



COMPENDIUM OF PROMISING PRACTICES

of African Faith Community
Interventions Against Paediatric
and Adolescent HIV

The contents in this document are those of the authors, and do not necessarily reflect the view of the U.S. President's Emergency Plan for AIDS Relief, the U.S. Agency for International Development or the U.S. Government.

© Joint United Nations Programme on HIV/AIDS (UNAIDS), 2023

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo/>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that UNAIDS endorses any specific organization, products or services. The use of the UNAIDS logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by UNAIDS. UNAIDS is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules>).

Suggested citation. Compendium of Promising Practices of African Faith Community Interventions Against Paediatric and Adolescent HIV; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by UNAIDS in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by UNAIDS to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall UNAIDS be liable for damages arising from its use.

COMPENDIUM OF PROMISING PRACTICES

of African Faith Community
Interventions Against Paediatric
and Adolescent HIV

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

United States Global AIDS
Coordinator and
Special Representative
for Global Health Diplomacy

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 6

The role of faith communities	7
Collecting promising practices	8
Findings	10
Recommendations	16

1. FAITH INSPIRED HEALTH SERVICE PROVIDERS 18

1.1	Quality improvement initiatives to improve paediatric and adolescent art regimen optimization, Uganda	20
1.2	HIV Viral Suppression in Lea Toto Programme through the 'Adopt A Child' Initiative, Kenya	24
1.3	Increasing access to HIV care, treatment and support for children and adolescents, Kenya	28
1.4	Paediatrics and adolescents' ART optimisation, Uganda	34
1.5	Paediatrics ART optimization, Zambia	38
1.6	Improving Early Infant Diagnosis of HIV for exposed infants by reducing the turnaround time (TAT) of HIV results, Zambia	40
1.7	Differentiated Service Delivery (DSD) Scholar Model, Zambia	44
1.8	Paediatric and adolescent adherence to ART support groups, Zimbabwe	48
1.9	Increasing access to HIV treatment for children and adolescents, Kenya	52
1.10	Care and support for orphans and vulnerable children and their families, Cote d'Ivoire	58
1.11	Eastern Deanery AIDS Relief Programme (EDARP's) Integrated Clinic-Community model, Kenya	64
1.12	Initiate Adolescent and Young People Friendly Care Services, Kenya	72
1.13	Mildmay's Integrated Family-Centred Approach, Uganda	74

2. COMMUNITY OUTREACH BY FAITH COMMUNITY GROUPS 78

2.1	Faith-engaged Community Outreach Posts, Zambia	80
2.2	Meaningful Engagement of the Muslim Community for ARV uptake through Elimination of Vertical Transmission, Kenya	88
2.3	Improving Parent and Child Outcomes (IMPACT), Malawi, Nigeria, DRC, Tanzania, Sierra Leone, Uganda	94
2.4	Improving HIV outcomes for parents, children and adolescents, Malawi	100
2.5	Coaching Boys into Men in the informal settlements of Nairobi, Kenya	106
2.6	Family Interventions for Adolescent HIV Prevention in Mpamba, Nkhata Bay, Malawi	112
2.7	Men Take Action to increase male involvement to increase prevention of vertical transmission (PVT) uptake, Zambia	116
2.8	Shiselweni Community Home-Based Care, Eswatini	124
2.9	Creating HIV awareness amongst adolescents, screening and placing positives on treatment, Cameroon	130
2.10	HIV & AIDS Stigma Reduction & Empowerment of people living with HIV, Zimbabwe	134
2.11	Teen Clubs, Eswatini	138
2.12	HIV care and support for adolescents living with HIV, Zimbabwe	142
2.12	Children born with HIV care and support programme—Marang Career Information Centre, South Africa	146
2.14	Educational Intervention on HIV prevention & lifestyle, South Africa	150
2.15	AJAN HIV Prevention Programme for the Youth (AHAPPY Generation), multiple countries	154

3. USING PLACES OF WORSHIP TO CREATE DEMAND FOR HIV SERVICES 160

3.1	Expanding integrated health service delivery through Health Posts within places of worship, Zambia	162
3.2	Congregation-based approach to HIV testing in pregnant women in Nigeria, Nigeria	168
3.3	Health & HIV Kiosks at Faith Worship Centres in Zimbabwe, Zimbabwe	172
3.4	Using places of worship to create demand for HIV services, Kenya	176
3.5	Faith Community HIV testing for children, adolescents, and adults, Eswatini	180
3.6	Role of the church in ending HIV stigma and discrimination, Zimbabwe	184

4. ADVOCACY BY RELIGIOUS LEADERS AND FBOs 186

4.1	Faith Paediatric Champions, Kenya	188
4.2	Faith Paediatric Champions, Global and Kenya	194
4.3	Faith-based advocacy on retention and adherence initiative in Ethiopia, Ethiopia	200
4.4	Faith Community Champions, Zimbabwe	204
4.5	The Rome Paediatric HIV & TB Dialogues and Action Plan(s): the convening power of religious leaders, Global	208
4.6	Building Hope for All—Training faith communities on HIV and AIDS, Namibia	214
4.7	Religious leaders advocating for better identification and linkage to paediatric HIV treatment, Nigeria	218

APPENDIX 224

Figure 4: Key findings about faith communities' promising practices (frequency by key asset)	225
Figure 5: Key Success factors helping the implementation of promising practices (frequency by key asset)	226
Figure 6: Key hindering factors constraining implementation of promising practices (frequency by key asset)	227

ABBREVIATIONS AND ACRONYMS 228

GLOSSARY OF TERMS 230

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 2021². 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 to 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 adults³. 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.



to finally address the challenges faced by children and adolescents living with HIV⁴. In addition, the latest UNAIDS Global AIDS Strategy 2021–2026 includes very ambitious targets and commitments to end vertical transmission and paediatric AIDS⁵.

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 practices⁶ 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 Guidance⁷.

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/>



A total of 41 promising practices, out of the original 55 received, met the specified criteria⁸. 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.

Carmin: 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).





- **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 (PP1.11 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.

Khaki: Faith community groups.

Carmine: Places of worship.

Cyan: Advocacy by religious leaders.

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.



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

FAITH INSPIRED HEALTH SERVICE PROVIDERS



1.



INTERVENTION 1.1

Quality improvement initiatives to improve paediatric and adolescent art regimen optimization, UGANDA

Summary

The optimization of regimens for ART is a critical component for improving paediatric and adolescent HIV services. This study in Uganda utilized a CQI approach involving 22 faith-based health facilities. From a baseline in September 2020 of 66% (2717/4104) of children and adolescents living with HIV on an optimal ART regimen, i.e., a protease-based inhibitor or dolutegravir based regimen, this number improved to 99% at the end of March 2021. This involved a total of 1169 children and adolescents living with HIV transitioning to optimal regimens between October 2020 and March 2021. Important factors accounting for the success of this intervention were high levels of collaboration between health facilities and communities, as well effective collaboration and lessons learned between health facilities.

Keywords



ART OPTIMIZATION; CONTINUOUS QUALITY IMPROVEMENT; HEALTH FACILITY–COMMUNITY COLLABORATION; MOBILE PHONE USE; MULTIMONTH DELIVERY; VIRAL LOAD SUPPRESSION, ZONING OF COMMUNITIES.

Name of the intervention: Quality improvement initiatives to improve paediatric and adolescent ART regimen optimization, Uganda.

Focus of the intervention: Access to quality HIV treatment.

Faith community asset area: Faith inspired health service providers.

Description of the intervention: Twenty-seven high volume health facilities were targeted for a CQI collaborative effort that focused on improving paediatric and adolescent HIV indicators along the cascade of care. Of the 27, the majority (22) were faith-based health facilities and 5 were civil society organizations (CSOs). Among the targeted priority indicators was improving optimization of the paediatric ART regimen at these health facilities. They were supported to list all children and adolescents living with HIV who were not part of the optimized regimen by abstracting these

data from the clinic electronic medical record system. A CQI approach was utilized at the health facilities to monitor their data and test changes to identify best practices. The practices tested included the following:

- Continuous medical education was conducted to equip health workers with the knowledge to optimize the ART regimen for children and adolescents living with HIV.
- Health workers were provided with airtime to call back to the health facility those children and adolescents living with HIV who had not received the optimized regimen.
- Health workers collaborated with members from community-based structures, such as expert clients and village health team members, to track and bring back those children and adolescents living with HIV who had not received the optimized regimen to the health facility.
- Health workers optimized children and adolescents living with HIV who could not be brought back to the health facility in the community.
- Data were regularly monitored to register improvements made.
- The facilities ensured that all children and adolescents living with HIV had adequate drugs for two and more months under the multimonth delivery model.

Lead organization: Uganda Protestant Medical Bureau.

Location: Uganda.

Where the intervention was implemented: Health facility and community outreach.

Year intervention started: 2020.

Is the intervention still being implemented: Yes.

Scale of change of activity required to introduce the intervention compared with existing practices¹: Moderate.

Results of the intervention: In October 2020, 73% (4194/5749) of the children and adolescents living with HIV were on an optimal ART regimen, i.e., a protease-based inhibitor or dolutegravir based regimen. In November 2020, this had increased to 78% (4509/5759) and to 83% (4400/5294) by December 2020. This demonstrated a significant improvement, from 83% in December 2020 to 92% in the month of January 2021, 98% at the end of February 2021 and 99% at the end of March 2021. By the end of March 2021, only 77 children and adolescents living with HIV were still on a suboptimal regimen. These included children below 20 kg of weight who remained on Efavirenz, pregnant and lactating adolescents, and children and adolescents living with HIV who were lost. The Uganda Protestant Medical Bureau is working with facilities providing care to the remaining children to closely monitor them and ensure that they are of the optimized regimen as soon as they become eligible.

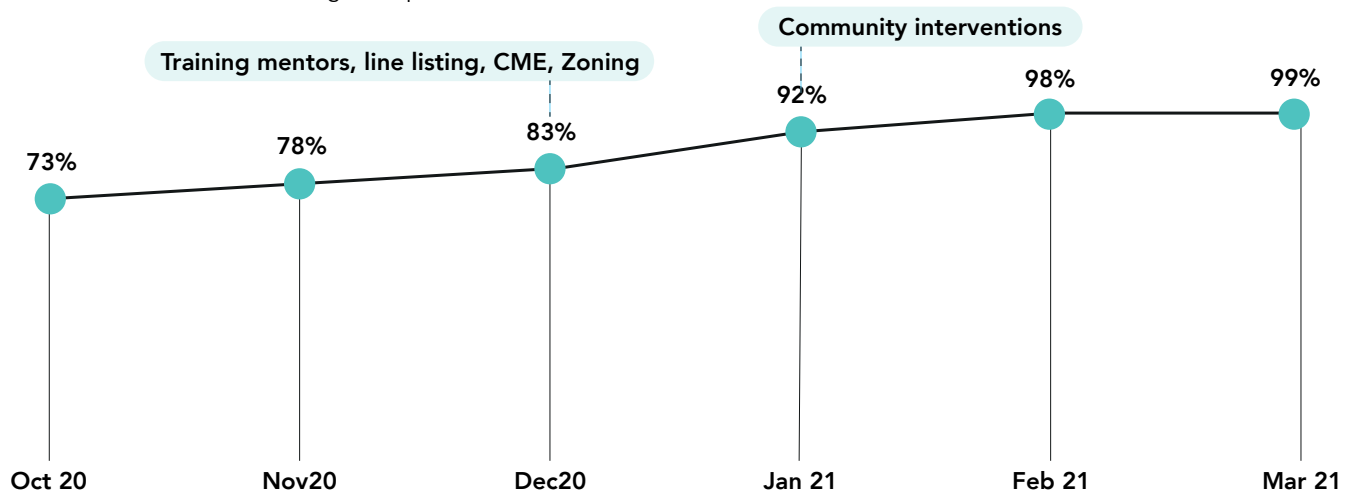
TABLE 1.

Indicator	Oct. 20	Nov. 20	Dec. 20	Jan. 21	Feb. 21	Mar. 21
N: Number of children and adolescents living with HIV on optimal regimen	4194	4509	4400	5123	5328	5363
D: Total number of children and adolescents living with HIV in care	5749	5759	5294	5557	5429	5440
Per cent optimized	73%	78%	83%	92%	98%	99%

¹ This question aimed to find out how much change was needed to introduce the intervention, compared with the previous activity. The scale of changes ranged from small, to moderate, to large.



CHART 1. Paediatric adolescent regimen optimisation



A nursing officer said: “With support, Kisiizi hospital was able to ensure all children and adolescents are fully optimized. Some children had to be followed in their homes to have the drugs delivered. It has also supported us in following up the lost children and children who miss appointment to ensure continuous care. The hospital, with support, has improved HIV care for children and adolescents by ensuring they receive all services they are eligible for.”

DIANA, NURSING OFFICER AT KISIIZI HOSPITAL.



A counsellor providing medicines to the mother of two children on care during a home visit.

© Uganda Protestant Medical Bureau

Impact of the intervention: A 36% improvement, from 73% to 99%, was realized by the end of March 2021 and a total of 1169 children and adolescents living with HIV were transitioned to an optimal regimen between October 2020 and March 2021. This improvement motivated health workers to map children and adolescents living with HIV who were still on a suboptimal regimen and move them to linkage facilitators, expert clients, and village health team members for follow-up. Children and adolescents living with HIV within the community who were unable to go back to the health facility also received the optimized regimen. Optimizing the paediatric and adolescent ART regimen will go a long way to improve viral load suppression rates for children and adolescents living with HIV.

Extent to which the intervention has been scaled up: Intervention expanded and implemented at 77 supported health facilities.

Source of funding to implement the intervention: PEPFAR/USAID.

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

- Health facility–community collaborations to implement activities at the health facility and in the community.
- Collaboration between health facilities to learn from each other during implementation.
- Zoning of the communities and assigning each zone to a health facility to ensure children and adolescents living with HIV for ART optimization are adequately followed up in the community.
- Regular monitoring of data to identify health facilities with gaps that needed support to improve the regimen optimization process.

Key factors constraining the implementation and scale-up of the intervention:

- Inadequate human resources at health facilities to conduct community follow-up of children and adolescents living with HIV.

Resources available for the intervention:

Penazzato M et al., Optimizing drugs to reach treatment targets for children and adolescents living with HIV, <https://onlinelibrary.wiley.com/doi/full/10.7448/IAS.18.7.20270>

Information on the intervention:

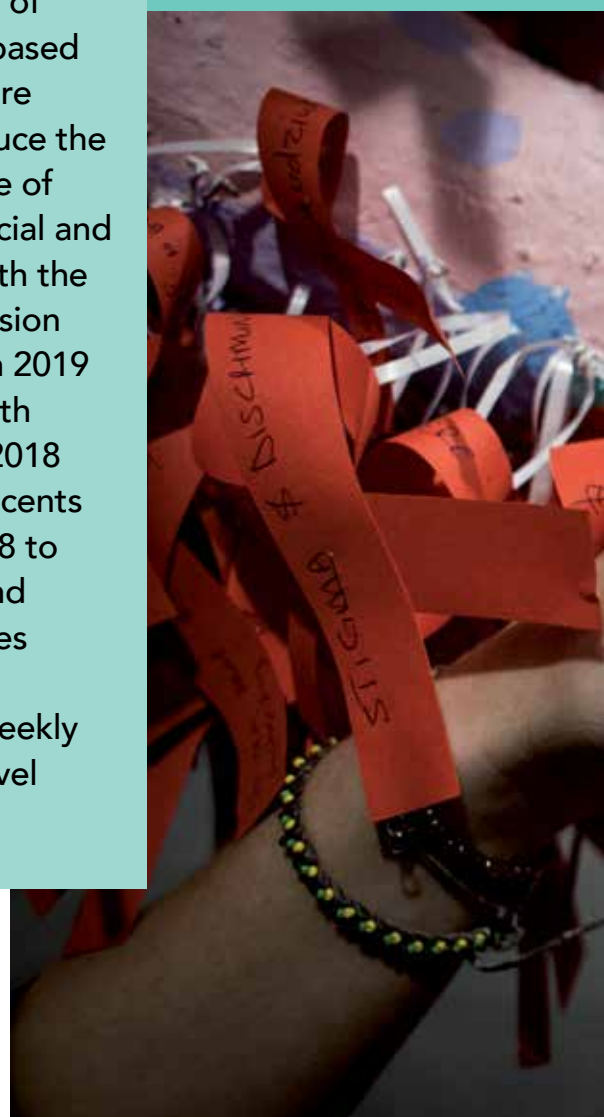
Uganda National Quality Improvement Database; Interfaith Health Platform at interfaith.health.platform@gmail.com

INTERVENTION 1.2

HIV Viral Suppression in Lea Toto Programme through the 'Adopt A Child' Initiative, KENYA

Summary

In 2018, the staff of Zimmerman Lea Toto Centre, one of eight Lea Toto programme health facilities located in slums in Nairobi, Kenya, became concerned about the very poor levels of adherence among the children and adolescents who were accessing HIV services at that facility. The most frequently reported barriers to adherence were: forgetfulness, bad taste of the medication, the child was away from home, the child refused to take the medication and the child felt healthy, as well as logistical constraints due to poverty and fear of disclosure. The key to the 'Adopt a Child' community-based initiative was providing holistic care and support to more than 3000 children living with HIV. The goal was to reduce the high viral load (VL) by providing a comprehensive range of services, including: health care and nutrition, psychosocial and spiritual support, and social and economic services. With the introduction of the Adopt a Child initiative, VL suppression increased from 2449 (81.7%) in 2018 to 2437 (84.5%) in 2019 to 2601 (89.7%) in 2020, while the number of clients with unsuppressed VL reduced by almost half (from 549 in 2018 to 297 in 2020). In addition, suppression among adolescents (aged 10–19 years) increased from 1538 (78.9%) in 2018 to 1683 (89.8%) in 2020. Cooperation of the caregivers and the clients was an important factor in realizing high rates of HIV viral suppression, as was having a large base of experienced staff and community health volunteers. Weekly multidisciplinary team (MDT) meetings at the facility level enabled speedy follow-up of identified cases.



