COMPENDIUM OF PROMISING PRACTICES

of African Faith Community Interventions Against Paediatric and Adolescent HIV

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FOREWORD

TO THE COMPENDIUM OF PROMISING PRACTICES OF AFRICAN FAITH COMMUNITY INTERVENTIONS AGAINST PAEDIATRIC AND ADOLESCENT HIV

This vital report brings together essential lessons from faith communities' exceptional leadership in addressing the challenge of HIV in children. It documents evidence from the core roles that faith communities have played in identifying undiagnosed children living with HIV, improving continuity of treatment, and supporting adherence to care and treatment.
It also documents lessons from how faith leaders have driven advocacy to tackle stigma and discrimination and push for targets to be achieved. It will help faith communities, and those who support and partner with them, to advance a step change in progress towards the goal of ending AIDS in children by 2030.

It is a disgrace that the world is not on track to end AIDS in children. Every hour eleven children die of AIDS. 1.7 million children are living with HIV. Access to life-saving treatment for children living with HIV is behind that for adults. While three quarters (76%) of adults living with HIV are on treatment, only half (52%) of children are. The gap in access to treatment between children and adults has been widening. Children living with HIV are even more vulnerable than adults: while children constitute 4% of people living with HIV, they represent 15% of AIDS-related deaths. It is an inequality that is heartbreaking.

But there is hope. This fight for our children is a fight we can win. The world can ensure that no child who is living with HIV is left without treatment, and that no child is newly born with HIV. We can make sure infants, children, and adolescents at risk of HIV are tested; we can guarantee the best treatments and care for those who test positive; we can close the treatment gap for pregnant and breastfeeding mothers living with HIV. Some countries are close to reaching paediatric treatment goals and other countries have pledged to do so. We have new tools, we have new commitments from world leaders through the Global Alliance to End AIDS in Children, and we have new evidence of what works—evidence that this Compendium brings to life so powerfully.

WINNIE BYANYIMA

UNAIDS Executive Director
and UN Under-Secretary-General

JOHN N. NKENGASONG

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Most importantly, we have the unstoppable determination of communities and of Faith-Based Organizations to ensure that every mother and child gets access to the life-saving services they need. Faith communities have been central in the provision of HIV-related health care since the beginning of the AIDS pandemic, particularly in resource limited settings. Faith groups and religious leaders have strong links with communities and are vital partners in work to shift opinions, provide data-led evidence and reach the most marginalized in society who are often the most in need of lifesaving health services. They are on the ground innovating services, challenging stigma, insisting that no child is left behind. They are challenging the inequalities which drive new HIV infections and are providing vital links to people living with HIV to access life-saving services. They have shown crucial leadership time and again, in programmes developed within the UNAIDS-PEPFAR Faith Initiative including: the 10 Million Campaign, the Interfaith Health Platform, and the Rome Paediatric HIV and TB Action Plan, and have been a driving force in bringing together the Global Alliance to End AIDS in Children.
In every community, in every country, faith communities and Faith-Based Organizations are uniquely trusted, respected and listened to. Their ability influence how people understand and react to HIV is unparalleled.

As the evidence set out in this Compendium demonstrates, the work of faith communities in addressing the challenge of HIV in children has been highly effective. In that work of practical delivery, faith communities and Faith-Based Organizations have also reminded the world of a deeper lesson: to truly embrace those who are most vulnerable and excluded, caring, compassion and love are essential.

We can end AIDS in children. We must end AIDS in children. Together, we will end AIDS in children.This informative, inspiring, Compendium will be used to save and change children's lives.

CONTENTS

INTRODUCTION

The situation of children living with HIV has been described as a "heart-breaking tragedy"[1]. The paediatric targets set at the 2016 United Nations HIV High-Level Meeting on Ending AIDS were missed and well off-track. In 2021, almost half (48%) of the world's 1.7 million children aged 0–14 living with HIV were not on antiretroviral therapy (ART). Disturbingly treatment coverage among children living with HIV remains far lower than it is among adults and widened to: 52% versus 76% in 2021[2]. Consequently, almost 100 000 children died from AIDS related illnesses in 2021. The greatest paediatric treatment challenge is to rapidly find children living with HIV who were missed at birth and during breastfeeding and link them to treatment. For younger children it is still concerning that only 62% of HIV exposed infants in 2021 were tested by two months of age, yet without treatment 50% of infants with HIV will die by two years of age. There is also great need to ensure that all children living with HIV are able to access optimal child-friendly treatment.

Globally there are 1.7 million (1.2 million–2.2 million) adolescents aged 10–19 living with HIV and many more are at risk of HIV infection. Young people continue be less likely to test for HIV, to link to care in a timely way and to stay engaged in care if they test HIV positive compared with adults[3]. The rates of comprehensive HIV knowledge of adolescents remain below 50% in most countries and yet it is imperative that adolescents possess comprehensive and correct knowledge of HIV prevention in order to protect themselves from infection.

The good news is that global leaders at the 2021 United Nations General Assembly High-Level Meeting on AIDS agreed on a new set of ambitious targets and commitments for 2025 and an interim target for 2023 which have the potential

1 Global AIDS update 2021. Confronting Inequalities. Geneva: UNAIDS, 2021.
2 Global AIDS update 2022. In Danger. Geneva: UNAIDS, 2022.
3 Archary M, Pettifor A, Toska E. Adolescents and young people at the centre: global perspectives and approaches to transform HIV testing, treatment and care. J Int AIDS Soc. 2020; 23:(SS)e25581.

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to finally address the challenges faced by children and adolescents living with HIV[4]. In addition, the latest UNAIDS Global AIDS Strategy 2021–2026 includes very ambitious targets and commitments to end vertical transmission and paediatric AIDS[5].

THE ROLE OF FAITH COMMUNITIES

Faith communities have been supporting the global AIDS response for many years to meet the needs of children and adolescents living with HIV. However, the size and scope of this contribution is not fully understood, as often it has not been well documented. As a result, faith communities have not been adequately engaged with to accelerate and sustain the global efforts designed to achieve the testing, prevention and treatment targets for children and adolescents.

Faith communities comprise a wide range of stakeholders: religious leaders, staff and volunteers working in faith inspired health providers and communities, members of congregations, faith community groups and faith-based organisations (FBOs). Faith communities are inspired by a set of spiritual beliefs, principles and practices that have motivated people of different faiths to provide HIV services and health care more broadly, to all persons in need, particularly the most marginalized. Faith communities have been meeting the needs of people living with and affected by HIV and their families, in many cases since the beginning of the AIDS pandemic in the early 1980s. However, the contribution of the faith community to the global AIDS response has only recently been widely acknowledged and documented.

4 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. 74th Plenary Meeting, 8 June 2021, Seventy fifth session, Agenda item 10. New York: UN General Assembly, 2021.
5 Global AIDS strategy 2021–2026. End inequalities, end AIDS. Geneva: UNAIDS; 2021.

COLLECTING PROMISING PRACTICES

To better understand the role of faith communities in the paediatric and adolescent HIV response, and specifically to identify interventions that have been innovative and successful and have the potential to support paediatric and adolescent HIV responses more broadly, the UNAIDS–PEPFAR Faith Initiative with the Inter-faith Health Platform undertook to collect and document evidence about promising practice interventions by faith communities. The study used a combination of methods, including literature review, an online survey and selected follow-up key informant interviews.

