengthen and reinforce community systems and community-led programming integrated within national health and social systems

SO3 Strengthen generation and use of quality, timely, transparent, and disaggregated digital and secure data at all levels, aligned with human rights principles

SO4 Strengthen the ecosystem of quality supply chains to improve the end-to-end management of national health products and laboratory services

SO5 NextGen market shaping focus on equitable access to quality health products through innovation, partnership, and promoting sustainable sourcing and supply chains at global, national, and community levels

SO6 As part of Global Fund efforts to strengthen country oversight of the overall health system, better engage and harness the private sector to improve the scale, quality, and affordability of services wherever patients seek them.

SO7 Deepen partnerships between government and nonpublic sector actors to enhance sustainability, transition-readiness, and reach of services, including through social contracting

Local faith communities can be strong partners in achieving results in SO1 and SO2 through holistic care and support for members and their families. In SO3, by gathering health data about their members and by ensuring the confidentiality of the data.

Faith-based hospitals and clinics must ensure that HIV programmes provide people-centred quality HIV prevention and treatment services (SO1) and can support SO3 by gathering and providing data about their service delivery and by ensuring the confidentiality of the data.

National and international faith communities and **faith-based relief and development organisations** can be instrumental in building the capacity of their affiliated local faith communities, hospitals, and clinics to achieve results in all SO1, SO2, and SO3.

National faith communities and **interfaith coalitions** are critical partners in integrating faith-oriented HIV service delivery into national health care delivery systems (SO2, SO6, SO7) and in aggregating data from local faith communities, hospitals, and clinics (SO3).

Contributory Objective 2: Maximizing the Engagement and Leadership of Most Affected Communities to Leave No One Behind

SO1 Accelerate the evolution of Country-Coordinating Mechanisms (CCMs) and community-led platforms to strengthen inclusive decision-making, oversight, and evaluation through Global Fund-related processes

SO2 Evolve Global Fund business processes, guidelines, tools, and practices to support community-led organizations to deliver services and oversight and to be engaged as providers of technical expertise

SO3 Support community- and civil society-led advocacy to reinforce the prioritization of health investments and drive toward Universal Health Care

SO4 Expand partnerships with communities living with and affected by emerging and related health areas to support more inclusive, responsive, and effective systems for health

National faith communities and interfaith coalitions must be strong partners in Global Fund CCMs (SO1).

International faith communities, international interfaith coalitions, and **faith-based relief and development organizations** can be key partners in the evolution of Global Fund business processes (SO2). They can do this, particularly through technical expertise, guidance, and capacity building in the implementation, monitoring and evaluation of HIV programmes by **national interfaith coalitions**, **national faith communities**, **local faith communities,** and **faith-based hospitals and clinics**.

All the faith actors, especially **national faith communities**, **national interfaith coalitions**, and **prominent religious leaders**, can play vital advocacy roles in supporting SO3.

Contributory Objective 3: Maximizing Health Equity, Gender Equality and Human Rights

SO1 Scale up comprehensive programmes and approaches to remove human rights and gender-related barriers across the portfolio

SO2 Support comprehensive sexual, reproductive health, and rights programmes and their strengthened integration with HIV services for women in all their diversity and their partners

SO3 Advance youth-responsive programming, including for adolescent girls and young women and young key and vulnerable populations and their partners

SO4 Deploy quantitative and qualitative data to identify drivers of HIV, tuberculosis, and malaria inequity and inform targeted responses, including by gender, age, geography, income, and for key and vulnerable populations

SO5 Leverage the Global Fund's diplomatic voice to challenge laws, policies and practices that limit the impact on HIV, tuberculosis, and malaria

Local faith communities can support SO3 through HIV services for their members—with particular attention to the needs of adolescent girls and young women—and reach out to marginalized populations.

National and international interfaith coalitions could support SO4 by helping to identify correlations between aggregated data about faith-based stigma reduction programmes and reductions of stigmatizing attitudes in the general population.

All the faith actors, especially **national faith communities**, **national interfaith coalitions,** and **prominent religious leaders**, can play vital advocacy roles in supporting SO1, SO2, SO3 and SO5.

Contributory Objective 4: Mobilizing Increased Resources

SO1 Increase international financial and programmatic resources for health from current and new public and private sources

SO2 Catalyze domestic resource mobilization for health to meet the urgent health needs of Sustainable Development Goal (SDG) 3

SO3 Strengthen focus on value-for-money to enhance economy, efficiency, effectiveness, equity, and sustainability of Global Fund-supported country programmes and systems for health

SO4 Leverage blended finance and debt swaps to translate unprecedented levels of debt and borrowing into tangible health outcomes

Faith-based relief and development organizations can be key partners in helping to increase financial and programmatic resources for health (SO1).