Keywords

ADHERENCE COUNSELLING; CASE MANAGEMENT; ECONOMIC EMPOWERMENT; HEALTH FACILITY-COMMUNITY COLLABORATION; HOLISTIC CARE; PEER MENTORS; PLACES OF WORSHIP; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; TREATMENT ADHERENCE; TREATMENT BUDDIES; VIRAL LOAD SUPPRESSION.

Name of Intervention: HIV Viral Suppression in Lea Toto Programme through the 'Adopt A Child' initiative, Kenya.

Focus of intervention: Access to HIV treatment, retention and adherence and VL suppression.

Faith community asset areas: Faith inspired health service providers and community outreach.

Description of the intervention: Lea Toto is a community-based programme run by the Children of God Relief Institute providing holistic care and support for over 3000 children living with HIV and their families in eight of Nairobi's poorest slums (Kariobangi, Zimmerman, Mukuru, Dandora, Kangemi, Kibera, Kawangware and



Dagoretti). Services include: health care and nutrition; psychosocial and spiritual support; and social and economic services. Adherence to ART is a principal requirement for the success of HIV treatment. Children and adolescents living with HIV face a lifetime of treatment with ART. Often, individuals who struggle with adherence to ART face multiple barriers that would therefore impact the success of their treatment. In 2018, the staff of Zimmerman Lea Toto Centre became concerned about poor ART adherence among the children and adolescents in that facility.

In Zimmerman and the other Lea Toto Centres, the most frequently reported barriers to adherence by either the caregiver or youth were: forgetfulness, the taste of the medication, the child was away from home, the child refused to take the medication and the child felt good. Other reasons included: logistical barriers due to economic strains and fear of disclosure. To improve the treatment outcomes for these children, an MDT in Zimmerman Centre which met once a week came up with an initiative called 'Adopt a Child'. The goal was to help reduce the cases of high VL among the adolescents they served. Each member of the ten-member team was given a maximum of seven clients who had high viral loads (>1000 copies/mL) and were struggling with adherence. The main tasks for staff involved in Adopt a Child were to:

- Follow up and determine the underlying issues causing poor adherence and refer them for support to the relevant departments.
- Link the children with peer mentors to be their treatment buddy.
- Follow up and ensure they complete enhanced adherence counselling (EAC).
- Travel with them to ensure they keep their clinic appointments and also attend viremia clinics.
- Celebrate their achievements in other areas, e.g. academic studies, and continue monitoring adherence while ensuring they received a second VL test once they had successfully completed their EAC to a satisfactory level.

The success rate at first was 71.4%, with the majority of the children improving greatly and a good number having suppressed the virus to low detectable levels (LDLs) of less than 400 copies/mL. In addition, child friendly activities and colour coding of the files also helped the clients and their caregivers to identify their results. Red coding represented a VL of >1000 copies/mL, yellow represented a VL of 400–1000 copies/mL, while green represented a low detectable VL of <400 copies/mL.

Lead Organization: Children of God Relief Institute.

Location: Nairobi, Kenya.

Where the Intervention was implemented: Implemented across the Lea Toto programme through health facilities, community and places of worship where orphaned and vulnerable children can remain with their caregivers in their communities.

Year Intervention started: 2018.

Is the Intervention still being implemented: Yes.

Scale of change from existing activity required by intervention: Large.

Results of intervention:

TABLE 2.

Variable	2018	2019	2020
Suppressed (<1000 copies/mL)	2449 81.7%	2437 84.5%	2601 89.7%
Total children in care	2998 100%	2883 100%	2898 100%

The table shows that after introduction of the Adopt a Child initiative, VL suppression increased from (81.7%) in 2018 to (84.5%) in 2019 to (89.7%) in 2020, while the number of clients with unsuppressed VL reduced by almost half. In addition, suppression among adolescents (aged 10–19 years) increased from (78.9%) in 2018 to (89.8%) in 2020.

Impact of the intervention: One of the success stories from this intervention is that of Molly (not her real name), a 17-year-old girl born in a family of eight children. She was enrolled in the programme in 2018 as a transfer. On enrolment, her VL was 96 582 copies/mL despite having been on ART since 2016. The father is the sole bread winner after Molly's mother passed on in 2018. Due to social, economic and psychosocial issues, Molly's drug adherence became less than optimal, and she developed high VLs. Being a shy adolescent girl, it became hard for her to open up to the medical team on her challenges. She was initiated in the 'Adopt a Child' initiative in March 2019 with a VL of 69 444 copies/mL. A member of the MDT was assigned for close follow-up of both medical and social progress, and after some time she began opening up to the staff. Some of the major issues the staff identified were: Lack of school fees; and having to share a single room with all her siblings, meaning that she had no space to study. In addition, she lacked a proper bed and slept on the floor on a tattered mattress. The staff then referred her case to the social services department who did an assessment and based on the case plan, offered support in the form of a double decker bed, mattresses and blankets. The social services department further linked her to the 'Hotcourses' scholarship (one of the programmes offered by Children of God Relief Institute) since she is a bright child and was placed under sponsorship. During this period, one on one counselling continued, and the caregiver was also assessed through the economic empowerment department for an income generating activity to enable him to provide for his family and also support Molly's treatment. The staff continued to closely monitor adherence and Molly greatly improved the LDL of the virus. Her self-esteem was boosted to the extent that she now motivates other adolescents and young people in the programme who still have high VL during her school holidays. She has further been considered for peer mentors training so that she can reach out to more peers. The team still follows up on her academic performance, offering the necessary support.

Extent to which the intervention has been scaled up: This initiative has worked for all the other children in Lea Toto centres in Kariobangi, Dandora, Mukuru, Kibera, Kangemi, Kawangware and Dagoretti.

Source of funding to implement the intervention: USAID.

Key success factors helping the implementation and scale-up of the intervention: Key success factors included a base of skilled and experienced staff as well as the community health volunteers at the community level. The weekly MDT meetings at the facility level and monthly medical meetings with the medical team enabled quick quality deliberations and follow-up of identified cases. The availability of resources from the various donors played a key role in the rollout of the intervention. Cooperation from the caregivers and the clients themselves was an important factor in realizing HIV viral suppression.

Key factors constraining the implementation and scale-up of the intervention: Given the holistic approach of the intervention, the number of needy cases is more than the available resources. The COVID-19 pandemic led to most caregivers losing their sources of income and therefore increasing the demand for services from the initiative. Given its unique nature, where only children and adolescents are targeted, there has been an increasing demand from areas where Lea Toto Programme does not operate and therefore is not able to benefit children in this situation.

Information on the intervention: <http://www.nyumbani.org/>

INTERVENTION 1.3

Increasing access to HIV care, treatment and support for children and adolescents, KENYA

Summary

From 2017, the Catholic Diocese of Kitui (CDOK) has worked with the Kitui County Government on a programme to identify children and adolescents living with HIV between the ages of 0 and 19 years, and to ensure they are able to access treatment and have suppressed VLs. To achieve this, CDOK has offered children and adolescents: (i) provision of psychosocial support through community Psychosocial Social Support (PSS) groups; and (ii) community education, sensitization counselling through social workers, community health volunteers and other community structures such as churches, schools, and other learning institutions. From 2017 to 2020, the programme increased the number of children and adolescents living with HIV who were tested and supported from 444 to 2657. Of these, 50% were enrolled for monthly monitoring and service delivery. Over three–four years, the intervention brought improved levels of retention for children and adolescents in care and treatment, resulting in an improvement in VL suppression from 69 to 89%. Critical to the success of the intervention was the engagement of leaders of different faiths in education and awareness-raising with their congregations, as well as community members being involved in every step of the programme's implementation, from fundraising to collaboration and partnership building.

© UNAIDS

Keywords



ACCESS TO EDUCATION; CASE MANAGEMENT; CHILD PROTECTION; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; COMPREHENSIVE ORPHAN AND VULNERABLE CHILDCARE; TRACING THOSE NO LONGER ON TREATMENT; DISCLOSURE; FINANCIAL SUPPORT; HEALTH FACILITY–COMMUNITY COLLABORATION; HIV PREVENTION; HOLISTIC CARE; IDENTIFICATION AND TESTING; NUTRITION, PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; STIGMA; SUPPORT GROUPS; TREATMENT ADHERENCE; VL SUPPRESSION.



Name of the Intervention: Increasing access to HIV care, treatment and support for children and adolescents, Kenya

Focus of the intervention: (i) Identifying and testing children and adults living with HIV not on treatment; (ii) Access to HIV treatment, retention and adherence and VL suppression; (iii) Access to comprehensive orphans and vulnerable children care and support, including nutrition, psychosocial and spiritual.

Faith community asset area: (i) Faith Inspired health service providers; (ii) community outreach; and (iii) using places of worship.

Description of the intervention: The Health Department of the Catholic Diocese of Kitui (CDOK), has for over 30 years been taking care of the poorest households in the communities with the goal of ensuring that children, adolescents and the households living with and affected by HIV are resilient and thriving. To achieve this, CDOK has offered the following interventions to children and adolescents: i) provision of psychosocial support through the community organized through formation and support of Psychosocial Social Support (PSS) groups, ii) community education, and sensitization through social workers and community health volunteers including other existing community structures such as; churches, schools, and other learning institutions. From 2017 to date, the CDOK has worked with the Kitui County Government on a programme to identify children and adolescents living with HIV aged 0 to 19 years and ensure they are able to access treatment and have suppressed viral loads.

There are several steps in the programme:

- a. **Needs assessment:** Households are assessed and categorized depending on their needs that informs the type of services to be offered. The goals are developed with household members.
- b. **Provision of essential services:** These are based on needs identified through home visits, school visits and referrals.
- c. **Enrolment of CDOK orphans and vulnerable children programme:** Identification of children living with HIV in health facilities across Kitui County for close monitoring and for provision of services.
- d. **HIV prevention and testing:** Screening of children at risk of HIV to assess eligibility for HIV testing, awareness creation for HIV prevention and linkage to those who have tested positive.
- e. **Viral load monitoring:** Accomplished using client self-reporting, confirmed through an SMS platform. Includes health facility records and National AIDS and STI Control Programme (NASCOP) website. This is to facilitate categorizing children into stable and unstable pairs for targeted interventions.
- f. **Monitoring and supporting HIV status disclosure among children** to ensure they know their HIV status at age 12 years to help them accept their treatment as they transition to adolescence.



- g. **Lost to follow-up:** Carried out jointly with the health facility staff to trace children who are no longer in care and return them back to care.
- h. **Improving nutrition services:** Aimed mainly at children under five years by monitoring their growth and development, linking malnourished children to supplementary feeding, food aid and encouraging caregivers to establish kitchen gardens.
- i. **Linkage:** Helping very vulnerable households connect with government social safety nets.
- j. **Support access for children to education:** Accomplished by payment of school fees, scholastic materials and linkage to scholarships and bursaries.
- k. **Facilitating support groups:** Aimed at caregivers of children living with HIV.
- l. **Support and promotion:** School based strategies in selected schools.

Lead organization: Catholic Diocese of Kitui has implemented HIV related programmes for over 30 years. The programme partnered with several organizations, faith-based, and government facilities, to reach out to the project beneficiaries.

Location: Kitui County, Kenya.

Where the intervention was implemented: Community health facilities and places of worship.

Year the intervention started: 2017.

Is the intervention still being implemented: Yes, but the programme is now closing as funding from Christian Aid has ended.

Scale of change from existing activity required by the intervention: Moderate

Results of the intervention: For a period of four years, starting in 2017, CDOK delivered services to orphans and vulnerable children living with and affected by HIV and their households using a case management approach on needs identification in four intervention areas: healthy, stable, safe and schooled. From 2017 to 2020, the programme increased the number of children and adolescents living with HIV who were tested and supported from 444 to 2657. Of these, 50% were enrolled for monthly monitoring and service delivery. The interventions over three–four years brought about an improvement for children and adolescents in retention to care and treatment, resulting in an improvement of VL suppression from 69 to 89%. In FY2019/2020, CDOK had an active case load of 4016 orphans and vulnerable children. The results in the four intervention areas were as follows:

- **Under healthy domain:** A total of 1316 children and adolescents living with HIV have been linked to care and treatment: 28 children living with disabilities linked for disability assessment; five MDTs for 32 children and adolescents living with HIV with persistently high VLs; 24 physical tracings of children and adolescents living with HIV but no longer accessing treatment; 19 joint follow-up visits of children and adolescents living with HIV with non-adherence issues; 26 children and adolescents living with HIV receiving transport for their appointments and access to specialized medical services; 19 children and adolescents living with HIV households subscribed to the Kitui County Health Insurance Cover; 341 children under five years received vitamin A, deworming treatment and growth monitoring.
- **On schooled domain:** A total of 268 orphans and vulnerable children received school fees; 58 received school uniforms, 58 received vocational skills training; 42 linked to government bursaries; and 672 adolescent girls provided with sanitary hygiene kits.
- **Under safe domain:** Four children and adolescents living with HIV were rescued from abuse and provided with legal assistance and placed in safe environments; five community barazas were held on child protection; 12 Area Advisory Council (AAC) meetings were convened; 120 children supported in acquiring birth certificates; and 2250 caregivers were sensitized on positive parenting.

- **Under stable domain:** A total of 256 caregivers were supported in various income generating activities; 38 village savings and loan association groups were established to support caregivers caring for orphans and vulnerable children to access finance through savings and loans; four participatory vulnerability capacity assessments were conducted; one participatory market systems development forums were convened; two market forums were held; and 117 caregivers attended financial literacy sessions

Impact of the intervention: The programme's activities¹ improved community support and integration of services increased the number of people seeking HIV services, including the number of HIV screenings, referrals, enrolment on to care and treatment and retention on care. Supported family stability through economic strengthening and improved treatment outcomes with VL suppression (i.e. undetectable viral loads).

Extent to which the intervention has been scaled up: The case management approaches used by CDOK in the orphans and vulnerable children project have been used in several other counties, notably the Comprehensive Assistance, Support and Empowerment of Orphans and Vulnerable Children (CASE-OVC) programme. These counties included: Machakos, Makueni, Kiambu, Muranga and Meru. The interfaith council has reached out to various communities in more than ten counties with positive messages of hope, yielding very good outcomes with regard to attitudes and changes in health seeking behaviour, including seeking HIV services. This has helped greatly in the scale-up of different health interventions such as finding men and children to adhere to various health interventions. The programmes have used the parent bodies of different churches, such as the Supreme Council of Kenya Muslims (SUPKEM), National Council of Churches of Kenya (NCCK), Seventh Day Adventists (SDA), evangelical councils and the Kenya Conference of Catholic Bishops (KCCB), to reach out to other faith leaders who have been engaged through structured capacity building. The messages of hope can be accessed in the PEPFAR website and printouts by National Aids Control Council and other organizations implementing similar projects relating to children.