The literature review of published and unpublished evidence about potential promising practices[6] identified that faith communities have four assets that support the HIV response generally and paediatric and adolescent HIV response in particular. The four assets are: (1) service delivery through faith inspired health service providers; (2) community outreach through faith community groups; (3) demand creation in places of worship; and (4) advocacy by religious leaders and FBOs speaking out on obstacles preventing children from accessing treatment and holding government accountable for their commitments.

The survey, conducted between March and June 2021, was in English, French and Portuguese and included a questionnaire to capture information about the promising practices. It was hosted on the Interfaith Health Platform website with linkages for key stakeholders to submit information directly online. The survey used a broad definition of how the interventions relate to children and adolescents living with and affected by HIV. They included a wide range of services provided to family members—young women, mothers, men and boys—enabling them to access prevention, testing, counselling, care and treatment, psychosocial and spiritual support services and the social roles played by different family members, such as men and fathers and their support for children and adolescents. A number of these promising practises were identified as part of the PEPFAR Faith and Community Initiative and are included in the PEPFAR 2022 Country Operational Plan Guidance[7].

A total of 55 potential promising practices were received through the online survey. A few did not have sufficient information to determine whether they should be included as innovative promising practices. Follow-up emails were sent to cover gaps in information and gather key data on results. An additional ten innovative promising practices were identified through the literature review. Interviews were conducted with selected key informants. The amount of detailed and quantified data available varied substantially across the different promising practices, in some cases because the interventions had not operated for long or were operating in challenging contexts. While some of the cases do not have as much quantified data as desired, they have all demonstrated significant value, at least conceptually, and is why they are called ‘promising practices’ and not ‘best practices’.

6 More than 100 published and unpublished documents, some dating back 15 years, were reviewed to identify potential promising practices.

7 https://www.state.gov/2022-country-operational-plan-guidance/

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A total of 41 promising practices, out of the original 55 received, met the specified criteria[8]. The interventions covered a wide range of paediatric and adolescent programme areas and the four most frequently areas included: (1) access to ART, retention and adherence; (2) identifying and testing children and adults not on treatment; (3) HIV and health awareness; (4) adolescent HIV prevention and training in life skills.

8 The criteria specified that interventions and practices should have many of the following characteristics:
- The practice should relate to one of four assets of the faith community: faith inspired health service providers; faith community groups; places of worship creating demand for HIV services; and religious leaders for advocacy.
- The intervention can demonstrably meet an expressed need of key beneficiaries/ participants.
- The intervention is effective and relevant to the local context.
- It should bear fruit in a reasonable period of time;
- The intervention should be sustainable, e.g. demonstration of local ownership and leadership and inclusion in budgets.
- The intervention should be viewed by its initiators and core users as a practice that is promising and worth replicating.

FINDINGS

The study found that faith communities make distinctive contributions to the paediatric and adolescent HIV response through a wide range of interventions. These interventions are often not well documented and hence their contributions are not fully understood. As a result, they are not well resourced. Yet they display considerable ingenuity and are grounded in a good understanding of local situations; many adopt a holistic and comprehensive approach to the situation of the children, adolescents and their families whom they are serving. Over many years, faith communities have been supporting the community in confronting the impact of HIV and, often with only limited resources, have been inspired by their faith to show compassion and kindness to those in need. The interventions in this compendium, identified as promising practices (PPs), identify a range of significant findings and highlight why faith communities should be included more fully in local and national plans aimed at achieving global targets to find and treat all children and adolescents living with HIV by 2025.

1. Faith communities have implemented approaches and interventions that have made significant contributions in the HIV response for children and adolescents. Analysis of the 41 promising practices has identified a total of 28 findings, which are listed in full in Fig. 4 of Appendix 1. The 12 most important findings, which are mentioned most frequently across all the promising practices, are listed in Fig. 1 and are explained in more detail in the following.

FIG 1. KEY FINDINGS ABOUT THE PROMISING PRACTICES OF FAITH COMMUNITIES (FREQUENCY BY FAITH ASSET)[9]

Increase the identification, testing, and linkage of children and adolescents living with HIV not on HIV treatment (1.3, 1.6, 1.8, 1.9, 1.11, 1.13, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 2.15, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 4.3, 4.4, 4.5, 4.7) **[28].**
Places of worship can provide integrated primary health and paediatric HIV services including holistic prevention, testing and treatment services (1.2,1.3, 1.11, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.9, 2.10, 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 4.1, 4.2, 4.3, 4.4, 4.6, 4.7) **[23].**
Faith leaders and communities **undertake activities to reduce HIV stigma** (1.3, 1.8, 1.9, 1.10, 2.2, 2.4, 2.5, 2.7, 2.10, 2.11, 2.12, 2.14, 2.15, 3.5, 3.6, 4.1, 4.2, 4.3, 4.6, 4.7) **[20].**
Mission hospitals collaborate closely with faith community groups to provide a range of service to increase antiretroviral adherence (1.1, 1.2, 1.3, 1.8, 1.9, 1.10, 1.11, 1.12, 1.13, 2.1, 2.2, 2.3, 2.7, 3.1, 3.4, 4.1, 4.4, 4.7) [**18].**
Increase levels of continuity of treatment for children and adolescents living with HIV (1.3, 1.5, 1.9, 1.10, 1.12, 1.13, 2.1, 2.2, 2.4, 2.12, 2.13, 2.14, 3.1, 3.2, 3.3, 3.4, 4.3) **[17].**
Increase viral load suppression rates for children and adolescents living with HIV (1.1, 1.2, 1.3, 1.4, 1.5, 1.7, 1.9, 1.10, 1.11, 1.12, 2.1, 2.11, 2.12, 3.1) **[14].**
Enable peer support groups to empower children and adolescents living with HIV (1.3, 1.8, 1.9, 1.10, 1.11, 2.2, 2.10, 2.11, 2.12, 2.13, 3.4, 4.1, 4.6) **[13].**
Mobilizing faith leaders and communities can increase **awareness about HIV primary prevention** (2.2, 2.3, 2.4, 2.5, 2.6, 2.10, 2.14, 2.15, 3.1, 3.3, 3.4, 3.5, 4.1, 4.2) **[14].**
Facilitate psychosocial support and spiritual support (1.2, 1.3, 1.9, 1.10, 1.11, 1.13, 2.1, 2.2, 2.4, 2.12, 2.13, 3.1, 3.4) **[13].**
Mobilize faith leaders and communities through awareness and sensitization to end **vertical transmission, increase access to antiretroviral treatment and maternal and new born health programming** (2.2, 2.3, 2.4, 2.7, 3.1, 3.2, 3.3, 3.5, 4.1, 4.2, 4.4, 4.5, 4.7) [**13].**
Utilize holistic care and support approaches to increase antiretroviral treatment adherence and increase viral load suppression (1.2, 1.3, 1.9, 1.10, 1.11, 1.13, 2.8, 2.13, 3.1, 3.2) **[10].**
Support **HIV-self testing** (1.11, 2.4, 2.6, 3.1, 3.4, 3.5, 4.4, 4.5, 4.7) **[9].**

COLOUR CODE LEGEND: The different coloured fonts indicate the four assets of faith communities that the promising practices relate to:
Aqua: Faith inspired health service providers.
Khaki: Faith community groups.
Carmine: Places of worship.
Cyan: Advocacy by religious leaders.