Evolving Objective: Contribute to Pandemic Preparedness and Response

SO1 Scale up investments that build the resilience of HIV, Tuberculosis, and Malaria programmes to current and future threats

SO2 Build front-line capacity for detection and rapid response to epidemics and pandemics at facility and community levels

SO3 Scale-up and integration of community systems capacity for detection and response

SO4 Strengthen disease surveillance systems, including the use of real-time digital data and detection capacity

SO5 Strengthen laboratory systems, supply chains, and diagnostic capacity to meet HIV, tuberculosis, and malaria programme demand and respond to outbreaks

SO6 Address the threat of drug and insecticide resistance and encouraging climate and environmentally sensitive and One Health approaches

SO7 Leverage the Global Fund's platform to build solidarity for equitable, gender-responsive, and human rights-based approaches

SO8 Champion community and civil society leadership and participation in pandemic preparedness and response planning, decision-making, and oversight

Because of their widespread reach, **local faith communities** can play a significant front-line role in detecting and responding rapidly to epidemics at community levels (SO2, SO3).

Like all health service providers, **faith-based hospitals and clinics** can also play an important role in detection and rapid response (SO2, SO3).

National faith communities and **interfaith coalitions** can support SO2 and SO3 through coordination and capacity-building for affiliated local faith communities and faith-based hospitals and clinics.

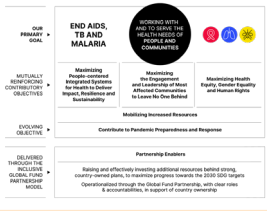
Partnership Model and Enablers

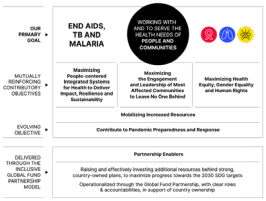
The Global Fund Strategy emphasizes country ownership of HIV, tuberculosis, and malaria policies and programmes implemented through Country Coordinating Mechanisms (CCM). The Global Fund partnership model includes specific roles and accountability for different types of partners. Within this partnership model, different faith actors have several key roles to play.

National faith communities and **interfaith coalitions** must actively participate in Global Fund Country Coordination Mechanisms, including policy and decision-making, as well as implementation, monitoring, and evaluation of HIV programmes in **local faith communities** and **faith-based hospitals and clinics**.

International faith communities, international interfaith coalitions, and **faith-based relief and development organizations** can be vital technical partners, particularly through expertise, guidance, and capacity building to support **national interfaith coalitions**, **national faith communities**, **local faith communities** and **faith-based hospitals and clinics**.

This analysis is summarized in the chart below.

	Local Faith Communities	National Faith Communities	International Faith Communities	National Interfaith Coalitions	International Interfaith Coalition	Faith-Based Hospitals and Clinics	FB Relief and FBvelopment Orgs	Prominent Religious Leaders
Primary Objective: End AIDS, TB and Malaria								
SO1	I	C	C			I	C	
SO2	I	C	C				C	
SO3	I	C, A	C, A	A	A	I	C	A
Contributory Objective 1: Maximizing People-centered Integrated Systems								
SO1	I	I, C	C			I	C	
SO2	I	I, C	I, C	I			C	
SO3	I	I, C	I, C	I		I	C	
SO4								
SO5								
SO6			I	I				
SO7			I	I				
Contributory Objective 2: Maximizing the Engagement and Leadership of Most Affected Communities to Leave No One Behind								
SO1			I		I		I	
SO2			I, C		I, C		I	
SO3		A		A				A
SO4								

Contributory Objective 3: Maximizing Health Equity, Gender Equality and Human Rights								
SO1		A	A					A
SO2		A	A					A
SO3	I	A	A					A
SO4			I		I			
SO5		A	A					A
Contributory Objective 4: Mobilizing Increased Resources								
SO1							I	
SO2								
SO3								
SO4								
	Local Faith Communities	National Faith Communities	International Faith Communities	National Interfaith Coalitions	International Interfaith Coalition	Faith-Based Hospitals and Clinics	FB Relief and Development Orgs	Prominent Religious Leaders
Evolving Objective: Contribute to Pandemic Preparedness and Response								
SO1								
SO2	I	I, C		I, C		I		
SO3	I	I, C		I, C		I		
SO4								
SO5								
SO6								
SO7								
SO8								
Partnership Model and Enablers								
Country Coordinating Mechanisms		I		I				
Monitoring and Evaluation		I		I				
Technical Partners			I, C		I, C	I, C		

I = Implementation, C = Capacity Building, A = Advocacy

The HIV epidemic continues to present a challenge for today's world. The engagement and action of faith communities, in coordination with other actors, are crucial if we want to realize the goal of ending AIDS as a public health threat by 2030.

How can the faith communities have sound and relevant responses to the current challenges of HIV? In *Faith Sector Implementation of the Global AIDS Strategy,* the authors summarize three global strategies on HIV and provide examples of interventions and actions for faith communities.

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Religion/Health/HIV

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