Source of funding to implement the intervention: USAID funding from the orphans and vulnerable children case project through Christian Aid as the primary grant recipient, local resource mobilization; in-kind support from well-wishers, the Government of Kenya and the Ministry of Health.

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

1. Engagement of different faith leaders in education and awareness raising with their congregations.
2. Involvement of the faith community in every step of the programme's implementation, including fundraising, lobbying for support from well-wishers, donors, collaboration, engagement and partnerships.
3. Working with a committed team of health service providers.

Key factors constraining the implementation and scale-up of the intervention:

1. Limited number of health facilities with long walking distances in some areas.
2. Limited resources for programme activities.
3. High levels of poverty.
4. COVID-19 challenges.
5. Lack of an adequate food supply for households.

¹ CDOK claims that these activities have reduced the levels of stigma but no strong data were provided as evidence of this impact.

6. Transport to the health facilities (e.g. to hospital for care and treatment). Some children and caregivers live far from a health facility and have to walk more than 30 km.
7. Some children and adolescents living with HIV have experienced rejection and neglect by unsupportive caregivers.
8. HIV stigma in schools and peers.

Resources available for the intervention:

The intervention has used several toolkits:

1. **Case plan achievement readiness assessment tool:** This is used to assess the vulnerability of households according to four categories: those that need rapid response; those that are in rebuilding stage; those that are stabilizing; and those that are ready to graduate (have achieved the 17 benchmarks).
2. **Case plan:** This is a tool for documenting agreed actions points that will help tracking the achievement of the 17 benchmarks.
3. **Children and adolescents living with an HIV tracker.** A tool for monthly tracking of children living with HIV, facility links; comprehensive care centre (CCC) data, pill count, date of appointment and next date of appointment, VL results, etc.
4. **Child protection information and management system:** An online system run by the Department of Children Services which has different modules and hosts information on children (e.g. biodata, services offered).

Information on the intervention:

The case management process materials, including its tools, can be accessed online:

- http://ovcsupport.org/wp-content/uploads/2017/06/4Children_a4-fact-sheet_17OS074.pdf
- <http://www.socialserviceworkforce.org/system/files/resource/files/Summary-Key-Finding-Case-Management-Case-Studies.pdf>
- Interagency Guidelines for Case Management and Child Protection: <http://ovcsupport.org/resource/inter-agency-guidelines-for-case-management-child-protection/>
- <http://nacc.or.ke/wp-content/uploads/2018/05/Faith-Sector-Booklet.pdf>
- https://www.unfpa.org/sites/default/files/resource-pdf/HIVTrainingManual_eng.pdf

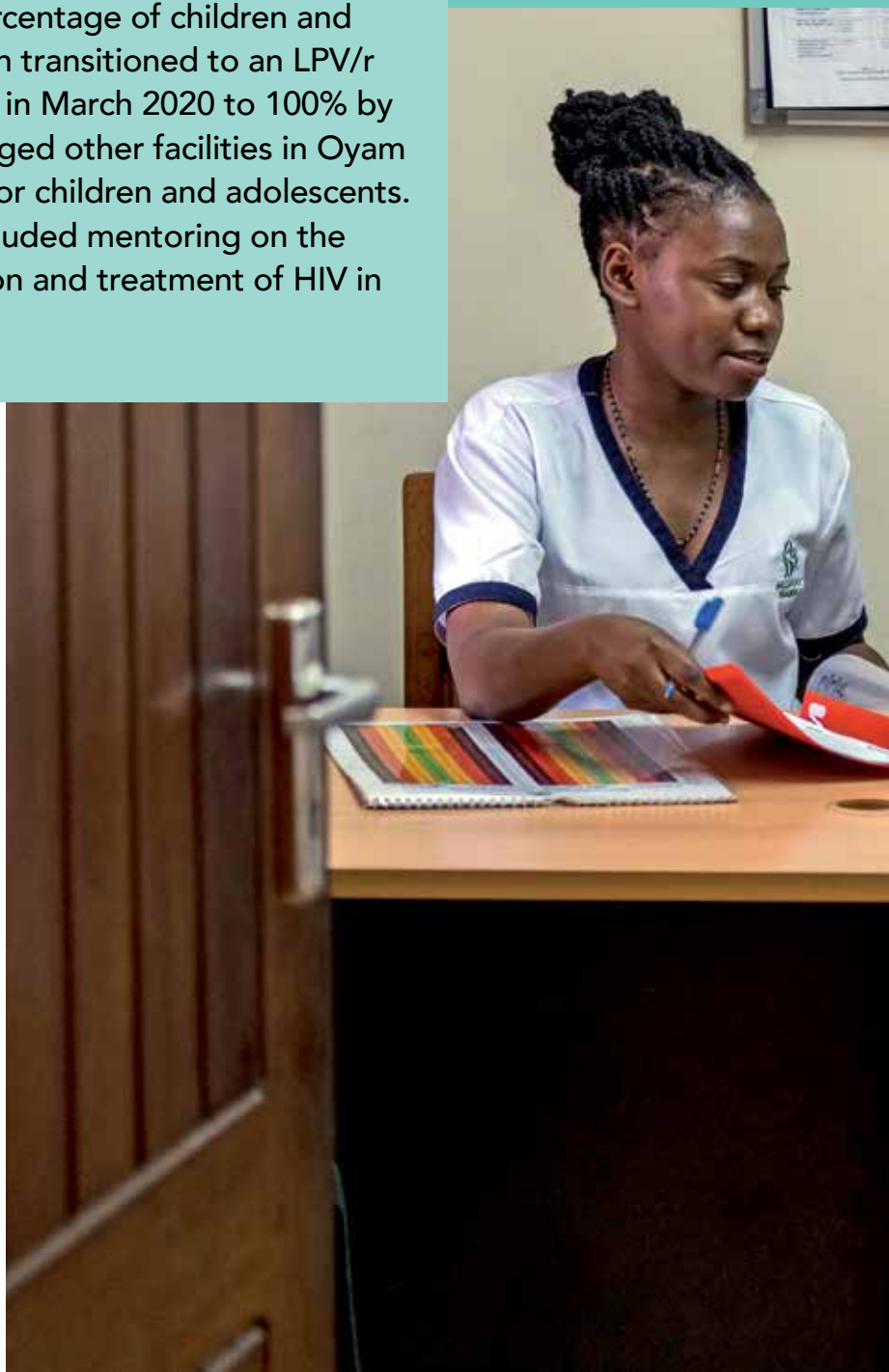


INTERVENTION 1.4

Paediatrics and adolescents' ART optimisation, UGANDA

Summary

Transitioning children and adolescents living with HIV to optimized ART treatments, particularly from Lopinavir/ Ritonavir (LPV/r) to Dolutegravir (DTG) based regimens, is a critical focus for paediatric HIV services. The St. John XXIII Hospital, a faith inspired health service provider in Oyam District, Uganda, used a facility based differentiated service delivery model to increase the percentage of children and adolescents in care who have been transitioned to an LPV/r or DTG based regimen, from 45% in March 2020 to 100% by December 2020. This has encouraged other facilities in Oyam District to optimize formulations for children and adolescents. Critical factors for this success included mentoring on the use of guidelines for the prevention and treatment of HIV in Uganda 2020.



Keywords

ART OPTIMIZATION; DIFFERENTIATED SERVICE DELIVERY; MENTORSHIP; VIRAL LOAD SUPPRESSION.

Name of the intervention: ART optimization for children and adolescents, Uganda.

Focus of the intervention: Access to HIV treatment; retention and adherence; and VL suppression

Faith community asset area: Faith Inspired health service provider

Description of the intervention: To improve the percentage of children and adolescents in care who have been transitioned to an LPV/r or DTG based regimen, from 45% in March 2020 to 100% by December 2020 through facility based differentiated service delivery models.







Lead organization: St. John XXIII Hospital—Aber, Oyam District, Uganda.

Location: Oyam District.

Where the intervention was implemented: Health facility.

Year intervention started: 2020.

Is the intervention still being implemented: Yes. Currently, the guidance from the Ministry of Health permits optimization from LPV/r based regimens to DTG based regimens for all children and adolescents above 20 kg in weight due to the advantages offered by DTG compared with LPV/r.

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

Results of the intervention: 100% (429/429) of children and adolescents in care optimized to a more potent LPV/r or DTG based regime.

Impact of the intervention: Improved VL suppression among children and adolescents, from 63% in March 2020 to 84% by February 2021. Improved adherence to treatment due to fewer side effects compared with Efavirenz or Nevirapine based regimens.

Extent to which the intervention has been scaled up: The intervention has been scaled up on a large scale within the facility since it achieved 100% success by the end of the target period. However, other facilities in Oyam District have also been encouraged to optimize formulations for children and adolescents.

Source of funding to implement the intervention: USAID Funding Under RHITES-N, Lango and currently Uganda Protestant Medical Bureau/LSDA project.

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

1. Mentorship on the use of guidelines for the prevention and treatment of HIV in Uganda in 2020 by teams from RHITES-N, Lango, Ministry of Health and, most recently, the Uganda Protestant Medical Bureau.
2. Timely laboratory services for VL testing.
3. Sending back eligible clients not optimized for clinicians for further evaluation at dispensing points.

Key factors constraining the implementation and scale-up of the intervention:

1. Delays in VL results from the Central Public Health Laboratory.
2. Pill burden with an LPV/r based regimen for children.

Resources for the intervention:

1. St. John XXIII Hospital—Aber ART department.
2. Electronic medical record system.
3. Central Public Health Laboratory Viral Load Dashboard.

Information on the intervention: The information can be found in the facility Electronic Medical System (EMRS) and Paediatrics/Adolescent Care Audit tool that will be shared.

INTERVENTION 1.5

Paediatrics ART optimization, ZAMBIA

Summary

This intervention, led by Catholic Relief Services (CRS) in Zambia, aimed to transition children and adolescents from non-nucleoside reverse transcriptase inhibitors (NNRTIs), particularly Nevirapine (NVP) and Efavirenz (EFV), to an improved regimen: either LPV-r or DTG based regimens. Working with 101 CRS supported health facilities, including mission hospitals, some 4659 children and adolescents living with HIV were initiated or switched to the most efficacious ART regimen; 85% were virally suppressed. The success of the intervention was enabled by CRS Technical Teams providing training and on-site mentoring for health care workers and community-based volunteers, as well as support for clinical mentors who provided guidance and leadership at selected high volume health facilities.

Keywords



ART OPTIMIZATION; COMMUNITY VOLUNTEERS; MENTORSHIP; RETENTION; VIRAL LOAD SUPPRESSION.

Name of the intervention: Paediatrics ART optimization, Zambia.

Focus of the intervention: Access to HIV treatment, retention and adherence and VL suppression

Faith community asset area: Faith inspired health service providers.

Description of the intervention: The paediatric and adolescent ART optimization intervention requires all HIV infected infants, children and/or adolescents to be initiated in more efficacious regimens (e.g. DTG, LPV-r based regimens). Those who were already initiated in NNRTIs, such as NVP or EFV, need to be transitioned to either LPV-r or DTG based regimens. LPV-r and DTG and being used for children below 20 kg and above 20 kg, respectively.

Lead organization: Catholic Relief Services (CRS) through its Epidemic Control 90/90/90 Project (EpiC 3-90).

Location: Zambia.

Where the intervention was implemented: 101 CRS supported health facilities, including mission hospitals and community health posts.

Year Intervention started: 2019.

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: As of 31 March 2021, EpiC 3-90 had a total of 4659 paediatric and adolescents receiving ARV care. All HIV infected paediatrics and adolescents were initiated or switched to the most efficacious ART regimen. The virological suppression rate was high with these regimens. Out of the 4659 children and adolescents receiving optimal ART regimens under EpiC 3-90 supported health facilities, 85% were virally suppressed. Zambia is yet to receive DTG 10 mg which will be used for children who are above 3–19.9 kg and aged over four weeks.

Impact of the intervention: The rate of hospitalization and death of children has been reduced significantly due to sustained VL suppression. In addition, the rate of school dropouts is closer to zero with the efficacious regimens.

Extent to which the intervention has been scaled up: All the 101 CRS/EpiC 3-90 FY21 supported health facilities have benefited from ART optimization.

Source of funding to implement the intervention: United States Government/PEPFAR/CDC

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

- Support from CRS technical and strategic information teams through training and on-site mentorship of health care workers, community-based volunteers and data officers. CRS technical staff work closely with the provincial and district hub offices who regularly visit the health facilities.
- In selected high-volume facilities, CRS has recruited and placed clinical mentors who provide guidance and leadership at the health facility levels.
- At the national level, CRS EpiC 3-90 senior technical lead staff actively participate in revising the national ART guidelines with the Ministry of Health and other implementing partners.

Key factors constraining the implementation and scale-up of the intervention:

- Dolutegravir 10 mg tablets are not yet in-country to support full rollout of paediatric ART optimization.
- There is a need to revise the ART forms to reflect all the new innovations.

Resources available for the intervention: The 2020 Zambia Consolidated Guidelines (ZCGs), and job aids are available to provide guidance to health care workers (HCWs). Soft copies of the 2020 ZCGs are available and shared with HCWs.

Information on the intervention: Interfaith Health Platform at: interfaith.health.platform@gmail.com



INTERVENTION 1.6

Improving Early Infant Diagnosis of HIV for exposed infants by reducing the turnaround time (TAT) of HIV results, ZAMBIA

Summary

Identifying children living with HIV of all ages is an essential component of paediatric HIV services and improving the turnaround time of early infant diagnosis (EID) is critical to this work. This intervention highlights work by the Catholic Relief Services (CRS) in Rufunsa District of Zambia to use point of care (POC) devices to dramatically reduce turnaround time. The intervention reduced the turnaround time of EID results in 26 rural supported health facilities, including Mpanshya Mission Hospital, from >30 days to 24–48 hours. Critical to the success of the intervention was placing POC devices in two nearby health facilities, at Mpanshya Mission Hospital and Chinyunyu Rural Health Centre. Equally important were staff training, provision of hands-on mentorship and provision of regular technical support, supervision and assistance.

Keywords



EARLY INFANT DIAGNOSIS; IDENTIFICATION AND TESTING; MENTORSHIP; POINT OF CARE TESTING; TURNAROUND TIME.

Name of the intervention: Improving early infant diagnosis of HIV for exposed infants by reducing the turnaround time (TAT) of HIV results, Zambia.

Focus of the intervention: Identifying and testing children and adults living with HIV who are not on treatment.

Asset area: Faith inspired health service providers.

Description of the intervention: Blood samples from HIV exposed infants (HEIs) were collected at scheduled times within the infant's early days of life, preferably between birth and the first two months of life. During antenatal care visits, pregnant women received HIV counselling and testing and were provided with results the same day. Women testing HIV positive were linked to same day ART initiation, monitored for VL testing with the aim of achieving viral suppression. Furthermore, all pregnant mothers were educated and informed that blood samples will be collected from their



HEIs at scheduled visits. At birth and during the subsequent scheduled visits, blood samples were collected and processed using near POC devices—GeneXpert (instead of sending samples by courier to the central polymerase chain reaction laboratories)—from all the HEIs. The results were returned rapidly back to the providers and mothers were informed.

Lead organization: Catholic Relief Services (CRS) through its Epidemic Control 90/90/90 Project (EpiC 3-90).

Location: Rufunsa District, Zambia.

Where the intervention was implemented: Rural health centres and mission hospitals.

Year the intervention started: 2020.

Is the intervention still being implemented: Yes

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

Results of the intervention: From April 2020 to March 2021, a total of 676 dry blood spot samples were collected and analysed using EID near POC devices located at both Chinyunyu Rural Health Centre and Mpanshya Mission Hospital (rural health facilities in Rufunsa District of Lusaka Province, Zambia). Out of the 676 samples, 16 HIV positive results were identified which were provided to the facilities within 24–48 hours. Out of the 16 positive infants, 14 were immediately initiated on lifelong ARVs, representing 88% linkage for Rufunsa district. The two baby–mother pairs are being followed up.