9 The survey used a broad definition of how the interventions relate to children and adolescents living with and affected by HIV. They include a wide range of services provided to family members—young women, mothers, men and boys—enabling them to access prevention, testing, counselling, care and treatment, psychosocial and spiritual support services and the social roles played by different family members, such as men and fathers and their support for children and adolescents.

- The issue with the largest number of promising practices (28) is **the identification and testing of children and adolescents** living with HIV that are not on HIV treatment. All four of the key assets of the faith communities contribute to this. This includes faith inspired health service providers using case management approaches in Kenya (PP1.3); introducing point of care diagnostics in Zambia (PP1.6); or Mildmay's Family-Centred Approach in Uganda (PP1.13). On the other hand, faith community groups have used community outreach posts in Zambia (PP2.1), and places of worship have been used as locations for health posts in Zambia (PP3.1) and as places to test pregnant women in Nigeria (PP3.2). Advocacy by faith paediatric champions has highlighted the importance of finding and testing children not yet on ART as in Kenya and globally (PP4.1 and PP4.5).

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- **The importance of places of worship** in the HIV response for children and adolescents is a key finding mentioned in 23 promising practices. A selection of these 23 interventions includes the following: Churches and mosques have played a central role in educating faith community members about HIV in Kenya and Zambia (e.g. PP2.2 and PP3.4) and have been used as locations for health & HIV kiosks in Zimbabwe to reach populations not on HIV treatment (PP3.3) as well as centres for HIV testing, e.g. as locations for health posts in Zambia (PP3.1). Places of worship have been used successfully as centres for distributing HIV self-testing kits, as in Eswatini, Kenya, Malawi and Nigeria (PP3.5, PP3.4, PP2.4 and PP4.7). They have also been the centres for advocacy by faith leaders working as paediatric faith champions, such as in Kenya and Zimbabwe (PP4.1 and PP4.4).
- Many faith leaders and faith communities have been working to **reduce levels of stigma in communities** and are cited in 20 promising practices. However, many of the claims to have reduced the levels of stigma have not provided strong data as evidence of this impact. Faith inspired health service providers have worked in conjunction with faith community outreach groups to tackle stigma such as in Kenya and Namibia (e.g. PP1.3 and PP4.6) and some have recognized the importance of doing this in order to successfully transition treatment optimization as in Uganda (PP1.1), or as a key aspect of improving adolescent ART adherence as in Zimbabwe (PP1.8). Some faith communities have organized sports events as occasions to tackle stigma, as in Kenya and Zimbabwe (PP2.5 and PP2.10).
- **Mission hospitals and health facilities have found it beneficial to collaborate closely with faith community groups**, and 18 promising practices highlighted the value of such partnerships. There are several promising practices that demonstrate the benefits of collaborating with faith community groups in Kenya to improve testing and treatment (PP1.11) and other practices (PP1.2, PP1.3 and PP1.9). High levels of trust and shared faith values have led to strong collaboration between faith inspired health service providers and faith community groups, such as in Uganda (PP1.13). Such strong collaborations can facilitate the formation of effective support groups, as in Zimbabwe (PP1.8), and mentoring schemes such as Improving Parent and Child Outcomes (IMPACT's) 'Mother Buddies' in several countries, including in Malawi (PP2.3 and 2.4).
- **Strengthening the continuity of treatment of children and adolescents on ART** has been an important goal for many (17) of the promising practices. This has included several interventions involving ART regime optimization as in Uganda that used a continuous quality improvement (CQI) approach (PP1.1) and other practices as in Zambia and Uganda (PP1.4 and PP1.5). Some promising practices, such as the Lea Toto programme in Kenya have used a comprehensive range of services to address the issue (PP1.2; see also PP1.3). Some promising practices have used a differentiated service delivery (DSD) approach, as Catholic Relief Services (CRS) has done in Zambia (PP1.7). For other practices, having a holistic approach including psychosocial and spiritual dimensions has been critical, as in Zambia (PP2.1 and 3.1) and Kenya (1.11).
- **Improving viral load suppression for children and adolescents living with HIV** has been a key focus for 14 of the promising practices and has been achieved in a variety of ways, especially those using holistic approaches. Unsurprisingly, there are strong similarities between those promising practices that have improved viral load suppression with those that have strengthened levels of treatment. Hence, viral load has been improved by those promising practices focused on treatment optimization (PP1.1, PP1.4 and PP1.5), as well as comprehensive programmes and those with a holistic focus including strong psychosocial and spiritual elements (PP1.3, PP1.9, PP1.12, PP2.1 and PP3.1).

- Faith communities have **helped to establish and strengthen peer support groups** and 13 promising practices highlight the importance of these groups for achieving their goals. The support groups have played an important role in helping programmes that prevent vertical transmission among pregnant women living with HIV, as in Kenya (PP2.2). There are several examples of strengthening support groups for adolescents living with HIV such as Teen Clubs and equivalents in Eswatini, Malawi and Zimbabwe (PP2.11, PP2.4 and PP2.12), as well as support groups for parents of children living with HIV as in Zimbabwe and Namibia (PP1.8, PP4.6). There are also several examples of support groups for those providing comprehensive care for children and adolescents living with or affected by HIV such as in Kenya (PP1.3).
- Faith leaders and faith communities have played a critical role **in increasing awareness about primary HIV prevention** and were found in 14 promising practices. This raising of awareness has been for different age groups and populations. It has involved working with pregnant women and their families in Kenya, Malawi and Nigeria (PP2.2, PP2.4 and PP3.2). It has engaged men and involved them more fully in HIV family programmes, as in Zambia (PP2.7). There have also been a range of promising practices targeting adolescents such as in Malawi that has used a family focused approach (PP2.6), some that involve sports events and sports coaches, such as in Kenya and Zimbabwe (PP2.5 and PP2.10). There have also been school-based approaches involving adolescents discussing HIV prevention as in a multi-country intervention, as well as in Cameroon (PP2.15 and PP2.9).
- **Psychosocial and spiritual support** has been an important feature of a significant number (13) of promising practices of faith communities. In some cases, this has been provided through peer groups, as for example for pregnant women in multiple countries including Malawi (PP2.3 and PP2.4), as well through mosques in Kenya (PP2.2). There are other examples of specific psychosocial and spiritual support being provided for people living with HIV as in Kenya (PP1.3 and PP3.4). In addition, several promising practices include providing psychosocial and spiritual support for staff working on the programmes as in Kenya and Zambia (PP.1.11 and PP3.1).
- Faith communities have played an important role in **increasing awareness about the importance of treatment, maternal health and eliminating vertical transmission**; 13 promising practices were identified. These practices involved men more fully in HIV family programmes, as in Zambia (PP2.7) and specifically to end vertical transmission by working with pregnant women and their families in Kenya, Malawi and Nigeria (PP2.2, PP2.3, PP2.4 and PP3.2). Faith leaders also played an important role as paediatric faith champions in undertaking advocacy on these issues in Kenya, Nigeria, Zimbabwe and globally (PP4.1, PP4.7, PP4.4, PP4.2 and PP4.5).
- Faith communities quite frequently **use holistic care and support approaches** to increase ART adherence and improve viral load suppression; ten promising practices were identified in the study. The key feature of these practices is that they provide individuals and families with comprehensive multisectoral support often including health care, nutrition, economic and social services as well as psychosocial and spiritual support as in promising practices in Kenya and Cote d'Ivoire (PP1.2, PP1.3, PP1.11 and PP1.10).
- **HIV self-testing** is a promising practice that was identified in nine of the interventions. Places of worship have been used successfully as centres for distributing HIV self-testing kits, as in Eswatini, Kenya, Malawi and Nigeria (PP3.5, PP3.4, PP2.4 and PP4.7). There were also three examples of faith communities advocating for increased access to HIV self-testing in Nigeria, Zimbabwe and elsewhere (PP4.7, PP4.4 and PP4.5).

- A major gap has been the almost complete **neglect of key populations** in the interventions by faith communities. Yet many children affected by AIDS have parents who are members of marginalized groups such as sex workers, transgender people, people who use drugs, and men who have sex with men. In many cases, the stigma surrounding their parents prevents the children from receiving the services they need because their families fear discrimination and/or legal repercussions in clinical or social services settings. However, only one promising practice (1.11) in Kenya mentions working with key populations and in that case it was due to significant attention being given to the ethos of "karibu" or welcome by all staff and community health workers to everyone using the programme's services. This negative finding must be addressed with urgency by faith communities if the most marginalized children and adolescents living with HIV are able to access HIV services.

2. A total of 30 success factors were documented among the 41 promising practices to have positively influenced the successful implementation of the practices, and these are listed in full in Fig. 5 in Appendix 1. The nine most important of these are listed in Fig. 2. The most important success factor has been the effective collaboration and effective networking by faith communities with staff in Ministry of Health (MoH) facilities and nongovernmental organizations (NGOs), many of whom were faith inspired or who supported their aims. The importance of highly skilled and dedicated staff, both paid and volunteers, is recognized as being critical for success. So too, has been effective interfaith collaboration, especially between leaders of different faiths. Active faith community involvement at all stages of planning and implementing has been important for many of the promising practices.

FIG 2. KEY SUCCESS FACTORS IN THE IMPLEMENTATION OF PROMISING PRACTICES, BY FREQUENCY

Good collaboration and networking between health facilities and other key stakeholders, e.g. MoH, NGOs, improved implementation 1.1, 1.6, 1.7, 1.8, 2.3, 2.10, 2.13, 3.2, 3.3, 3.6 4.2, 4.5 **[12]**.
Highly skilled, committed and experienced staff base, including community health volunteers, is critical: 1.2, 1.4, 1.9, 1.12, 2.1, 2.8, 2.9, 2.11, 3.1, 3.3 **[10].**
Engagement and support of leaders from different faiths in HIV education and awareness raising with their congregations: 1.3, 2.1, 2.3, 2.10, 2.11, 2.12, 3.3, 3.4, 4.1 **[9]**
Active faith community involvement at every step of the programme's implementation, including fundraising: 1.3, 1.9, 1.13, 2.2, 2.6, 2.7, 2.8, 3.3 **[8].**
Presence of places of worship in the community motivates members of faith communities to engage in HIV programmes: 2.3, 2.4, 2.9, 2.12, 3.2 **[5].**
Support from faith inspired NGO-Headquarters (NGO-HQ) leadership and mentoring, including technical and strategic information through training and on-site mentoring of health care workers, community based volunteers: 1.5, 1.6, 2.1, 2.5 **[4].**
Adolescents like being able to interact freely with peers without interference from adults: 1.7, 1.9, 2.9, 2.14 **[4].**
Strong collaboration between faith and traditional leadership: 1.8, 2.5, 2.7, 2.8 **[4].**
Faith leaders, including pastors and imams, are knowledgeable about HIV and receive regular updates about HIV prevention, treatment, care and support: 1.11, 3.2, 3.5, 4.1 **[4].**
COLOUR CODE LEGEND: The different coloured fonts indicate the four assets of faith communities that the promising practices relate to: **Aqua:** Faith inspired health service providers. **Khaki:** Faith community groups. **Carmine:** Places of worship. **Cyan:** Advocacy by religious leaders.

3. A total of 19 factors that hindered the implementation of the 41 promising practices were documented and a complete list is outlined in Fig. in Appendix 1. The seven most important of these factors are listed in Fig. 3. The most important factor found to be hindering implementation of the practices was limited levels of funding and resources. Since 2020, COVID-19 has also provided a range of challenges that inhibited success as did the continued high levels of stigma and discrimination faced by people living with and affected by HIV. While some of the faith inspired health facilities are found in remote locations, there are still relatively long distances for community members to travel which, combined with poor transport services, has reduced levels of accessibility to HIV services in those areas. A few practices were hindered by inadequate levels of human resources at health facilities and lack of training for staff, community health workers and faith leaders.

FIG. 3. KEY FACTORS CONSTRAINING IMPLEMENTATION OF PROMISING PRACTICES BY FREQUENCY

Limited funds and resources for programmes: 1.3, 1.9, 1.12, 1.13, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.12, 2.13, 3.2, 3.3, 3.5, 3.6, 4.2, 4.6 **[18]**.
COVID-19 challenges reduced attention given to HIV and health services by community members: 1.1, 1.2, 1.9, 1.12, 2.3, 2.4, 2.5, 2.7, 2.9, 2.10, 3.1, 3.4, 3.5, 4.4 **[14].**
HIV stigma and discrimination: 1.3, 1.9, 1.13, 2.1, 2.2, 2.9, 2.10, 2.11, 2.13, 4.7 **[10].**
Long distances to some health facilities and poor transport services: 1.3, 1.6, 1.9, 1.10, 1.13, 2.1, 2.2, 2.10, 2.11 **[9].**
Inadequate human resources at health facilities and community health centres: 1.1, 1.7, 1.9, 1.13, 2.1, 2.2, 2.6 **[7].**
Lack of training for staff, community health workers and faith leaders: 1.13, 2.1, 2.2, 2.9, 2.10, 3.5 **[6].**
Stockouts of ARVs, test kits and viral load tests: 1.5, 1.9, 2.9, 3.4 **[4].**