Quantitative data showing results of the intervention. Comparisons of turnaround time:

- Between March 2019 and March 2020: 30–42 days.
- Between April 2020 and March 2021: NAT system, 24–48 hours.

Impact of the intervention: The intervention has reduced the TAT of EID results in 26 rural supported health facilities (Rufunsa District) from >30 days to 24–48 hours. All HIV infected infants are quickly identified, and efficacious ART regimens prescribed and initiated immediately once diagnosis has been made.

Extent to which the intervention has been scaled up: Two near POC devices were placed at two health facilities in Rufunsa District. An additional device was procured and placed at Mtendere Mission Hospital in Chirundu (another rural district supported by the CRS EpiC 3-90 project).

Source of funding to implement the intervention: United States Government/PEPFAR/CDC.

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

- The intervention of placing EID near POC devices in Mpanshya Mission Hospital and Chinyunyu Rural Health Centre in Rufunsa District reduced the TAT from 30–40 days to 24–48 hours.
- The staff were trained and received hands-on mentorship, registers were printed, and distributed to the sites.
- CRS EpiC 3-90 technical staff provide regular technical support, supervision and assistance.
- CRS works in collaboration with other local implementing partners and the Ministry of Health to support the transport of EID samples from great distances to reach rural health centres.

Key factors constraining the implementation and scale-up of the intervention:

- Some health facilities were non-delivery sites which resulted in a lack of birth sample collections for some HEIs.
- Other facilities were in remote locations with poor network services which hindered communication between the health facility for collecting the sample dry blood spot EID samples and the site conducting the sample analysis.

Resources available for the intervention: Job aids developed by CRS in collaboration with MOH Laboratory TWG are available to provide guidance to the HCWs which provide services in the field.

Information on the intervention: Interfaith Health Platform at: interfaith.health.platform@gmail.com



INTERVENTION 1.7

Differentiated Service Delivery (DSD) Scholar Model, ZAMBIA

Summary

Adapting HIV service provisions for children and adolescents is an important means of increasing access to treatment and increasing retention and adherence. This intervention by the Catholic Relief Services (CRS) in Zambia is an example of DSD as it enabled children, often accompanied by their caregivers, to attend ART clinics on weekends and avoided missing school lessons. A total of 146 children and adolescents were able to access their ART services over the last weekend of every month and during these clinic days they received health education, clinical reviews, pharmacy dispensations, laboratory investigations and adherence counselling. They spent less time at health facilities as they did not have to wait in long queues which are often mixed with adults. A factor contributing to the intervention's success was that the children and adolescents, as well as their caregivers, were able freely interact with each other and discuss the benefits of lifelong ART treatment. Similarly, the flexibility of staff to support the optimal treatment times of children, was another important success factor.

Keywords



ACCESS TO EDUCATION; ADHERENCE COUNSELLING; ANTIRETROVIRAL TREATMENT; CASE MANAGEMENT; DIFFERENTIATED SERVICE DELIVERY; DISCLOSURE; PEER MENTORS; TREATMENT ADHERENCE; VIRAL LOAD SUPPRESSION.

Name of the intervention: Differentiated Service Delivery Scholar Model, Zambia.

Focus of intervention: Access to HIV treatment, retention and adherence and VL suppression.

Faith community asset area: Faith inspired health service providers.

Description of the intervention: Children and adolescents living with HIV are enrolled in the model to optimize their care while enabling them to continue and attend school lessons without missing their ART clinic appointments. CRS is currently

supporting the DSD Scholar model in four health facilities in Rufunsa District (a rural setup), in Lusaka Province. By 31 March 2021, a total of 146 children and adolescents were scheduled to access their ART services over the last weekend of every month. The table below gives TX_CURR and VL coverage and suppression as of March 2021.

TABLE 3.

Name of supported health facility	TX_CURR of children and adolescents	VL coverage	VL suppression
Kankumba Rural Health Centre	29	89%	76%
Chinyunyu Rural Health Centre	35	79%	85%
Chimusanya Health Post	40	92%	81%
Mpanshya Mission Hospital	42	95%	91%

Since it is a rural location, most of the recipients of care (RsoC) must cover long distances to access the ART services scheduled during the weekend. The caregivers usually accompany them to the health facilities and are given synchronized appointment dates. This allows for interaction of the RsoC of children and adolescents during the clinic hours as well as caregivers interacting among themselves. Health facility staff (nurses, laboratory staff, clinicians and community-based volunteers (CBVs) who are scheduled to support these weekend clinics are paid a lunch allowance and transport refunds by the EpiC3-90 Project. During clinic days, activities conducted include: health education, clinical reviews, pharmacy dispensations, laboratory investigations and adherence counselling. RsoC and caregivers are always given an opportunity to ask questions during the clinic's process.

Lead organization: Catholic Relief Services (CRS) through its Epidemic Control 90/90/90 project (EpiC 90/90/90)/.

Location: Rufunsa District, Zambia.

Where the intervention was implemented: Health facilities.

Year the intervention started: 2020.

Is the intervention still being implemented: Yes.

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

Results of the intervention: Implementation of the Scholar Model has contributed to improved retention in care among children and adolescent RsoC in the supported facilities, improved VL coverage and suppression, and facilitated HIV disclosure.¹ Children and adolescents, as well as their caregivers, freely interact with each other. They spend less time at health facilities as they do not wait in long queues which are often mixed with adults.

1 CRS claims that these activities have improved retention in care, improved VL coverage and suppression, and facilitated HIV disclosure, but no strong data were provided as evidence of this impact.



Impact of the intervention: The DSD model has contributed to focused management of adolescents living with HIV and allows them to receive ART care without missing school. It has also improved case management of adolescents, contributing to the third 2020 UN target that 90% of adolescents living with HIV who are receiving treatment have suppressed VL.

Extent to which the intervention has been scaled up: The DSD Scholar model has been implemented in four health facilities in Rufunsa District, with plans under way to roll out the model to other health facilities in CRS supported districts.

Source of funding to implement the intervention: United States Government/PEPFAR/CDC.

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

- Implementation of the DSD Scholar model has been successful because the health facilities have adopted the intervention by offering weekend clinics.
- Adolescents like the idea of being able to interact freely with peers without interference from adult RsoC.
- Both adolescents and caregivers share experiences regarding the challenges and benefits of lifelong ART treatment.

Key factors constraining the implementation and scale-up of the intervention:

- Key factors hindering implementation of the model include staff shortages among HCWs during the weekend.
- Lack of support and planned activities to fully engage the caregivers who accompany the adolescents demotivates them to escort the adolescent to the health facilities for care.

Resources available for the intervention: None.

Information on the intervention: Additional information about the intervention can be obtained by contacting the Interfaith Health Platform: interfaith.health.platform@gmail.com

INTERVENTION 1.8

Paediatric and adolescent adherence to ART support groups, ZIMBABWE

Summary

The main aim of the intervention is to encourage the formation of support groups at Bonda Mission Hospital and other faith-based rural health centres in Zimbabwe to encourage adherence of ART among children and adolescents. The intervention is implemented by the Chiedza Community Welfare Trust, which is a community faith-based organization working closely with the Bonda Mission Hospital.

The support groups are assisted in providing a range of services including: positive living information; information and services related to adolescent sexual reproductive health and rights (ASRHR); peer to peer counselling; and other socioeconomic activities. Faith leaders are involved in several ways: helping to tackle HIV stigma; encouraging their members to adhere to their ART medication; and encouraging members to participate in the support groups. The number of children and adolescents who have undergone an HIV test increased from 606 in 2015 to 1122 in 2020. A total of 69 children and adolescents continued to adhere to their ART medication in hard-to-reach communities. There was an increase in the number of children returned to treatment. Factors important to the intervention's success have been the role of faith and traditional leaders, as well as using a tracker for those no longer receiving treatment. The intervention has successfully been scaled up to 17 communities across Mutasa District.



Keywords

ACCESS TO EDUCATION; ADHERENCE COUNSELLING; ANTIRETROVIRAL TREATMENT; CHILD PROTECTION; COMMUNITY EDUCATION; TRACING THOSE NO LONGER ON TREATMENT; ECONOMIC EMPOWERMENT; HEALTH FACILITY–COMMUNITY COLLABORATION; HOLISTIC CARE; NUTRITION; PEER MENTORS; SEXUAL REPRODUCTIVE HEALTH AND RIGHTS; STIGMA; SUPPORT GROUPS; TREATMENT ADHERENCE.

Name of the intervention: Adherence of children and adolescent ART support groups, Zimbabwe.

Focus of the intervention:

- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence, and VL suppression.

Faith community asset area:

Faith inspired health service providers.

Advocacy by religious leaders.

Community outreach.



Description of the intervention: The main aim of the intervention is the formation of support groups at Bonda Mission Hospital and other faith-based rural health centres to encourage ART adherence by children and adolescents. The support groups are made up of between three- and six-members comprising parents/caregivers of children living with HIV, as well as children and adolescents living with HIV. The faith leaders are involved in several ways: helping to remove stigma associated with HIV in their congregations; encouraging their members to take and adhere to their ART medication; seek medical attention when required; and participate in the support groups. The intervention has several key elements:

- Children and adolescents on ART are identified from the health facility and in the school health programme.
- The school health teacher supported the children to take their medication.
- A tracker was used to find those no longer on treatment and support ART adherence, liaising with the school and health facility. Monthly meetings and collection of ART for adolescents and children were organized for those who lived far away from a health facility. During the monthly meetings the tracker for those no longer on treatment checked if every child in the ART register was taking the medication. Advice on healthy living was provided.
- The parents or guardians of these children also formed support groups. Children who were brought to the monthly meetings would also meet and support each other about adherence and other issues.
- The tracker for those no longer on treatment was used to follow up children who had not turned up for their medication.
- The support groups provided assistance and capacity building for the following:
 - Positive living information.
 - Adolescent sexual reproductive health and rights (ASRHR) information and services.
 - Educational support for the needy children and adolescents.
 - Nutritional support where there is a need.
 - Peer to peer counselling.
 - Capacity building in income generating activities for parents/caregivers of children/adolescents living positive with HIV.

Lead organization: Chiedza Community Welfare Trust (CHIEDZA) is a community faith-based organization working with the Bonda Mission Hospital. The latter is a service provider and the Chiedza Community Welfare Trust (CHIEDZA) is a community based organization which operates in the catchment area of Bonda Mission Hospital. CHIEDZA supports the hospital through its mobile outreach clinic to the communities with integrated comprehensive HIV, maternal and child health care, adolescent sexual reproduction health and rights, women and girls' health and child protection information and services. Bonda Mission Hospital provides skilled health cadres, while CHIEDZA provides the resources required to implement the services.

Location: Mutasa District, Manicaland, Zimbabwe.

Where the intervention was implemented: The intervention was carried out at three faith-based health facilities and 14 government rural health centres in hard to reach communities.

Year intervention started: 2014.

Is the intervention still being implemented? Yes.

Scale of change from existing activity required by the intervention: Moderate.

Results of the intervention: Support groups comprising three–six members were set up at all 17 health facilities which had HIV positive children and adolescents. They were supported by the involvement of local authorities, traditional and religious

leadership, parents and the community at large. The number of children and adolescents having an HIV test increased from 606 in 2015 to 1122 in 2020. There were 69 children and adolescents who adhered to their ART medication in hard-to-reach communities (see table below).

TABLE 4.

Year	No. of children and adolescents tested	No. of children and adolescents on ART	No. of children and adolescent support groups	No. of children and adolescents adhering to ART	No. of children and adolescents not followed up	No. of children and adolescents brought back into care after engagement by religious leaders
2014	0	8	1	6	3 Their faith did not allow them to continue taking ART	1
2015	606	14	4	12	2	2
2016	546	16	4	15	1	1
2017	722	8	2	8	0	0
2018	862	10	2	9	1	1
2019	1098	11	2	11	0	0
2020	1122	9	2	8	1	1

Impact of the intervention¹:

- More adolescents and children were tested for HIV.
- Greater number of children and adolescents adhered to ART.
- More children and adolescents returned to care after stopping treatment

Extent to which the intervention has been scaled up: The intervention has been scaled from just the community Bonda Mission to 17 communities in Mutasa District.

Source of funding to implement the intervention: Formally, the Southern African AIDS Trust, now SRHR Africa Trust (SAT)

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

- Working with faith and traditional leadership.
- Working with local health service centres.
- Having a tracker to follow up on those no longer on treatment.

Key factors constraining the implementation and scale-up of the intervention:

‘White garment’ religious sects which do not believe in modern medicine.

Resources available for the intervention: ART registers; transport to reach communities; and a tracker for those no longer on treatment.

Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com

¹ The programme claims that these activities have reduced the levels of stigma, but no strong data were provided as evidence of this impact.

INTERVENTION 1.9

Increasing access to HIV treatment for children and adolescents, KENYA

Summary

For 20 years the Marigat Catholic Mission Health Centre in Baringo County, Kenya, has been taking care of the less fortunate households in the communities with the goal of ensuring that children, adolescents and households living with and affected by HIV are resilient and thriving. To achieve this, the Catholic mission has offered community support through the formation of psychosocial support groups and community education and sensitization using social workers and community health volunteers, including community structures such as churches, schools and other learning institutions. Between 2018 and 2020, the programme increased the number of children and adolescents living with HIV from 5 to 54 who were tested, linked to care and supported. Of these, 45% of were enrolled for monthly monitoring and service delivery. The interventions brought about an improvement in retention to care and treatment for the children and adolescents that resulted in improvement of VL suppression from 35–86% over the period. Two critical success factors have been: (1) the community has been involved at every stage of the programme's implementation; and (2) support groups have encouraged those living with HIV about the importance of adhering to ARVs and of attending clinics.

© UNAIDS

Keywords



ACCESS TO EDUCATION; ANTIRETROVIRAL TREATMENT; CASE MANAGEMENT; CHILD PROTECTION; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; COMPREHENSIVE ORPHANS AND VULNERABLE CHILD CARE; TRACING THOSE NO LONGER ON TREATMENT; DISCLOSURE; ECONOMIC EMPOWERMENT; FAMILY BASED INDEX TESTING; FINANCIAL SUPPORT; HEALTH FACILITY–COMMUNITY COLLABORATION; HOLISTIC CARE; HUMAN RESOURCES; IDENTIFICATION AND TESTING; NUTRITION; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; STIGMA; SUPPORT GROUPS; TREATMENT ADHERENCE; VL SUPPRESSION.



Name of the intervention: Increasing access to HIV treatment for children and adolescents, Kenya

Focus of the intervention:

- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and VL suppression.
- Access to comprehensive care, treatment and support, including nutrition, psychosocial and spiritual.

Faith community asset area:

- Faith inspired health service provider.
- Community outreach.

Description of the intervention:

The Health Department of the Marigat Catholic Mission has for over 20 years been taking care of families with lower incomes in the communities with the goal of ensuring that children, adolescents and households affected and infected by HIV & AIDS are resilient and thriving. To achieve this, the Catholic mission has offered the following interventions for children and adolescents:

- Provision of psychosocial support through the community organized through psychosocial support groups.
- Community education and sensitization through social workers and community health volunteers, including existing community structures such as churches, schools and other learning institutions.

Since 2013, USAID has worked with the Baringo County Government on a programme to identify children and adolescents living with HIV aged 0–19 years and ensure they are able to access treatment and have suppressed VL counts. There are a number of steps in the programme:

- Provision of essential services based on needs identified through home visits, school visits and referrals.
- Enrolment in a food programme; identification of children living with HIV in health facilities across Baringo for close monitoring and provision of services.
- HIV prevention and testing through a family testing programme; screening of children at risk of HIV to access eligibility to HIV testing; awareness creation for HIV prevention; and linkage to those who have tested positive.
- Monitoring of the VL using client self-reporting confirmed through an SMS platform (NASCOP EID VL), health facility records; and national AIDS and STI control programme (NASCOP) website.
- Monitoring and supporting HIV status disclosure among the children. This is to ensure they know their HIV status at age of 12 years to help them accept their treatment as they transition to adolescence.
- Together with the health facility staff, tracing the children no longer accessing treatment and supporting their return.
- Improving and providing nutrition services, mainly to children under five years, by monitoring their growth and development; linking malnourished children to supplementary food assistance; and encouraging care givers to establish kitchen gardens.
- Support access for children to education through the payment of school fees and linkage to scholarships and bursaries.
- Facilitating support groups for caregivers of children living with HIV.
- Supporting and promoting school-based strategies in selected schools through school health programme.