COLOUR CODE LEGEND: The different coloured fonts indicate the four assets of faith communities that the promising practices relate to:
Aqua: Faith inspired health service providers.
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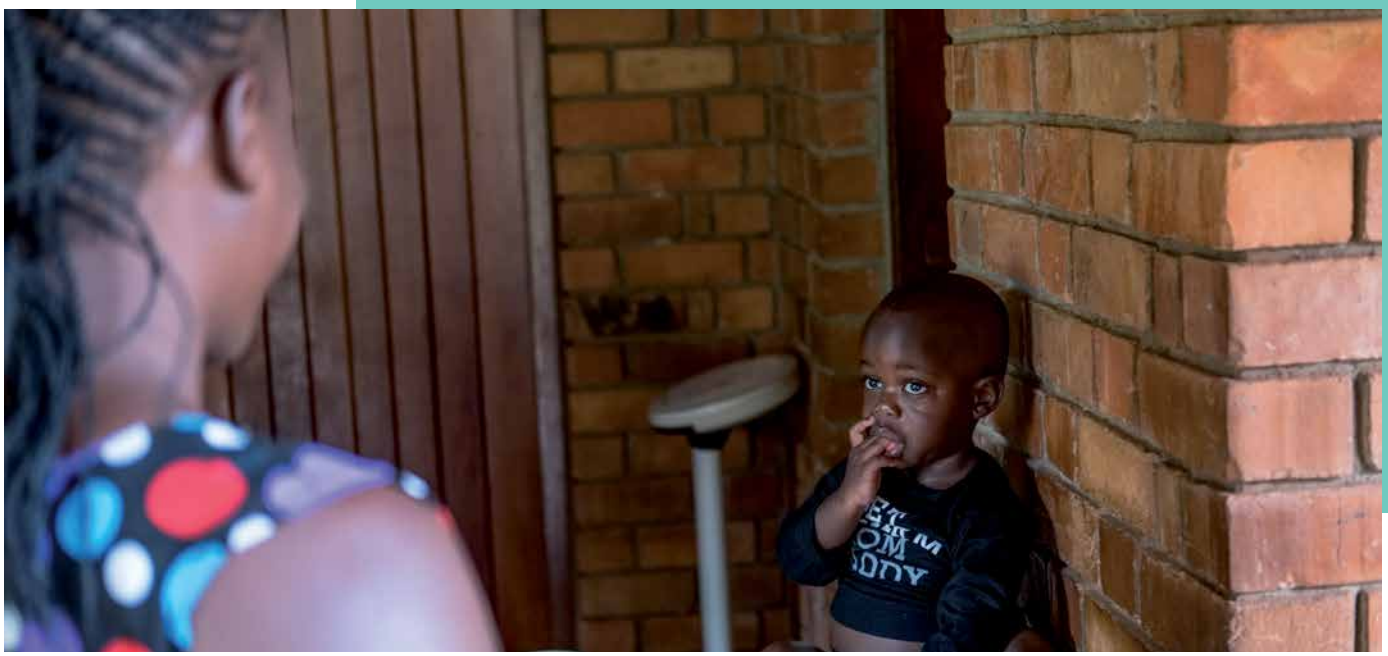
RECOMMENDATIONS

The study highlighted the important role played by faith communities in paediatric and adolescent HIV programming. Several recommendations emerged from the study:

1. Faith communities should be supported with resources and capacity building to measure and document their promising practices, particularly in a format that can enable peers to understand what it would take to implement and scale up the intervention.
2. Support the development of material about the promising practices, particularly by producing videos that interview implementors and beneficiaries, to explain the processes involved in planning and implementing the interventions and how they overcame any difficulties that may have arisen. It is also important to collect guides and tool kits related to the promising practices to support their scale-up.



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3. Only one of the promising practices mentions working with key populations, including women and children from key populations. This is a major gap in the interventions of faith communities and requires urgent attention by all sections of the faith community, with strong leadership from faith leaders.
4. Faith communities should make greater efforts to ensure that their HIV activities uphold human rights and strengthen the meaningful leadership and engagement of affected communities of women living with HIV, families living with HIV, adolescents and children living with HIV
5. Encourage those planning future paediatric and adolescent programmes, particularly those seeking to meet the 2023 and 2025 targets agreed at the 2021 United Nations HIV High Level Meeting, to consider promising practices by faith communities that could be supported for scaling up. There are three areas of activity faith communities could contribute to:

   (i) Implement innovative tools and strategies to find and diagnose all children living with HIV, including point of care early infant diagnostic platforms for HIV exposed infants and rights-based index, family and household testing and self-testing to find older children and adolescents living with HIV not on treatment.
   (ii) Prioritize rapid introduction and scale up of access to the latest WHO recommended, optimized, child-friendly HIV treatment and achieve sustained viral load suppression.
   (iii) Address stigma, discrimination and unequal gender norms that prevent pregnant and breastfeeding women, especially adolescent girls, young women and key populations, from accessing HIV testing, prevention and treatment services for themselves and their children.

6. Organize national workshops—in-person and/or online—to encourage local level sharing of experience of promising interventions and potential operationalization.
7. Support the recruitment and capacity building of faith paediatric champions and networks to promote key interventions.

Further information about these can be obtained from the Interfaith Health Platform, at interfaith.health.platform@gmail.com

COMMUNITY OUTREACH BY FAITH COMMUNITY GROUPS

2.

INTERVENTION 2.15

AJAN HIV Prevention Programme for the Youth (AHAPPY Generation),

MULTIPLE COUNTRIES

Summary

The African Jesuits AIDS Network (AJAN) designed an HIV Prevention Programme for the Youth (AHAPPY Generation) that is implemented in multiple countries in Africa. It focuses on making adolescents and youth champions of a generation in Africa free of HIV and AIDS. The youths in this programme advocate for HIV prevention among other youths, HIV testing among them, fighting against stigma, supporting peers living with HIV in adherence, supporting responsible behaviour and positive living, advocating for testing in communities and institutions, and acting as peer influencers. The AHAPPY programme has several unique features: (1) it focuses on the whole person (integral growth) rather than on the HIV virus, aiming to empower young people to face other social, mental and economic challenges; and (2) it is youth centred and the design gives young people space to provide solutions and the means of going about it. The intervention has had a wide range of results in the 11 countries where it has been implemented, including: reduced levels of stigma among youth (Kenya); increased youth HIV testing (Central Africa Republic and Togo); increased levels of self-knowledge and responsible behaviour (Uganda and Rwanda); fewer sexual harassment incidents against girls (Madagascar); and improved ARV adherence (Kenya). Broad impacts have been identified in three areas: improved health and reduced deaths among youths living with HIV; encouraged responsible behaviour and positive living among youths; and improved academic performance, healthy living and discipline.

Keywords *

ADOLESCENT FRIENDLY APPROACHES; HIV PREVENTION; LIFE SKILLS; SCHOOL-BASED HEALTH PROGRAMMES; STIGMA; TREATMENT ADHERENCE.

Name of the intervention: AJAN HIV Prevention Programme for the Youth (AHAPPY Generation); multiple countries.
Focus of the intervention: Adolescent HIV prevention and life skills training.
Faith community asset area: Faith schools.

Description of the intervention: AHAPPY is a programme developed by the Religious Society of Jesus (Jesuits). It focuses on making adolescents and youths champions for a generation in Africa free of HIV and AIDS. The youth in this programme: advocate for HIV prevention among youth; promote HIV testing among youth; fight against stigma; support peers living with HIV in adherence; encourage responsible behaviour and positive living; advocate for testing in communities and institutions; and act as peer influencers. The plan is to reach out to more youth where they are, especially with Covid-19. The programme has several unique features:

- It focuses on the whole person (integral growth) rather than HIV and AIDS. This prepares the youth to address HIV and AIDS through responsible behaviour and choices emerging from self-awareness, appreciation of self and others. The approach empowers the youth to face other social, mental and economic challenges they encounter daily.
- It is youth-Centred. The programme arose following detailed discussions with youth and the design gives them space to provide solutions and the means of achieving it.
- Youth educational short movies that are part of the training materials were scripted and acted by the youth in AJAN centres. A total of 20 short movies were completed—in French and English.
- The programme is solid: it is grounded in the ministry of the Jesuits in Africa and is a long-term project.
- AHAPPY is replicable. It is designed in such a way that it can address many issues affecting young people, including STIs, drug abuse and violence, mental issues, and teenage pregnancies, in addition to HIV.
- Its high capacity allows it to be scaled up throughout Jesuit institutions in Africa, including Catholic structures, Christian structures and cultural non-religious structures.
- Development of AHAPPY online training. This helps the youth interact with AHAPPY online.

The AHAPPY Programme has five target groups:

a. The AHAPPY generation handbook is tailored to youth between 10 and 24 years.
b. AJAN field project directors and coordinators of AHAPPY are based in institutions of learning in various countries which directly run the AHAPPY programme through youth sensitization and awareness creation events, organizing youth forums, symposia, clubs, peer education, HIV testing and community outreach.
c. Most trainees are youth between 18 and 35 years because of their impact on other youth as role models for younger youth and adolescents.
d. Jesuits and their collaborators working in the HIV and AIDS field. They make up the largest teams of pastoral agents working in schools, social centres, cultural centres, or youth forums. They participate in church activities and communicate messages on preventing HIV and living with HIV.
e. Family members, caregivers and the community. They are an indirect target group because they are the first contact with the youth in the household as the basic unit and level of interaction.

This programme is administered in three ways:

- Training of trainers (ToT). AJAN empowers youth leaders, teachers, mentors, peers, community leaders, church leaders, professionals and pastoral agents to promote the growth and empowerment of the youth they accompany.
- Training of learners (ToL). Held as part of sensitization forums for youth between the ages of 0 to 24 years. Most of them are in various stages of school or college programmes. Like ToT, these activities run at two levels: the AJAN secretariat and through AJAN field centres in countries.
- Youth led initiatives. Young people are empowered and given roles as agents to themselves.

Lead organization: African Jesuits AIDS Network (AJAN). The AJAN HIV & AIDS Prevention Programme for the Youth (AHAPPY) was developed in 2012. It emerged during a youth meeting involving 33 Jesuit institutions and collaborators from 12 countries. At the meeting, young people expressed the need for an HIV prevention programme for youth designed for African educational institutions, observing that nothing concrete was then being offered to the youth even though they were being equally infected and affected by the HIV epidemic. This programme is carried out at two levels. First, at the Secretariat level with the mandate to build the capacity of AJAN field centres and collaborators through ToT, and to conduct ToL. The Secretariat is responsible for conducting evaluations of the syllabus through surveys and research. It is also responsible for the scale-up initiatives of the programme across the network, among others. Second, the programme is implemented at field centres where the activities for and with the youth take place. The centres autonomously plan initiatives responding to their realities and the needs of the young people attending the centres.
Location: Jesuit centres in Benin, Central African Republic, Democratic Republic of the Congo (Kisangani), Kenya, Liberia, Madagascar, Rwanda, South Sudan, United Republic of Tanzania, Togo and Uganda.
Where the intervention was implemented: Jesuit Catholic schools, communities and churches.
Year the intervention started: Developed in 2012, with pilot activities beginning in 2015 following publication of a handbook.
Is the intervention still being implemented: Yes.

Scale of change of activity required to introduce the intervention compared with existing practice: Large.

Results of the intervention[1]:

- Reduction of teenage pregnancies from 13 girls per year in 2013 to 1 by 2018: St. Aloysius Gonzaga-Kenya.
- Increased number of youth being tested for HIV: Central African Republic and Togo.
- Increased number of youth led activities and youth community engagement: Uganda and Togo.
- Self-acquired knowledge and exercise of responsible behaviour: Uganda and Rwanda.

Some specific achievements of the AHAPPY programme have been recorded in relation to the three key activity areas.

TABLE 10. TRAINING OF TRAINERS (TOT)

Description of activities	Period	Number trained	Country/AJAN centre
Piloting of AHAPPY	2015	176	Kenya, Nigeria, Zimbabwe, Burundi, Central African Republic, Democratic Republic of the Congo, Togo
ToT sessions conducted by AJAN secretariat	2015–2020	358	Togo, Liberia, Benin, Kenya, South Sudan, United Republic of Tanzania, Rwanda, Madagascar, Central African Republic, Democratic Republic of the Congo
ToT sessions conducted by Centre Maisha, DRC	2014–2020	208	Centre Maisha-Kisangani Democratic Republic of the Congo
Linkage to VCT after sensitization through AHAPPY by Centre Maisha, DRC	2015–2010	4472	Centre Maisha-Kisangani, Democratic Republic of the Congo
Screening for STIs	2019	58 girls	Centre Sociaux Loyola, Togo
Youth entrepreneurship activities by Centre Sociaux Loyola, Togo	2019	30	Centre Sociaux Loyola, Togo

TABLE 11. TRAINING OF TRAINERS (TOT)

Description of activities	Period	Number reached	Country/AJAN Centre
ToL by AJAN Secretariat	2015–2020	6500	Over 50 institutions
Youth sensitization by Centre Maisha, Democratic Republic of the Congo	2014–2020	131 548	Centre Maisha, Kisangani, Democratic Republic of the Congo
Student sensitization by Ocer Campion High School, Uganda	2014–2020	2250	Ocer Campion, Gulu, Uganda
Student sensitization by St. Aloysius Gonzaga	2014–2018	2148	St. Aloysius Gonzaga, Kenya
Student sensitization by Mercy Education Office	2018–2020	3100	Kenya

1 The AHAPPY programme claims that stigma levels have been reduced and sexual harassment incidents reduced, but no strong data were provided as evidence of these impacts, apart from stating that training and sensitization had occurred.

TABLE 12. YOUTH LED INITIATIVES

Description of activities	Period	Number reached	Country/AJAN Centre
HIV testing campaigns, CIEE Centre, Central African Republic	2017–2020	7417	Jesuit Centre d'information, d'education et d'ecoute (CIEE), Bangui
HIV and hepatitis testing for youth, Centre Social Loyola, Togo	2019–2020	3000	Centre Sociax Loyola, Togo
Sports for HIV by the Youth of Rumbek, South Sudan	2019	400 community members	St. Teresa's Parish, Rumbek, South Sudan
AHAPPY influencers—reaching peers through community radio station talks, Ocer Campion, Uganda	2014–2020	5000 youth	Ocer Campion, Gulu, Uganda
Youth for youth against drug abuse and sexual violence	2019–2020	20 000	Centre Sociax Loyola,Togo

Impact of the intervention:

- Improved health and reduced deaths among youth living with HIV.
- Responsible behaviour and positive living among youth.
- Improved academic performance, healthy living and discipline.

Extent to which the intervention has been scaled up: The AHAPPY programme has been scaled up in 11 countries in sub-Sahara Africa where Jesuits are present. It seeks to reach youth in refugee camps who are vulnerable to sexual exploitation (e.g. in the Kakuma Refugee camps). It is also helping youth in prison and correctional centres through the Catholic prison chaplaincy, currently within the Nairobi region in Kenya. AHAPPY is widening its target group to include parents and communities. It is using youth to reach to families and larger societies since the youth understand their respective cultures and friendly communication mechanisms and language to speak to the community. Their creativity by way of communication channels like dramas, communal activities, games, etc., have led to results (e.g. the case of St. Teresa's Youth in Rumbek, South Sudan). Some Jesuit centres are encouraging the AHAPPY programme to be adopted as a tool of advocacy by the youth on HIV prevention at regional or national levels, for example the Centre Maisha–Kisangani, Democratic Republic of the Congo, and the Urumuri Jesuit Centre, in Rwanda. Recently, work started with an AHAPPY ToT for prison pastoral agents to work with young people serving sentences in prisons in youth correctional facilities in the Nairobi region, which it is hoped will be scaled up across Kenya.

Source of funding to implement the intervention: Jesuit Conference of Africa and Madagascar, Jesuit Missions globally.