Lead organization: Marigat Catholic Mission Health Centre was initiated in 1982 by the organization of Franciscan Missionaries of St. Joseph Sisters. The programme partnered with several organizations, faith-based, well-wishers and government facilities, to reach out to the project beneficiaries.

Location: Marigat, Baringo County, Kenya.

Where the intervention was implemented: Marigat Catholic Mission Health Centre and communities surrounding the facility.

Year the intervention started: 2013

Is the intervention still being implemented: Yes, but some partners including USAID, are ending their support.

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

Results of the intervention: From 2013 the intervention demonstrated that it was able to deliver services to infected and children and adolescents affected by HIV and AIDS and their households using need identification in four interventional areas: healthy, stable and unstable, safe and schooled domains.

Between 2018 and 2020, the programme increased the number of children and adolescents living with HIV from 5 to 54 who were tested, linked and supported, of these, 45% were enrolled for monthly monitoring and service delivery. The interventions brought about an improvement for children and adolescents in retention to care and treatment, resulting in improvement of VL suppression from 35 to 86% between 2018 and 2020.

The results in the four intervention areas were:

1. Healthy domain: A total of 25 children and adolescents living with HIV have been linked to care and treatment. There were 30 cases of physical tracing of children and adolescents living with HIV but no longer on treatment which facilitated follow-up of children and supported adolescents living with HIV having challenges with adherence. Finally, 14 under five-year-olds were supported with vitamin A, dewormers and growth monitoring activities.
2. Schooled domain: Ten children were supported with school fees, 15 provided with school uniforms from well-wishers and ten linked to government bursaries.
3. Safe domain: Seven children were rescued from abuse and provided with legal assistance and placed in a safe environment. Three staff meetings were held to train staff on how to deal with child abuse. And 50 caregivers were sensitized on positive parenting.
4. Stable domain: Up to 50 caregivers were supported in starting such activities as setting up merry-go-rounds, renting chairs, setting up kitchen gardens and rearing chickens.

Impact of the intervention¹: The intervention increased the number of children and adolescents freely seeking to access HIV services. The health facility also marked Mother's Day, Women's Day, Father's Day and World AIDS Day to destigmatize HIV. These actions encouraged large numbers of people to visit the health facility to access HIV and other services.

Before these interventions, children and adolescents were escorted by their caregivers to the facility. However, since the start of this intervention, most of the children/ adolescents have come alone and freely without fear for care and treatment services, leading to improved treatment outcomes with VL suppression (undetectable VLs). Those on ARVs have kept their health and strength with treatment against opportunistic diseases.

¹ The programme claims that these activities have reduced the levels of stigma, but no strong data were provided as evidence of this impact.

Extent to which the intervention has been scaled up: The programme has led to good viral suppression results (undetectable VL). The approach used in Baringo County has also been used in Kisumu, Malindi and Lamu. The Kenyan Ministry of Health and some NGOs have used this approach in: Baringo north (Kabartonjo), Baringo Central (Baringo referral hospital), Koibatek (Mercy Mission Hospital, Eldama Ravine Hospital, Nakuru County, Laikipia, Samburu and Kajiado.

Source of funding to implement the intervention: USAID, local resource mobilization, in-kind support from well-wishers and the Government of Kenya through the Ministry of Health.

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

- Having one health worker full-time with the clients.
- The community has been involved in every step of the programme's implementation, including lobbying for support from well-wishers and donors, and also collaborating and partnering.
- Support groups have encouraged each other about the use of ARVs and the importance of attending clinics.
- Community outreach has enhanced the availability of medicines to clients in the various communities.
- Having regular testing and screening follow-up.

Key factors constraining the implementation and scale-up of the intervention:

- Lack of sufficient staff.
- Limited resources for the programme activities.
- High poverty levels.
- Covid-19 challenges.
- Lack of sufficient food supply for households.
- Delay in receiving drugs and testing commodities.
- High stigma levels in schools and peers.
- Some children and adolescents infected and affected with HIV have experienced rejection and neglect by unsupportive caregivers.
- Lack of transport to the health facilities for care and treatment of some of the children and caregivers who live far from the health facility and have to walk for over 25 km.
- Insecurity in different communities, which has meant that many people have not been able to access care and treatment services.
- Most of the places have experienced flooding, hindering interventions.

Resources available for the intervention:

- Facility registers, mobile phone, website (www.marigatphc.org).
- The management of the Marigat Catholic Mission ensures that all staff has full information on child protection.
- Tracker of children and adolescents living with HIV for monthly tracking of children living with HIV, facility linked to Comprehensive Care Centre (CCC) numbers, pin count, date of appointments, and VL results to track progress.

Information on the intervention: Facility website: www.marigatphc.org. Additional information: Interfaith Health Platform: interfaith.health.platform@gmail.com



INTERVENTION 1.10

Care and support for orphans and vulnerable children and their families, COTE D'IVOIRE

Summary

The Vie et Paix NGO was set up by the Community of Our Lady of Peace of Abidjan in Côte d'Ivoire to deliver sustainable and comprehensive community-based services to those families with lower incomes, particularly to strengthen the care and support of 200 orphans and vulnerable children and their families. A key focus has been to ensure that all children who test positive for HIV are enrolled in ARV treatment, as well as providing psychosocial, nutritional and medical support. As a result of the intervention, more than half of the children and adolescents in the project area have been monitored and have suppressed VL, there were no losses to follow-up, and all were in care. In April 2021, 75 children out of 105 living with HIV had achieved VL suppression. The success of the intervention has been attributed to its comprehensive and wide range of components as well as to the role of support groups that have helped participants to understand the experiences of other people in the same situation and that they are not alone living with HIV.

Keywords



ANTIRETROVIRAL TREATMENT; COMMUNITY VOLUNTEERS; COMPREHENSIVE ORPHANS AND VULNERABLE CHILDREN CARE; ECONOMIC EMPOWERMENT; HEALTH FACILITY–COMMUNITY COLLABORATION; HIV PREVENTION; HOLISTIC CARE; NUTRITION; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; SUPPORT GROUPS; TREATMENT ADHERENCE; VIRAL LOAD SUPPRESSION.

Name of the intervention: Care and support for orphans and vulnerable children and their families, Cote d'Ivoire.

Focus of the intervention:

- Access to comprehensive orphans and vulnerable children care and support.
- Access to HIV treatment, retention and adherence, and VL suppression.

Faith community asset area:

- Faith inspired health service provider.
- Community outreach.

Description of the intervention: Strengthening of care and support services for 200 orphans and vulnerable children and their families. The activities included:

- Support for orphans and vulnerable children and their families.
- Care and support for people living with HIV. The activity is carried out in the community, but all children who test positive for HIV in the community or in the hospital are enrolled in ARV treatment.
- Fighting poverty.
- Health promotion.



Lead organization: VIE et PAIX, CNDP/VIP NGO, formerly CNDP, was set up by the Community of Our Lady of Peace of Abidjan, Côte d'Ivoire. Life and Peace's mission is to change lives through the compassion and commitment of a team of professionals and volunteers dedicated to delivering sustainable, high impact, community-based services for families on lower incomes. The purpose of the association is to:

- Make a significant contribution to the prevention and care of people affected and infected with HIV and AIDS.
- Provide technical support for the fight against poverty and health promotion.
- Strengthen the capacity of community, faith-based NGOs, private and public institutions for a more effective and appropriate response.
- Work closely with governments, local authorities, local development NGOs, national and international associations and institutions.
- Provide technical support for the national and subregional response to HIV and AIDS.

Location: Within the Catholic Mission, close to the Vavoua General Hospital.

Where the intervention was implemented: In the community, but also the hospital whenever necessary through an active referral.

Year the intervention started: 2008.

TABLE 5.

Year	No. of children and adolescents tested	No. of children and adolescents on ART
2008–2009	388	ICAP
2009–2010	433	ICAP
2010–2011	502	ICAP
2011–2012	693	SEVCI
2012–2013	756	SEVCI
2013–2014	789	VIE ET PAIX SEVCI
2014–2015	843	VIE ET PAIX SEVCI
2015–2016	895	VIE ET PAIX SEVCI
2016–2017	920	OEV
2017–2018	948	SEVCI PNOEV
2018–2019	958 OEV, with 43 graduated	PNOEV
2019–2020	200	FNLS
2020–2021	200	FNLS

Between 2020 and 2021, the National Fund for HIV/AIDS Control Project (FNLS) took care of 200 of the most vulnerable and underprivileged orphans and vulnerable children out of a total of 915 orphans and vulnerable children in the health district of Vavoua.



Is the intervention still being implemented: Yes

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

Results of intervention¹: The intervention improved the well-being of orphans and vulnerable children, increased the VL suppression rate and enabled children living with HIV to resume schooling:

- HIV ARV treatment: From January 2020 to December 2020, there were 67 children with a VL suppression rate of 79%.
- Psychosocial support was provided to 200 out of 915 children through the FNLS project; they had good emotional health (i.e. they were cheerful, with a good mood, and are hopeful).
- Food support was provided to 200 out of 915 orphans and vulnerable children who ate regularly and were well nourished.
- Health support for medical care was provided to 200 out of 915 orphans and vulnerable children. This included: purchase of medication; hospital costs; exemption from health care costs; education in ARV treatment and opportunistic infection care and community support; and management of symptoms such as diarrhoea, fever, pain, cough and referrals for HIV testing to family members.
- Apprenticeship support was provided to 14 orphans and vulnerable children in 2012 and 20 in 2020–2021.
- Support was provided to socioeconomic income generating activity to 120 families in 2012 and to 12 in 2020.

Impact of the intervention: More than half of the children and adolescents in the district that the project has monitored have suppressed VL; there were no losses to follow-up and are all in care. In April 2021, 75 children living with HIV out of the 105 had achieved VL suppression.

Extent to which the intervention has been scaled up: The activities have only been undertaken in Vavoua Department and sub-prefectures of Deragon, Ancien-Prozi, CSR Bahoulifla, Bazra-natis, Bienoufla, Gbabo, Gouriela, Mignoré, Monocozi, Neounefla, Pelezi, Cebedoufla, Tenefero, Vaafla, Vahou, Yooredoula, CSU Dania, Seitifla, D U Vavoua, CSU Bodouasso, Bonoufla, Dananon, Dediafla, Ketro–Bassam, Trafla–gotron Vouro II, Zueigotron, H G Vavoua, CSR Denzerville, and SSSU-JAJ Vavoua.

¹ The programme claims that the intervention had reduced the number of deaths of orphans and vulnerable children, but no strong data were provided as evidence of this impact.





Source of funding to implement the intervention: 2008–2011 International Center for AIDS Care and Treatment Program (ICAP); 2012–2018 Health Hope Life, Côte d'Ivoire; 2018–2019 PNOEV; March 2020–March 2021, Fonds National de Lutte Contre le VIH (FNLS).

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

- Importance of taking medications at regular times.
- Distribution of food kits.
- Provision of income generating activities.
- Prescription fees paid for sick children.
- Transport costs paid for relatives who live a long distance from a facility.
- Recognition that some parents are better at monitoring their children's medication adherence.
- Recognition that support groups play an important role in helping participants understand the experiences of other people in the same situation and understanding that they are not alone living with the virus; in the process, bringing back the joy of living.
- Support provided to some parents for follow-up with their children, to accompany children for hospital appointments and encouraging them to take their ARV medications.

Key factors constraining the implementation and scale-up of the intervention:

- Lack of involvement of some parents in the follow-up to their child.
- Difficulty of accessing children far from the city.
- Lack of transport.

Resources available for the intervention:

- Communication tool: picture boxes.
- Household identification card.
- Orphans and vulnerable children support activity sheet.
- Tracking register.
- A summary of the organization's activities.
- Reference sheet and against reference.
- Information sheet on the child status index.
- Household scorecard.
- School tracking sheet.

Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com

INTERVENTION 1.11

Eastern Deanery AIDS Relief Programme (EDARP's) Integrated Clinic-Community model, KENYA

Summary

The Eastern Deanery AIDS Relief Programme (EDARP) is a Catholic faith-based organization providing quality clinic–community based HIV and TB prevention, testing, treatment and care services in the Eastern slums of Nairobi, Kenya. EDARP has developed a highly effective model of integrated clinic–community HIV care which uses a comprehensive and holistic approach to assessment and treatment, acknowledging and integrating the unique physical, emotional, social and spiritual needs of each person. The intervention includes targeted HIV testing strategies, including HIV self-testing, antenatal care, prevention of vertical transmission (PVT), screening, testing and treatment for both TB and drug resistant TB, and voluntary medical male circumcision (VMMC). In 2021, the programme provided services to over 30 000 HIV positive persons, including 1500 children under the age of 18 years. Viral load suppression among adults was at 94%. Of the 1500 HIV positive children in EDARP's care, 88% of children under 10 years of age were virally suppressed, and 92% of children 10–18 were virally suppressed. The success of EDARP has been due to several factors. First, the critical role played by 1100 CHWs, motivated by their faith and supported by their local congregations, provided the key link between the clinic and the community. Second, EDARP has been strongly rooted in and inspired by local faith communities from its inception in 1993. Not only the role of individual CHWs, but local faith leaders from a variety of religious and spiritual traditions have been provided with regular support, updates and education, as well as 9 of EDARP's 14 outpatient clinics being located on the grounds of a church. Third, the success highlights the importance of integrating both the community–clinic model and the bio–psychosocial–spiritual model of care. Fourth, EDARP has always placed a high value on quality human resource management, including supporting staff, in both their individual and local office spiritual support.



Keywords

ADHERENCE COUNSELLING; ANTIRETROVIRAL TREATMENT; BIO–PSYCHOSOCIAL–SPIRITUAL PATIENT CENTRED MODEL; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; EARLY INFANT DIAGNOSIS; EDUCATION FOR FAITH LEADERS; HEALTH FACILITY–COMMUNITY COLLABORATION; HIV PREVENTION; HIV SELF-TESTING (HIVST); HOLISTIC CARE; IDENTIFICATION AND TESTING; PEER MENTORS; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; STIGMA; SUPPORT GROUPS; TREATMENT ADHERENCE; PREVENTION OF VERTICAL TRANSMISSION; VIRAL LOAD SUPPRESSION.



Name of the intervention: EDARP's integrated clinic–community model, Kenya.

Focus of the intervention:

- HIV and health awareness.
- Preventing vertical transmission (PVT).
- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and VL suppression.
- Adolescent HIV prevention and life skills training.

Faith community asset area:

- Faith inspired health service providers.
- Community outreach.
- Places of worship.

Description of the intervention: The EDARP model's key features are strong community linkages fostered by trained, supervised community volunteers supported by Catholic Church parishes and other local faith communities providing comprehensive, integrated HIV and TB prevention, testing, care and treatment and empowerment for patient education and advocacy. This includes targeted HIV testing strategies, including HIVST, ANCs and PVT, screening, testing and treatment for both TB and drug resistant TB, and VMMC. Key components of EDARP are:

- The 1100 EDARP CHWs, who were the key to the success of treatment adherence and, most recently, finding the missing HIV positive men, young adults and children. These CHWs, motivated by their faith and supported by their local congregations, provide the critical link between the clinic and the community, including communities of faith. The CHWs are identifying and visiting parishioners who are sick and/or frequently asking for prayers for improved health and screening them for TB and HIV testing or offering HIVST. During the COVID-19 pandemic, these CHWs provided valuable public health education in their local communities
- HIV positive mentor mothers, who identify, accompany and support HIV positive new mothers through ANCs and PVT. Working within the community they continually search for any missing HIV positive children and encourage all pregnant women to avail themselves to prevention of vertical transmission (PVT) services.
- EDARP's 'Men Only' clinic hours and designated days so that male health workers can provide clinical assessment, care, treatment and support services for men. This includes screening for mental health and substance abuse issues, assisted HIVST, and partner notification services.
- Male community health workers, who reach out to provide community support for men by men.
- The ethos of 'karibu', or welcome, by all staff and CHWs for those who come to EDARP for services, especially those from key population groups.
- Training of adolescent and young adult peer mentors (virally suppressed for six months or more) in screening and targeted HIVST for their high-risk peers who are reluctant or unable to access clinic-based HIV testing and counselling.
- Providing evidence-based screening for spiritual distress for all newly enrolled patients and linking those with spiritual distress with HIV positive pastors and clergy already enrolled in care. In addition, providing training for local pastors to integrate spiritual care and support with biomedical interventions.
- Local faith communities, with which EDARP has been strongly rooted and inspired from its inception in 1993. Each of the 1100 CHWs is rooted in a local faith community. Nine of EDARP's 14 outpatient clinics are located on the grounds of a church. This 'mainstreams' HIV care and support for the whole community and provides a degree of confidentiality and privacy for the client accessing services. These places of worship provide meeting and training spaces for EDARP's CHWs, staff for public health education. The presence of EDARP, both within local churches and the wider community, provides a beacon of hope and life.