Key success factors helping the implementation and scale-up of the intervention:

- The presence of the African Jesuit AIDS Network (AJAN), a continental Jesuit body bringing together all Jesuit centres across Africa which have responded to HIV and AIDS since 2002. Interventions include: medical care; EVT; paediatric and adolescent HIV; GBV; livelihood. For people living with HIV: Service Yezu Mwiza, Burundi; home based care, Zambia; Centre Sociaux Loyola; Association of Volunteers–ABE, Burkina Faso; St. Joseph's Parish, Kenya.
  HIV prevention for youth and adolescents: St. Aloysious, Kenya; Ocer Campion, Uganda; St. Teresa, South Sudan; Centre Maisha, Democratic Republic of the Congo; Urumuri Jesuit Centre, Rwanda; Centre d'Information; d'Education and d'Ecoute, Central African Republic; CREC, Benin; Holy Family Parish, Liberia; Family, adolescents, youth and HIV: Centre Social Arrupe, Madagascar.

- The Jesuits are highly respected and a trusted Catholic institution in Africa and the world.
- Large presence of Jesuit congregations in Africa, especially at the grassroots levels.
- Well established and efficient Jesuit structures.
- Huge base of Jesuit collaborators both in the Church and outside.
- Highly educated and competent staff in all Jesuit institutions.
- Well-developed programmes, such as AHAPPY.
- Strong research base.
- Strong and well-coordinated leadership from the grassroots to the Vatican in Rome.
- Strong collaboration among Jesuits globally.

Key factors constraining the implementation and scale-up of the intervention:
Changing priorities from HIV.
Limited funding, especially from non-Jesuit organizations.
Very little government support from AJAN centres at the community level.
Strong opposition from global players on value based education.

Resources available for the intervention:
AHAPPY Handbook: https://ahappy.ajan.africa
'Impact stories' from field centres—evidence of success.
Research outcomes of the AHAPPY assessment survey.
AJAN website: https://ajan.africa/
AHAPPY online training link: https://ahappy.ajan.africa/
Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com

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APPENDIX

FIG. 5. KEY SUCCESS FACTORS HELPING THE IMPLEMENTATION OF PROMISING PRACTICES (FREQUENCY BY KEY ASSET)

1.	**Good collaboration and networking** between health facilities and other key stakeholders e.g. MoH, NGOs, improved implementation **1.1, 1.6, 1.7, 1.8, 2.3, 2.10, 2.13, 3.2, 3.3, 3.6, 4.2, 4.5** **[12]**
2.	**Highly skilled, committed and experienced staff base**, including community health volunteers is critical: **1.2, 1.4, 1.9, 1.12, 2.1, 2.8, 2.9, 2.11, 3.1, 3.3** **[10]**
3.	**Engagement and support of leaders from different faiths** in HIV education and awareness-raising with their congregations: **1.3, 2.1, 2.3, 2.10, 2.11, 2.12, 3.3, 3.4, 4.1** **[9]**
4.	**Active faith community involvement** in every step of the programme's implementation including fundraising: **1.3, 1.9, 1.13, 2.2, 2.6, 2.7, 2.8, 3.3** **[8]**
5.	**Presence of places of worship** in the community is motivating for members of faith communities to engage in HIV programmes: **2.3, 2.4, 2.9, 2.12, 3.2** **[5]**
6.	**Support from faith inspired NGO-HQ leadership and mentoring**, including technical and strategic information through training and on-site mentorship of health care workers, community based volunteers: **1.5, 1.6, 2.1, 2.5** **[4]**
7.	**Adolescents like being able to interact freely with peers** without interference from adult: **1.7, 1.9, 2.9, 2.14** **[4]**
8.	**Strong collaboration between faith and traditional leadership**: **1.8, 2.5, 2.7, 2.8** **[4]**
9.	**Faith leaders, including pastors and imams, are knowledgeable about HIV** and receive regular updates about HIV prevention, treatment, care and support: **1.11, 3.2, 3.5, 4.1** **[4]**
10.	**Availability of funding**, including from various donors: **1.2, 1.5, 2.3** **[3]**
11.	**Mentorship on the use of guidelines for HIV** service implementation: **1.4, 1.5, 1.6** **[3]**
12.	**HIV service provision with close follow-up**, including effective tracking system for those no longer accessing treatment: **1.4, 1.8** **[2]**
13.	**Support groups**, for young people, men and women, have encouraged members to have HIV test, adhere to ART and attend clinics: **1.9, 1.10, 2.7** **[3]**
14.	**Community health workers and volunteers** motivated by their faith and supported by their congregations to work on HIV: **1.11, 2.1, 2.6** **[3]**
15.	**Involvement of parents** can help to motivate community volunteers and their children's response to HIV services: **1.10, 2.5, 2.13** **[3]**
16.	**The active involvement of men** in HIV programmes, including tackling stigma, is important: **2.2, 2.7, 3.2** **[3]**
17.	**The use of holy texts, scripture, sermons and teachings** used in HIV messages are highly motivating for faith communities: **2.2, 2.10, 3.2** **[3]**
18.	**Strong health facility—community collaborations** strengthened implementation at health facilities and in communities: **1.1, 3.6** **[2]**
19.	**Local staff receive regular spiritual care and support** and regular psychosocial debriefing: **1.12, 2.1** **[2]**
20.	**Scaling-up of interventions must be done slowly and gradually**: **1.11, 2.8** **[2]**
21.	**Integrated and on-site use of health and HIV testing in places of worship** reduces stigma and is motivating: **3.2, 3.3** **[2]**
22.	**Faith paediatric** champions work most effectively when recruited from religious leaders of different faiths and from faith groups, e.g. men's and women's groups: **4.1, 4.3** **[2]**
23.	**Faith paediatric champions worked best in close collaboration with community health workers** and understand local culture and values: **4.1, 4.6** **[2]**
24.	**Task shifting towards nurse-led clinics** with community outreach support: **1.13** **[1]**
25.	**Sports coaches** can be highly motivating for young people: **2.5** **[1]**
26.	**Availability of evidence based information** on HIV and reproductive health: **2.6** **[1]**
27.	**Organizing events to celebrate achievements** motivates staff: **2.1** **[1]**
28.	**Faith paediatric champions should be well connected** and have positions of influence: **4.4** **[1]**
29.	**Advocacy should get commitments to actions agreed by CEOs** and those in senior leadership: **4.5** **[1]**
30.	**Regular data monitoring at health facilities** helped identify gaps needing support: **1.1** **[1]**

COLOUR CODE LEGEND: The different coloured fonts indicate the four assets of faith communities that the promising practices relate to:

Aqua: Faith inspired health service providers. **Khaki:** Faith community groups.

Carmine: Places of worship. **Cyan:** Advocacy by religious leaders.

FIG. 6. KEY FACTORS CONSTRAINING IMPLEMENTATION OF PROMISING PRACTICES (FREQUENCY BY KEY ASSET)

1.	**Limited funds and resources** for programmes: **1.3, 1.9, 1.12, 1.13, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.12, 2.13, 3.2, 3.3, 3.5, 3.6, 4.2, 4.6 [18]**
2.	**COVID-19 challenges** reduced attention given to HIV and health services by community members: **1.1, 1.2, 1.19, 1.12, 2.3, 2.4, 2.5, 2.7, 2.9, 2.10, 3.1, 3.4, 3.5, 4.4 [14]**
3.	**HIV stigma and discrimination**: **1.3, 1.9, 1.13, 2.1, 2.2, 2.9, 2.10, 2.11, 2.13, 4.7 [10]**
4.	**Long distances to some health facilities and poor transport services**: **1.3, 1.6, 1.9, 1.10, 1.13, 2.1, 2.2, 2.10, 2.11 [9]**
5.	**Inadequate human resources** at health facilities and community health workers: **1.1, 1.7, 1.9, 1.13, 2.1, 2.2, 2.6 [7]**
6.	**Lack of training for staff, community health workers and faith leaders**: **1.13, 2.1, 2.2, 2.9, 2.10, 3.5 [6]**
7.	**Stockouts of ARVs, test kits and viral load tests**: **1.5, 1.9, 2.9, 3.4 [4]**
8.	**Unsupportive caregivers and lack of activities to fully engage caregivers** accompanying adolescent: **1.7, 1.9, 1.10 [3]**
9.	**Challenging beliefs of some religious sects and churches**, including faith healing: **1.8, 2.1, 2.9 [3]**
10.	**Lack of security and political instability** resulted in interruptions to treatment: **1.9, 2.9, 3.2 [3]**
11.	**Lack of infrastructure** and adequate room space: **1.12, 2.1, 2.2 [3]**
12.	**Suspicion among community members** due to community belief systems: **2.1, 2.2, 4.7 [3]**
13.	**Some indifference, limited understanding and suspicion** among some faith leaders about working on HIV: **4.1, 4.3, 4.7 [3]**
14.	**High levels of poverty**: **1.3, 1.9 [2]**
15.	**Delays in receiving viral load and test results**: **1.4, 1.5 [2]**
16.	**Need to vary intervention model for different faiths**: **3.2, 3.5 [2]**
17.	**Opposition, politics of ownership and jealousy amongst partners**, including international partners: **2.1 [1]**
18.	**Lack of understanding and suspicion about the intervention** amongst health care providers, CHWs, community members: **2.1 [1]**
19.	**Sometimes challenging to find local partners** able to provide support: **4.2 [1]**

COLOUR CODE LEGEND: The different coloured fonts indicate the four assets of faith communities that the promising practices relate to:
Aqua: Faith inspired health service providers. **Khaki:** Faith community groups.
Carmine: Places of worship. **Cyan:** Advocacy by religious leaders.

ABBREVIATIONS AND ACRONYMS

AHAPPY	AJAN HIV Prevention Programme for Youth
AJAN	African Jesuit AIDS Network
ANC	antenatal clinic
ART	antiretroviral treatment (and antiretroviral therapy)
ARV	antiretroviral
BCC	behaviour change communication
CBIM	coaching boys into men
CDC	Centers for Disease Control and Prevention (USA)
CDOK	Catholic Diocese of Kitui
CHAK	Christian Health Association of Kenya
CHIEDZA	Chiedza Community Welfare Trust
CHV	community health volunteer
CHW	community health worker
CMMB	Catholic Medical Mission Board
CoH	Circle of Hope
COGRI	Children of God Relief Institute
CP	community post
CQI	continuous quality improvement
CRS	Catholic Relief Services
CSO	civil society organization
DSD	differentiated service delivery
DTG	dolutegravir
EAC	enhanced adherence counselling
EAM	Evangelical Association of Malawi
EDARP	Eastern Deanery AIDS Relief Programme
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	early infant diagnosis
EVT	elimination of vertical transmission
FBO	faith-based organization

FC	faith community
FCI	faith community initiative
FCIC	faith community initiative champions
FIHP	faith inspired health provider
GBV	gender based violence
HCW	health care workers
HIVST	HIV self-testing
ICAP	International Center for AIDS Care and Treatment Program
IEC	information education communication
IMPACT	Improving Parent and Child Outcomes project
INERELA+	International Network of Religious Leaders Living with or personally Affected by HIV
KAP	knowledge, attitude and practices
KCCB	Kenya Conference of Catholic Bishops
KCIU	Kenya Council of Imams and Ulamaa
LDL	low detectable level
LPV/r	lopinavir/ritonavir
MCH	maternal and child health services
MDT	multi-disciplinary team
MoH	Ministry of Health
MTA	Men Take Action
NACRO	New Apostolic Church Relief Organization
NGO	nongovernmental organization
OTZ	Operation Triple Zero
PACF	Positive Action for Children Fund
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PLA	participatory learning and action
POC	point of care
PP	promising practice
PrEP	pre-exposure prophylaxis
PVT	prevention of vertical transmission
RsoC	recipients of care
SDA	Seventh Day Adventists
SHBC	Shiselweni Home Based Care
SUPKEM	Supreme Council of Kenya Muslims
TBA	traditional birth attendant
TLC	The Luke Commission
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
VL	viral load
VMMC	voluntary medical male circumcision

GLOSSARY OF TERMS

adolescent. A person between 10 and 19 years of age.

Baraza. Public meeting place, in East Africa.

child. A child, as defined by the United Nations Convention on the Rights of the Child, means every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier.

congregation. A local groups of believers such as a church, mosque, temple or synagogue which meet on a regular (usually weekly) basis.

faith-based organizations (FBOs). Defined as faith influenced nongovernmental 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.

faith communities. A wide range of stakeholders: religious leaders, staff and volunteers working in faith inspired health providers and communities, members of congregations, faith community groups and FBOs. Faith communities are inspired by a set of spiritual beliefs, principles and practices that have motivated people of different faiths to provide HIV services and health care more broadly to all persons in need, particularly the most marginalized.

faith inspired health providers (FIHPs). Like FBOs, these are organizations influenced by religious or spiritual beliefs in their mission history, and/or work and which include primary, secondary and tertiary hospital and health facilities[1]. FIHPs play an important role in providing health care services in many countries in Africa[2]. The lack of systematic data about the role and magnitude of FIHPs led authors of the Lancet Series in 2015 on faith-based health care to conclude that broad generalizations about FIHPs should be avoided. While there is general agreement that hospitals and facilities run by FBOs have historically been established where service needs are greatest and often remain active regardless of political changes or humanitarian crises[3], there is evidence that contests the view that FIHPs have a preferential option for poor and marginalized people compared with public health providers[4]. In terms of HIV related health services, it is estimated that faith-based health facilities provide approximately 30% of all HIV clinical care across sub-Saharan Africa (UNAIDS, 2019[5]). A key feature of HIV related services is that they are frequently described as having integrated and comprehensive holistic care to address the emotional, social and spiritual aspects of HIV infection[6].

faith leader. People of all genders who are recognized by their faith community, both formally and informally, as having authority and playing influential roles within faith institutions to guide, inspire or lead others. As respected, trusted and well-known members of the communities, faith leaders are influential in guiding cultural and social norms and practices.

infant. A child younger than one year of age.

Mother Buddies. Mother Buddies In the 'Improving Parent and Child Outcomes (IMPACT) programme are trained church volunteers, mainly mothers living with HIV, who want to pass on their learning and experience to other expectant mothers who they visit eight times over a 12–15 month period.

RECIPE approach of Circle of Hope, Zambia. The 'RECIPE' approach comprises: responsibility, empathy, compassion, integrity, passion and ethics.

Teen Clubs. Teen Clubs in Eswatini aim to provide a safe and welcoming space for children and young adults to gain life skills and to encourage adherence among HIV+ youth by providing a stigma-free environment for receiving ARV refills.

youth/young person. A person between 15 and 24 years of age.

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