Lead organization: The EDARP is a Catholic FBO providing quality clinic community-based HIV and TB prevention, testing, treatment and care services in the eastern slums of Nairobi.

Location: Nairobi, Kenya. Nairobi County has the highest HIV burden in Kenya with 178 270 people estimated to be living with HIV and an HIV prevalence of 6.1%. EDARP serves a target population within Nairobi County with a much higher prevalence estimated at 12% in urban slums.

Where the intervention was implemented: Health facilities and in communities. Most EDARP clinical sites are located on the compound of the faith community.

Year the intervention started: 1993.

Is the intervention still being implemented? Yes.

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

It is difficult to provide an exact model for replication of the EDARP clinic–community model, given the humble origins of one priest and one nurse looking for ways to help those living with HIV and TB. EDARP’s original vision emerged from the community to provide additional layers of support for family caregivers for those dying from AIDS related illnesses. Eventually, many of these family members requested training as a CHW and provided care not only for their own family member, but for others in the local community. As the organization grew, EDARP worked with local pastors and faith leaders for their recommendations on individuals who may be interested in training as a CHW. These CHWs have emerged from local faith communities and many have served for 10–15 years. This longevity, and the fact that they come from and are supported by their community, adds to the trust, hope and inspiration which these individuals generate. When creating a model for community–clinic services, it is essential that first the voices, the concerns and needs of community members are listened to and valued so that as clinical programmes are developed, they respond to the specific needs of the community. As care and support for people with HIV developed, including the advent of ART, the roles and functions of the CHWs also developed. Since 2004, a main function of a CHW is to provide treatment support, and since 2017 to encourage VL suppression (undetectable = untransmissible). Additionally, these CHWs have been instrumental in EDARP’s 100% linkage between testing and HIV care and treatment.

*Providing support
to clients*

© Sean Sprague





An EDARP team

© Maryknoll

Results of the intervention: In 2021, the programme provided services to over 30 000 HIV positive persons, including 1500 children under the age of 18 years. Viral load suppression among adults is currently at 94%. This has been maintained during COVID-19 through SMS support and CHWs visiting and supporting clients with physical distancing and personal protective equipment (PPE). During 2021, 602 pregnant HIV positive women were enrolled in the PVT programme. All were on ART and supported by a welcoming (Karibu) staff and each woman is assigned a CHW mentor mother to guide and support her through this process. Each pregnant mother is assessed through a bio-psychosocial-spiritual model of care that results in a unique person-centred treatment plan to support the mother through her pregnancy and delivery. These CHW mentor mothers have received additional training in PVT, are often HIV positive themselves and have given birth to HIV negative children. They are from the local community and provide a critical link between the community and clinic. Almost all of these young mothers rely on their spiritual and religious beliefs and practices during this time. Of the 602 women, only three of these babies have tested positive. Of the 1500 HIV+ children in EDARP's care, 88% of children under ten years of age are virally suppressed, and 92% of children 10–18 are virally suppressed. CHWs from local faith communities provide constant support to young mothers and guardians to ensure regular ART adherence. Of these children, 86% are enrolled in the Operation

Triple Zero (OTZ) programme—a structured initiative that encourages zero missed doses (of medication), zero missed appointments, and zero VL. Indeed, EDARP's motto is 'Heroes are ZEROES!' Each child is assigned a CHW and each adolescent is paired with an HIV positive peer mentor who has achieved VL suppression. During COVID, much of the support has been provided through texting and a closed WhatsApp group. Peer mentors and CHWs were also provided PPE for home visits and support.

Impact of the intervention: Local faith communities provide a safe, secure and judgment free venue to support clients in their unique needs. The EDARP programme started as grassroots, community-based intervention and has never lost these roots while continuing to grow over the past 28 years. These essential CHWs are recruited from and supported by local faith communities, as well as supported institutionally by EDARP with monthly support meetings and quarterly continuing education. The programme has resulted in outstanding clinical care in a high density, slum environment.

Extent to which the intervention has been scaled up: In 1993, the programme consisted of one priest and one nurse providing basic care and ensuring 'no one dies alone'. While basic nursing and hospice services could be provided, the focus often was on spiritual support and understanding each patient's unique needs. There were no buildings other than the parish church. A few years later, with some support from Catholic donors in Germany, the first clinic was begun, which highlights that EDARP's roots are in the community. As the model has progressed, other organizations have tried to integrate the community-clinic model into their own activities, including the Kenyan Ministry of Health (MoH) with their CHFs. Currently in Kenya (and Namibia) many of the government programmes initially attracted EDARP's volunteers (and paid them), but many returned to work with EDARP because they preferred the spiritual aspects of EDARP's activities.

Source of funding to implement the intervention: The main source of funding is through PEPFAR through a cooperative agreement with the US Centers for Disease Control and Prevention (CDC). The Government of Kenya provides most of the ART medications and laboratory supplies as in-kind donations. The Maryknoll Fathers and Brothers provide some additional funding.

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

- The key to this intervention is the use of comprehensive and holistic assessment and treatment, acknowledging and integrating the unique physical, emotional, social and spiritual needs of each person.
- Creating a deep sense of welcome during each clinical visit and community support visit by the CHW. An important success factor in treatment adherence and, most recently, finding the missing HIV positive men, young adults and children, are the EDARP CHFs. Motivated by their faith and supported by their local congregations, these 1100 people provide the critical link between the clinic and the community, including communities of faith. This link is not only for new referrals, but the sustained community-based support essential for long term VL suppression.
- The link with local faith communities is part of the origin of the intervention. However, it is also critical that local faith leaders, including pastors, imams and community leaders, also received regular updates regarding HIV care, treatment and support. During the early years of HIV, before treatment, faith leaders were integral to care and support. However, with the advent of ART in EDARP in 2004, there was so much emphasis on treatment protocols, the pastors were often forgotten. Regular support, updates and education for faith leaders is essential in our community-clinic model of care.

- HIV care, support and treatment is challenging work, especially in a slum environment which has so many social problems and difficulties. Staff support, including spiritual care and support for staff, regular psychosocial debriefing and support, and regular opportunities for continuing education are critical. EDARP has always placed a high value on quality human resource management. This includes supporting staff, from a variety of religious and spiritual traditions, in both their individual and local office spiritual support.
- Scale up must be slow and gradual. Even though there is constant pressure from donors to scale up successful models, basic organizational psychology and development reveal that slow and steady is the key to successful growth.
- The bio–psychosocial–spiritual patient centred model of care, including one social worker at each site, has also been key to success.

Key factors constraining the implementation and scale-up of the intervention: In the early years when EDARP was scaling up, particularly while initiating patients on ART, there was a tendency to ignore the complex bureaucracies of most Kenyan governmental systems. This is a mistake made by many faith-based organizations. EDARP has continually worked to have an open, positive relationship with Kenya's governmental partners in terms of policy, provision of services and referrals. EDARP believes that governments are ultimately responsible for the health of a nation and that churches should provide services and support where others will not or cannot.

Resources available for the intervention: EDARP'S success highlights the importance of integrating both the community–clinic model and the bio–psychosocial–spiritual model of care. It not only links the person in the community to the clinic and back, but also treats and respects the person, understanding pain and distress in physical, emotional, social and spiritual terms. It is when the clinician understands the patient as a person, and the person's environment, that true patient centred care is possible. Three articles explain the importance of these issues:

- Saad M, de Medeiros R, Mosini AC. Are we ready for a true biopsychosocial–spiritual model? The many meanings of "spiritual". *Medicines (Basel)*: 2017; 4(4):79. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5750603/>
- Szaflarski M, Spirituality and religion among HIV-infected individuals. *Current HIV/AIDS Reports*: 2013; 10(4):324–332; <https://pubmed.ncbi.nlm.nih.gov/23996649/>
- Tuck I, McCain NL, Elswick Jr. RK. Spirituality and psychosocial factors in persons living with HIV. *J Adv Nurs*. 2001; 33(6):776–783. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2211369/>

Information on the intervention:

- Ending AIDS as a public health threat: faith-based organizations (FBOs) as key stakeholders: <https://jilifc.com/resources/ending-aids-as-a-public-health-threat-faith-based-organizations-fbos-as-key-stakeholders/>
- Work of EDARP in Nairobi, Kenya: https://www.youtube.com/watch?v=uYho0Blm-Q&ab_channel=EasternDeaneryAIDSReliefProgram-EDARP



INTERVENTION 1.12

Initiate Adolescent and Young People Friendly Care Services, KENYA

Summary

The intervention by CHAP-UZIMA, a project of the Christian Health Association of Kenya (CHAK), focuses on creating adolescent and young adult friendly services to promote this target population's welfare by encouraging them to develop a positive attitude towards HIV care and treatment and by empowering them and rebuilding their self-esteem. The intervention includes activities in three areas: disclosure to identify the non-disclosed adolescents and young adults; caregiver education that includes initiating support groups and also on health education to educate young people about the importance of treatment adherence. As a result of peer support and addressing sub-optimal suppression, the intervention has improved suppression rates which increased over the project's timeline from 45.8 to 83%. The intervention also contributed to improving the levels of friendliness among adolescents and young adults. The importance of enthusiastic and cooperative staff has been identified as a key factor behind the project's success.

Keywords



ADOLESCENT FRIENDLY APPROACHES; ANTIRETROVIRAL TREATMENT; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; HEALTH FACILITY-COMMUNITY COLLABORATION; RETENTION; TREATMENT ADHERENCE; VIRAL LOAD SUPPRESSION.

Name of the intervention: Initiate adolescent and young people friendly care services, Kenya.

Focus of the intervention: Access to HIV treatment, retention and adherence and VL suppression.

Faith community asset area: Faith inspired health service providers; community outreach.

Description of the intervention: The intervention promotes the welfare of the target group by encouraging them to develop a positive attitude towards HIV care and treatment, as well as empowering them and helping to rebuild their self-esteem and realize their dreams. Activities were undertaken in three areas:

- Disclosure: Identify and list all adolescents and young adults, identify the non-disclosed adolescents and young adults.
- Caregiver education: Identify principal care givers for all adolescents and young people, initiate a caregiver support group.
- Health education: Educate the young people in the group to empower the adolescents. Educate everyone on the importance of treatment adherence for achieving suppression

Lead organization: CHAP-UZIMA is a five-year project implemented by the Christian Health Association of Kenya with funding provided by PEPFAR–CDC and has been running from April 2017 to 31 March 2022. CHAP-UZIMA is mandated to oversee HIV care and treatment, as well as services for orphans and vulnerable children in 79 faith-based and affiliated health facilities spread over 19 counties in Nairobi, Central, Eastern, Coast and Rift Valley regions.

Location: Health facilities in 19 counties in the Nairobi, Central, Eastern, Coast and Rift Valley regions.

Where the intervention was implemented: Health facilities.

Year the intervention started: 2018.

Is the intervention still being implemented: Yes.

Scale of change of activity required to introduce the intervention compared with existing practices: Moderate.

Results of the intervention: A total of 24 people enrolled in Operation Triple Zero (OTZ) and of the target group, 13 had a high VL prior to the start of the project and since then they achieved a suppression rate of 69%. The general suppression rate increased over the same period increased from 45.8% to 83%.

Impact of the intervention:

- It has significantly increased general facility VL suppression.
- It has improved client–client relationships and HCW–client relationship.

Extent to which the intervention has been scaled up: Intervention is still within the facilities.

Source of funding to implement the intervention: Chap UZIMA, funded by PEPFAR-CDC.

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

- Availability of willing and cooperative staff.
- Dedicated clients.
- Financial support.

Key factors constraining the implementation and scale-up of the intervention:

- Lack of adequate room space.
- Inadequate financial resources.
- Decline in enrolment in some of clients.
- Corona virus pandemic has hindered the meetings.

Resources available for the intervention: OTZ register.

Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com

INTERVENTION 1.13

Mildmay's Integrated Family-Centred Approach, UGANDA

Summary

Mildmay Uganda introduced the family centred approach to its work in 2003 to integrate paediatric early diagnosis, prevention, treatment and care (including outpatient and inpatient care), maternal and child health services, and HIV care using a multidisciplinary approach. This holistic approach focuses on the physical, social, spiritual, and emotional well-being of clients. The family centred approach focuses on engaging all stakeholders within the household or the family. The approach resulted in a 50 fold increase of families registered in HIV care at Mildmay and supported facilities; from 2003 to 2010, Mildmay experienced a 43 fold increase in the number of children actively enrolled in care and a 23 fold increase of children on ART. Critically, the Mildmay scale-up experience confirms that family centred care approaches are operationally feasible and that there is an urgent need to realign care provision towards integrated service packages that incentivize care-seeking as a family, and in child-friendly environments. Factors behind the success of this intervention were the need for shifting tasks towards nurse led clinics with community outreach support and the use of more diversified service entry points facilitated by community outreach mechanisms such as targeted volunteer efforts at the household level, engagement with local leaders, service outreach to churches, schools, and orphanages.



© Albin Hillert, WCC/EAA

Keywords



ANTIRETROVIRAL TREATMENT; BIO-PSYCHOSOCIAL-SPIRITUAL PATIENT CENTRED MODEL; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; EARLY INFANT DIAGNOSIS (EID); FAMILY-BASED INDEX TESTING; HEALTH FACILITY-COMMUNITY COLLABORATION; HOLISTIC CARE; IDENTIFICATION AND TESTING; INTEGRATED FAMILY CENTRED APPROACH; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; TREATMENT ADHERENCE; PREVENTING VERTICAL TRANSMISSION.



Name of intervention: Mildmay's integrated family centred approach in Uganda.

Focus of the intervention:

- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and VL suppression.
- Preventing vertical
- Access to comprehensive care and support of orphans and vulnerable children, including nutritional, psychosocial and spiritual services.

Faith community asset area:

- Faith inspired health service providers.
- Community outreach.

Description of the intervention: The family centred approach introduced in 2003 integrates paediatric early diagnosis, prevention, treatment, outpatient and inpatient care, maternal and child health services, and HIV care using a multidisciplinary approach. This holistic approach stresses the physical, social, spiritual and emotional well-being of clients. The family centred approach focuses on engaging all stakeholders within the household or the family. It is not only the client or the patient who is prioritized, since each of the family members have a role to play in sustainable care. It is also based on the reality that some family members, e.g. men, have poor health care seeking behaviour. The family centred approach engages all stakeholders.

Lead organization: Mildmay Uganda, a Christian organization which works with over 140 000 of the most vulnerable and hard to reach people living with and affected by HIV and other related health issues, including 8000 children and their families, vulnerable children and orphans and other vulnerable groups. Mildmay's inspiration and values come from its Christian faith and it is these values, including those of other faiths and those of no religious faith, that underpin their work. Mildmay works with government health facilities and community clinics.

Location: Kampala, Uganda.

Where the intervention is implemented: Inpatient at hospital and health facilities and outpatient in communities.

Year intervention started: 2003.

Is the intervention still being implemented: Yes.

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

Results of the intervention: Mildmay was one of the first organizations to begin providing ART treatment for children in Uganda. After the introduction of the family centred approach at the Mildmay main site, the numbers of children enrolled in HIV care, receiving cotrimoxazole prophylaxis, and on ART treatment increased dramatically. The approach resulted in a 50-fold increase of families registered in HIV care at Mildmay and supported facilities. From 2003 to 2010, Mildmay experienced a 43-fold increase of children actively enrolled in care and a 23 fold increase of children on ART. There are two other indicators that highlight the HIV related results of the family centred approach:

- Individuals (adults and children) tested for HIV and results returned: 2015–2016 (758 091); 2016–2017 (634 164); 2019–2020 (666 962).
- Clients (adults and children) of lifesaving drugs (ART):
- 2012–2013 (44 740); 2014–2015 (81 046); 2015–2016 (89 889); 2016–2017 (89 000); 2019–2020 (120 480).

Impact of the intervention: The Mildmay experience highlights the critical need to realign care provision towards integrated service packages that incentivize care seeking as a family, and in child-friendly environments. The Mildmay scale-up experience emphasizes that family centred care approaches can be operationally feasible.

Extent to which the intervention has been scaled up: The approach has been integrated into a health care system by the districts that are supported by Mildmay Uganda under the Health Systems Strengthening (HSS) programme. The family centred approach to care is integrated at the facilities supported by Mildmay Uganda. They are public health facilities managed and supported by the Ministry of Health. It is hoped that at some point, the Ministry of Health will adopt the approach in all other health facilities.

Source of funding to implement the intervention: Used its own and government funds, as well as donor funding.

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

- The Mildmay experience highlights the critical need to realign care provision towards integrated service packages that incentivize care seeking as a family, and in child-friendly environments.
- Mildmay's approach was aided by provider initiated or facilitated testing and counselling to target index clients and families for care.
- Shifting tasks toward nurse led clinics with community outreach support.
- These community outreach mechanisms diversified service entry and provided critical adherence support, including targeted volunteer efforts at the household level; engagement with local leaders; and service outreach to churches, schools and orphanages.

Key factors constraining the implementation and scale-up of the intervention:

The Mildmay experience identified several potential considerations for scaling up the intervention, including:

- Human and financial resources for scale-up of integrated care and a secure procurement and supply chain system.
- Staff level and facility infrastructure to provide quality services to the increased patient loads and task shifting.
- Staff training and support to avoid attrition.
- Logistical support for community-based activities.
- Advocacy to tackle stigma and discrimination.

Resources available for the intervention:

Mildmay annual reports on the website.

Scaling Up Paediatric HIV Care with an Integrated, Family-Centred Approach:

An Observational Case Study from Uganda: <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0069548&type=printable>

Information on the intervention: <https://mildmay.or.ug/who-we-are>







COMMUNITY OUTREACH BY FAITH COMMUNITY GROUPS

2.

INTERVENTION 2.1

Faith-engaged Community Outreach Posts, ZAMBIA

Summary

The Circle of Hope (CoH), a faith-based organization in Zambia, introduced community posts (CPs) to increase statistics on children, adolescents and adults not already tested for HIV, in Lusaka. The aim of the CP intervention was to close the gap in coverage of ART for men and children. This was achieved by expanding access to HIV services through decentralized, faith engaged CPs. Multidisciplinary teams from local faith communities are supporting the CPs, which are not identifiable as clinic sites, and they provide confidential, compassionate, comprehensive HIV services in areas of high activity that men frequently visit (e.g. markets, transport hubs, churches/mosques). The results have been impressive: over the 37 months following the introduction of CPs (March 2018–March 2021), as compared with the 17 months before, the median number of new HIV cases identified per month increased by 1889% for men and by 1990% for children.

Equally impressive retention rates were achieved: of the 11 457 clients identified as new HIV cases at CPs, >96% were linked and >92% were retained on ART. The importance of index testing was demonstrated as from October 2018 to September 2019, 2418 adults and 149 children were identified through index testing services (28% of all adults and 65% of all children identified). An important success factor has been harnessing the social infrastructure of the community: >90% are from faith congregations inside the hotspots and are leaders known and trusted within and beyond the faith congregation. The role of CHWs has been critical to the intervention's success, as too has been the supportive role played by senior leadership, especially in organizing events to celebrate successes. The intervention's success can also be seen in the fact that it is being replicated in Nigeria, Zimbabwe and the United Republic of Tanzania.



Keywords

ANTIRETROVIRAL TREATMENT; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; COMMUNITY MAPPING HIV HOT-SPOTS; COMMUNITY POSTS MODEL, DECENTRALIZATION OF HIV SERVICE DELIVERY; TRACING THOSE NO LONGER ON TREATMENT; DIFFERENTIATED SERVICE DELIVERY; EARLY INFANT DIAGNOSIS (EID); EDUCATION OF FAITH LEADERS; FAMILY BASED INDEX TESTING; HEALTH FACILITY–COMMUNITY COLLABORATION; HUMAN RESOURCES; IDENTIFICATION AND TESTING; MENTORSHIP, PLACES OF WORSHIP, RETENTION; RISK BASED SCREENING FOR TARGETED TESTING; VIRAL LOAD SUPPRESSION.

Name of intervention: Faith engaged community outreach posts, Zambia.

Focus of intervention:

- Identifying and testing children and adults living with HIV not on treatment.
- Providing access to HIV treatment, retention and adherence and viral load suppression.

Faith community asset area:

- Community outreach.
- Advocacy by religious leaders.



Description of the intervention: Faith-based outreach posts were established to increase case finding of the number of children, adolescents and adults tested in Lusaka. To close the ART coverage gap for men and children, the Circle of Hope project expanded access to HIV services by introducing decentralized, faith engaged CPs. Multidisciplinary teams from local faith communities provide staff for the CPs, which are not identifiable as clinic sites, and provide confidential, compassionate, comprehensive HIV services in areas of high activity that men frequently visit (e.g. markets, transport hubs, churches/mosques). Testing strategies include risk-based testing and index testing of sexual contacts and biological children. The model has the following elements:

- Decentralization of service delivery, including HIV testing, ART initiation and continuation, and phlebotomy, from an ART facility to static CPs (five posts in early 2018, since expanded to 21).
- Community mapping to identify hot spots of individuals at high risk for HIV transmission to inform the placement of static CPs.
- Each CP is staffed by a multidisciplinary team: one psychosocial counsellor and tester, one ART initiator (clinical officer), four CHWs (gender balanced with ≥2 CHWs local to the surrounding community, and most commonly a trusted member of a faith community), and one data associate.
- Each CP is seamlessly embedded in a high activity and busy setting (e.g. markets, bus stations or church premises) to establish a catchment area and has minimal branding and footprint to allow for confidential delivery of services.
- Early and continued engagement of local stakeholders (community leaders, including faith leaders) and use of expert clients among staff and CHWs to build community trust.
- Continuous mentoring and feedback to CP teams to assess progress, identify barriers, and build morale, including the use of monetary incentives, daily targets and performance updates using mobile technology, and quarterly non-monetary recognition and awards.

Lead organization: Circle of Hope (CoH), which is an NGO, was formed in 2005 by the Northmead Assembly of God (NAOG) church in Lusaka in response to the HIV/AIDS epidemic. The NAOG church is one of the largest Pentecostal churches in Zambia and CoH was set up as a means of engaging Zambia's Pentecostal churches in the HIV response. Over 1400 churches in various parts of the country belong to this network (Pentecostal Assemblies of God, Zambia) and are served by CoH, which hosts an 'HIV Desk' as a resource to the over 1000 pastors that are part of its network. They provide training and HIV/AIDS information to the network. CoH has also collaborated with other faith-based groups in the HIV/AIDS response, including the Evangelical Fellowship of Zambia (EFZ), Expanded Church Response (ECR) Zambia, Churches Health Association of Zambia, Chreso Ministries and the National AIDS/STI/TB Council. All of these organizations are either current or former PEPFAR Zambia partners.

Location: Eastern, Lusaka, Southern and Western Provinces, Zambia

Where the intervention was implemented: Community locations in areas of high activity in Lusaka that men visit frequently, e.g. markets, transport hubs, churches/mosques.

Year the intervention started: 2018.

Is the intervention still being implemented? Yes.

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

Results of the intervention: During the 37 months following introduction of CPs (March 2018–March 2021), as compared with the 17 months before, the median number of new HIV cases identified per month increased 1522% overall (1889% in men and 1990% for children). During the programme period, the testing yield for men was 32% (modalities included highly targeted testing using risk markers known through trusted relationships, e.g. relationship conflict, attending healing services, sickness in the family, substance use, as well as indexing) and 7.0% for children. Of the 11 457 clients identified as new HIV cases at CPs, >96% were linked and >92% were retained on ART. From October 2018–September 2019, 2418 adults and 149 children were identified through index testing services (28% of all adults and 65% of all children identified). The table below presents HIV test results and yield for clients served by Circle of Hope.

TABLE 6.

	Before community tests (Oct. 2016–Feb. 2018)	After community tests (March 2018–March 2021)
Months observed	17	37
Tested (N, col % by age/sex)	3902	85 706
Children (<15)	127 (3%)	10 402 (12%)
Adult males (>15)	1500 (38%)	39 225 (46%)
Adult females (>15)	2275 (58%)	37 729 (44%)
Identified (N, col % by age/sex)	866	28 723
Children (<15)	15 (2%)	680 (2%)
Adult males (>15)	292 (34%)	12 510 (44%)
Adult females (>15)	559 (65%)	15 533 (54%)
Testing yield (all)	22%	34%
Children (<15)	12%	7%
Adult males (>15)	19%	32 %
Adult females (>15)	25%	41%

Impact of the intervention: Implementation of this faith engaged CP model led to substantial improvements in finding cases, linkage and retention. HIV services provided in faith engaged CPs were easily accessed and resulted in greater uptake of HIV testing services. This was especially the case for men and children—populations which do not typically access conventional health care settings. In terms of efficiency, the identification of people living with HIV through HIV testing services was very efficient in faith engaged CPs, with testing yields exceeding historic performance and PEPFAR programme benchmarks.





Extent to which the intervention has been scaled up: The CP model began with five sites and has since expanded to 21 sites in Lusaka and eight sites in other provinces, including rural Zambia. One challenge faced thus far is the ability to train and mentor staff in other parts of the country who can faithfully replicate this model. There is also the emerging challenge of silent transfers, which were discovered while investigating the high testing yields from the CPs. Viral load testing of a small sample of newly diagnosed positives at some of the CPs found that greater than 30% were already virally suppressed, indicating that they were likely already in treatment elsewhere. As DSD models are scaled up to help reduce the congestion in health facilities while strengthening patient transfer processes at the facility level, this should significantly reduce the impact of silent transfers. The CoH Executive Director has been a passionate advocate for scaling up this model to reach people who may be missed by current efforts, due to their limited access to health facilities. The intervention is being replicated in Nigeria, Zimbabwe, and Tanzania.

Source of funding to implement the intervention: The organization's own funds, and CoH is a subgrantee under an existing PEPFAR/CDC Zambia cooperative agreement with Catholic Relief Services.

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

There are important elements of CoH staff management, including:

1. Hiring of staff for CPs:
 - Harness the social infrastructure of the community. More than 90% are from faith congregations inside the hotspots, and are leaders known and trusted within and beyond the faith congregation.
 - Compassion as the top motivation is an essential criterion; motivation of the hired staff must be to 'help care for my community'.
2. Support: The Executive Director (ED) and his senior management team meets daily in the morning before work with all staff from each CP to review targets and give them encouragement for the day. At end of the day, every CP reports back through group messaging to the ED on how the day went. The ED provides encouragement for success and assists with addressing challenges as needed.
3. Celebration: Quarterly celebration events, non-monetary in nature, hosted by the ED for all CP staff to celebrate progress toward helping their community build hope and life.
4. Social screening as a precursor to risk factor screening for targeted HIV testing. This is due to the stigma associated with many of the risk factors in common clinical screening tools. CP staff (pastors, CHWs, and expert clients) who have social relationships with their communities use social markers to guide further assessment of HIV risk factor-based screening. Known risk factors for HIV include marital problems, participation in healing services and recent family death.
5. CoH has recognized the immense value and contribution that CHWs bring to the HIV treatment continuum. The amount of time, persuasive skills and tact required for index testing, contact tracing and counselling and testing is especially high. The sustained, consistent testing performance of CoH is a testimony to the skill level and importance of CoH CHWs. They, and all the other CHWs working from CPs that CoH has opened for its facility partners and international partners, are paid bi-weekly stipends of \$65. These payments have proved to be a source of motivation as the CHWs look forward to receiving their stipend while attempting to meet their weekly target of one newly identified person living with HIV per day for each CHW. In addition, CoH has built the leadership capacity of all staff through its 'RECIPE' approach which comprises: responsibility, empathy, compassion, integrity, passion and ethics.

Key factors constraining the implementation and scale-up of the intervention:

- People were concerned the CPs would not be a permanent facility.
- Challenge of finding a room that would be suitable and affordable.
- Importance of 'politics of ownership' and attributing success to overcome jealousies and envy from partners and other stakeholders about facilities.
- Lack of understanding about the model by CHWs and community members.
- Shortage of capable local CHWs and danger of compromising the quality of the CHWs recruited.
- Partners can take time to understand the model and adapt supervision and monitoring required, including logistical support and providing resources.
- Suspicion among some community members because of community belief systems.
- Limited funds for logistical support and limited transport.
- Orientation and training needed for CHWs to understand the model and the RECIPE approach.
- Perceived stigma at community, health care providers and sectoral levels.
- Challenging religious beliefs.
- Opposition from international partners and facilities
- 'Silo mentality' of health care providers and CHWs.

The steps taken to mitigate the challenges include:

- Periodic meetings to reassure community members and their leaders.
- Inviting community leaders to tour facilities and offices, especially during scanning and at inception.
- Programme staff attending meetings organized by communities, MoH and international partners to foster relationship building.
- Orientation of stakeholders in the RECIPE approach.
- Coaching, mentoring and training health care providers, CHWs and community leaders.
- Orienting MoH, agencies and international partners in the CoH model.
- Customer care training across the HIV cascade of care and support.
- Leveraging stakeholder relationships.
- Sharing results of past performance and explaining the RECIPE approach.
- Being open for stakeholders to conduct independent VL tests on new positives.
- Ensuring the steady supply of test kits through stock sharing with other facility partners.

Resources available for the intervention: PEPFAR Solutions, www.cohzambia.org
Information on the intervention:

- PEPFAR Solutions, www.cohzambia.org
- PEPFAR 2021 country and regional operational plan (COP/ROP): Guidance for all PEPFAR countries: <https://www.state.gov/wp-content/uploads/2020/12/PEPFAR-COP21-Guidance-Final.pdf>
- Circle of Hope: Using faith-based community outreach posts to increase HIV case finding, linkage and retention on treatment in urban and rural settings in Zambia, PEPFAR SOLUTIONS PLATFORM (BETA): <https://www.pepfarsolutions.org/solutions/2019/9/30/circle-of-hope-using-faith-based-community-outreach-posts-to-increase-hiv-case-finding-linkage-and-retention-on-treatment-in-urban-and-rural-settings-in-zambia>
- YouTube video about Circle of Hope: https://youtu.be/eQUM8z_EwBQ



INTERVENTION 2.2

Meaningful Engagement of the Muslim Community for ARV uptake through Elimination of Vertical Transmission, KENYA

Summary

The goal of this intervention, organized by the Kenya Council of Imams and Ulamaa (KCIU), was to assist the Muslim community, focusing on mobilization and linkage to nearby health care facilities to reduce vertical transmission by reducing infections in women, and improving post-natal care and support services for mothers living with HIV in the Rift Valley in Kenya. The intervention included increased awareness about HIV prevention, PVT and HIV counselling and testing using a family centred approach. The intervention mobilized community health volunteers (CHVs), who included 25 imams (religious leaders) and 85 Maalimats (women counsellors) who are key Muslim authorities in religious and socio-cultural affairs. Activities were carried out using both formal and informal community structures such as mosques, madrassas, social events and gatherings with the support of District Community Health Extension Workers from the MoH. The key results included: reaching 90 030 community members with messages on HIV prevention and family planning; 3213 women attending ANCs during which 3127 were tested for HIV and linked up for various services; 215 HIV positive mothers initiated on ART and 171 exposed infants tested by EID. Two key success factors were: men were actively involved in supporting the health of their families; and secondly, the use of Islamic perspective/teachings to encourage Muslim communities to adhere to preventive measures against HIV and AIDS and encourage male partner involvement on issues of health.



Keywords

ANTIRETROVIRAL TREATMENT; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; COMMUNITY FAMILY DAYS; EARLY INFANT DIAGNOSIS; ECONOMIC EMPOWERMENT; EDUCATION FOR FAITH LEADERS; HEALTH FACILITY—COMMUNITY COLLABORATION; HIV PREVENTION; HUMAN RESOURCES; IDENTIFICATION AND TESTING; MALE INVOLVEMENT; MOBILISING FAITH COMMUNITIES; PLACES OF WORSHIP; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; SCRIPTURES AND TEACHINGS; STIGMA; SUPPORT GROUPS; TREATMENT ADHERENCE; PREVENTION OF VERTICAL TRANSMISSION.

Name of the intervention: Meaningful engagement of the Muslim community for ARV uptake through prevention of vertical transmission, Kenya.

Focus of the intervention:

- Preventing vertical transmission.
- HIV and health awareness.
- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and viral load suppression.

Faith community area:

- Community outreach.
- Advocacy by religious leaders.



Description of the intervention: The goal of the project was lower transmission of HIV from mothers to children by reducing infections in women of reproductive age and increasing use of PVT and post-natal care and support services for mothers living with HIV in the Rift Valley. This was achieved through four objectives:

- Increase awareness of men and women of reproductive age of primary HIV prevention and PVT and HIV counselling and testing.
- Increase access to care and treatment for HIV exposed infants and HIV infected young children.
- Strengthen and integrate community structures that address SDH using a family centred approach focusing on mothers and young children.
- Strengthen monitoring and evaluation and documentation of PVT and related services.
- There were several key components:
- Use of community owned resource persons and structures.
- Community friendly behaviour change communications (BCC) and information education and communication (IEC) materials and events, e.g. community family days.
- Working closely with the MoH, facility staff capacity building, religious leaders (imams and Maalimats), women's groups, and People Living with HIV CBOs/self-help.

Lead organization: Kenya Council of Imams and Ulamaa (KCIU).

Location: Rift Valley, Kenya.

Where the intervention was implemented: Health facilities, community and places of worship.

Year the intervention started: 2011.

Is the intervention still being implemented? No.

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



*Imams visiting
a Health Facility—Nakuru*

© KCIU



Results of the intervention: The project's goal was to assist the Muslim community in mobilizing and linking to nearby health care facilities. These were women and men of reproductive age group, antenatal mothers, HIV positive women (PVT clients), infants and children. Twenty collaborating health facilities and 22 mosques were identified for capacity building in community PVT and 110 CHVs trained to mobilize and facilitate referrals. The CHVs were 25 imams (religious leaders) and 85 Maalimats (women counsellors) who are key Muslim authorities in religious and socio-cultural affairs. The project was carried out using both formal and informal community structures such as mosques, madrassas, social events and gatherings with the support of District Community Health Extension Workers from the MoH. Twelve traditional birth attendants (TBAs) were integrated into the programme and trained to change their home assisted delivery practices for expectant mothers to become birth companions in referring and accompanying pregnant women to the health facilities for antenatal care and other PVT services. The programme had a number of results:

- **90 030** community members were reached with messages on HIV prevention, care and support, antenatal care and post-natal care (PNC), and family planning.
- The project disseminated **14 312** IEC materials.
- **1865** women were FP acceptors who were referred and linked to health facilities.
- **3213** women attended ANCs during the period of which **3127** were tested for HIV and linked up for various services.
- **1436** ANC mothers were counselled on infant feeding options and **1899** deliveries were registered by CHVs with **1691** deliveries in the hospital and **208** at home who were linked to health facilities for maternal and child health services (MCH).
- **215** HIV positive mothers were initiated on ART and **171** exposed infants were tested by EID.
- **1252** male partners accompanied their spouses to health facilities for reproductive health services and 1095 received HIV testing at MCH.
- Three women's support groups were formed which also acted as a link between the facilities and the community, where mothers testing HIV positive are linked for psychosocial service support. The groups were also able to access infant feeding option counselling services. Through the support groups, the members provided support for follow-up and adherence to drug treatment to clients who are HIV positive and their infants.
- There were 12 networking and linkages meetings with government ministries and other community-based organizations that led to improved access to other health services and improved capacity for the project staff on matters of EVT.
- KCIU facilitated 35 technical and supervisory support activities led by the MoH PVT staff who helped improve project deliverables and management for quality PVT services.

Impact of the intervention: Through capacity building, Community Own Resource Persons was able to create awareness and sensitization in the community with PVT related messages. There was increased access to, and referrals for, skilled deliveries, child immunization, male involvement, behaviour change, linking of women living with HIV to support groups leading to stigma reduction and disclosure.

The increased referrals led to an increased demand for PVT services at the health facilities and the community, which increased the uptake of antenatal care, PNC, family planning and reproductive health (RH), and HIV testing and counselling, leading to PVT, stigma reduction, adherence to prophylaxis support and care to Muslim pregnant women living with HIV and their partners, men and women of reproductive age and their families. PNC referral by CHVs led to early identification and management of HIV exposed infants, improved nutritional support and increased access to family planning services. Exclusive breastfeeding and care of the breast, and hygiene during the PNC period helped to detect any complications for both the mothers and the infants, reducing maternal morbidity and mortality. The community's increased uptake of family planning led to informed decisions among Muslim men and women of reproductive age, reduction in unintended pregnancies and re-infection, thereby addressing the aims of PVT Prongs 2 and 4. Reproductive health referrals led to improved access to information and treatment for reproductive health related issues, i.e. sexually transmitted infections (STIs), and breast and cervical cancer screening.

Through organizational capacity building activities and other technical and supervisory support offered by EGPAF's Technical Team and the MoH during the project period, KCIU improved its overall project management that ensured quality results. There has been an improvement in monitoring and evaluation (M&E) in terms of data management and strong linkages and networking have been developed as a result. The coordinated monthly and quarterly meetings on sharing of experience to discuss future directions and review of strategies in liaison with the MoH, health facility staff and Muslim religious leaders increased community ownership, participation and networking with health facility staff, acting as a catalyst for strong community–facility linkages and vice versa.

Extent to which the intervention has been scaled up: Limited. There was limited scale-up of the intervention. However, a long-term legacy was created by the project in several areas:

- The project trained CHVs in community PVT health education in collaboration with the facility's CHWs for intensified mobilization and tracing of HIV positive pregnant and post-natal women no longer accessing treatment, and HIV exposed infants for enrolment and retention in care and treatment.
- Both men and women who were involved and benefitted from the community PVT project have continued offering voluntarily mentorship to other women in the community and have been focal points that have championed their health needs in local area development agendas. This has increased the number of pregnant women seeking antenatal care services and helping those seeking to finish attending four scheduled ANCs. Some men have continued accompanying their spouse to the hospital facility, thus increasing ownership and sustainability. The project, in partnership with the MoH, held community forums on PVT services in selected facilities to mobilize for uptake; as a result, ANCs and skilled delivery improved.
- Support for HIV positive mothers was enhanced through support groups that leveraged linkages to other psychosocial support activities such as family counselling and introduction to income generating activities. CHVs conducted regular household visits to encourage support by family members to the patients to adhere to medication and follow-up appointments. These activities also worked towards reducing stigma.

Source of funding to implement the intervention: Positive Action for Children Fund (PACF) (financial support) and Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) (technical support).

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

- The success of the PVT project within the Muslim community; men needed to be actively involved in supporting the health of their families.
- Islamic perspective/teachings used to encourage Muslim communities to adhere to preventive measures against HIV and AIDS and encourage male partner involvement on issues of health.
- Engagement of the community and other key stakeholders was critical to the programme. HIV prevention is achievable through multi-sectoral stakeholders.

Key factors constraining the implementation and scale-up of the intervention:

- Inadequate capacity and structures for follow-up, especially for HEI and infected children.
- Limited ability to reach ANC clients early and link them to facilities for skilled delivery.
- Limited community friendly IEC materials.
- Limited ability to help the community to deal with stigma and discrimination.
- Inadequate resources for building capacity of community owned resource persons for ownership in addressing SDH and harmful social-cultural practices.
- Inability to provide nutritional supplements for pregnant mothers, infants and infected children.
- Inadequate funding to update and revise M&E tools to be in sync with revised MoH guidelines.

Resources available for the intervention: Community friendly BCC/IEC materials. The community PVT logbooks for data collection are available by contacting the Interfaith Health Platform at: interfaith.health.platform@gmail.com

Information on the intervention:

<https://childrenandhiv.org/wp-content/uploads/MoHammed-Fatuma-Meaningful-Engagement-of-the-Muslim-Community-for-ARV-uptake-through-PMTCT.pdf>
<http://kciurift.org/whatwedo.html>

Prevention of vertical transmission: mothers after attending a clinic, Kajiado.

© KCIU



INTERVENTION 2.3

Improving Parent and Child Outcomes (IMPACT), MALAWI, NIGERIA, DRC, TANZANIA, SIERRA LEONE, UGANDA

Summary

The Improving Parent and Child Outcomes (IMPACT) is a comprehensive intervention with the objectives of PVT of HIV and improving maternal and infant health. IMPACT's main intervention strategy is to provide the support of a trained peer mother ('Mother Buddy') in communities which can support vulnerable pregnant women and their families through pregnancy, delivery and until their child is two years old (first 1000 days). The Mother Buddies are trained church volunteers, mainly mothers living with HIV, who want to pass on their learning and experience to other expectant mothers whom they visit eight times over a 12–15 month period.

In some countries, Mother Buddies are assisted by a mobile phone system called MiHope (Mobile Interactions Bringing Hope), which provides communications, information and data collection capabilities. Large scale KAP studies in Malawi and Nigeria found significant improvements in attendance at ANCs (minimum of four visits), birth planning, delivery care, male partner involvement (including HIV testing), accessing family planning counselling. Although not statistically significant due to small sample size, testing for HIV, use of ARVs, and early infant diagnosis all increased and the transmission rate in both countries went down, from around 20–50% at baseline to 0–5% at end line. Two key success factors were: the presence of churches in the community, as they were the base from where the community was mobilized and Mother Buddies were trained and supported. Second, the use of Android mobile phones and the software developed for IMPACT were crucial in providing guidance for the Mother Buddies and in the collection of data.

Keywords

ADHERENCE COUNSELLING; ANTIRETROVIRAL TREATMENT; BIO-PSYCHOSOCIAL-SPIRITUAL PATIENT CENTRED MODEL; COMMUNITY VOLUNTEERS; TRACING THOSE NO LONGER ON TREATMENT; EARLY INFANT DIAGNOSIS HEALTH FACILITY-COMMUNITY COLLABORATION; HIV PREVENTION; IDENTIFICATION AND TESTING; MALE INVOLVEMENT; MOBILE PHONE USE; MOBILIZING FAITH COMMUNITIES; MOTHER BUDDIES, NUTRITION; PEER MENTORS; PLACES OF WORSHIP; SEXUAL REPRODUCTIVE HEALTH AND RIGHTS; TREATMENT ADHERENCE; TREATMENT BUDDIES; PREVENTION OF VERTICAL TRANSMISSION.



Name of the intervention: Community Outreach-Improving Parent and Child Outcomes (IMPACT); Malawi; Nigeria; Democratic Republic of Congo (DRC); United Republic of Tanzania; Sierra Leone; Uganda.

Focus of the intervention:

- Preventing vertical transmission.
- HIV and health awareness.

Faith community asset area:

- Community outreach.
- Using places of worship.

Description of the intervention: IMPACT is a comprehensive programme with the objectives of preventing vertical transmission of HIV and improving maternal and infant health. It was developed based on experience with Tearfund's Guardians of our Children's Health programme which was more narrowly focused on PVT. However, it was realized that only PVT of HIV was not a good development outcome if other issues were not addressed simultaneously, e.g. preventing maternal deaths during pregnancy and childbirth. There were initially nine parts in the programme; more recently, in some countries, a tenth area was added to address gender-based violence. IMPACT's main intervention strategy is to provide the support of a trained peer mother ('Mother Buddy') in communities who can support vulnerable pregnant women and their families through pregnancy, delivery and until their child is two years old (first 1000 days). The Mother Buddies are trained church volunteers, mainly mothers living with HIV, who want to pass on their learning and experience to other expectant mothers in their community. They visit vulnerable pregnant women about eight times over a 12–15 month period, covering six–nine months of pregnancy, six months after birth and then follow-up visits until the child is two years old. The IMPACT framework covers everything from family planning through pregnancy and birth to two years after the baby is born. Mother Buddies in some countries are assisted by a mobile phone system called MiHope which provides communications, information and data collection capabilities. The Mother Buddies are equipped with a smartphone and software that guides them through the key questions to ask in each of the visits. The phones also store helpful training and spiritual resources and allow the Mother Buddies to collect data on the women they care for. Information is collected on the phone, which in some cases links to the MoH. There is also a facility to automatically remind mothers of their next clinic appointment. All data collected is then not just available on the phone but also in a securely accessed web portal—enhancing monitoring, analysis and evaluation.

Lead organization: Tearfund and Chasing Zero, implemented in partnership with FBOs in the country.

Location: Communities in Malawi, Nigeria, Democratic Republic of the Congo, United Republic of Tanzania, Sierra Leone and Uganda, plus partial implementation in Ethiopia.

Where intervention was implemented: Mainly in the community, but also in churches as HIV testing sites, mobilization and training centres.

Year the intervention started: 2011.

Is the intervention still being implemented? Yes.



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

Results of the intervention: IMPACT has been independently evaluated in the first two countries where it was implemented, Malawi and Nigeria. Large scale KAP studies were undertaken to show differences that would be statistically significant between mothers who had the support of a Mother Buddy and those that did not. Summarizing the detailed results given below, there were significant improvements in attendance levels at ANCs (minimum of four visits), birth planning, delivery care, male partner involvement (including HIV testing), and accessing family planning counselling, including an increase in the use of modern contraceptives. Although not statistically significant due to the small sample size, testing of HIV, use of ARVs and early infant diagnosis all increased and the transmission rate in both countries reduced from around 20–50% at baseline to 0–5% at end line.

The results of the IMPACT programme in Malawi have shown significant improvements for women supported by Mother Buddies compared with women who have not received this help:

- There was a 38% increase in the number of pregnant women attending four antenatal care visits (as recommended by the World Health Organization).
- The number of men accompanying their female partners to antenatal care appointments went up by 28%.
- The number of women going for counselling regarding family planning increased by 34%. Similarly, the number of women using modern contraceptive methods went up by 22%.
- Women supported by Mother Buddies had better standards of nutrition and were 40% more likely to have three meals a day.
- The Mother Buddies project also benefited the wider community. By the end of the project, more children were being tested for HIV and more HIV positive people were using ART.

In Nigeria, the IMPACT programme resulted in statistically significant reductions as follows:

- A 15% increase in more than four ANC visits.
- A 13% increase in deliveries in a health care facility, with a 22% increase in professionally attended births.
- A 34% increase in male partner involvement.
- An 89% increase in birth plans.
- A 62% increase in access to family planning.
- In addition, there were overall community benefits, including:
- Reduction in vertical transmission from 50% to 0%.
- Increase of HIV testing among clients, with 92% of clients receiving tests compared with 83% of non-clients.
- Up to 84% of clients attend four or more antenatal care visits.
- 43% of clients accompanied by male partners to ANC visits.

Impact of the intervention: Despite diminishing corporate support from Tearfund for HIV and health programmes, local country managers and their indigenous partner organizations have continued with the IMPACT programmes because it is highly effective. The programme continues in each country, often with minimal external funding. The KAP studies pointed to at least a short-term general community impact as the end line measurements (both active and control) were at least two years after the baseline. General community benefits included: an increase in comprehensive HIV and maternal health knowledge; practical support during and after pregnancy; and levels of support to households (medical social, material). There were also changes in some attitudes, particularly around family planning, as Mother Buddies became a key source of information second only to nurses.

Extent to which the intervention has been scaled up: The original programme was designed to begin in Malawi, followed by Nigeria and Democratic Republic of the Congo. After successful implementation and evaluation in Malawi and Nigeria, other countries—United Republic of Tanzania, Sierra Leone and Uganda—also decided to implement the programme. In addition, the scope of the programme was broadened in two countries—Democratic Republic of the Congo and Nigeria—to address the issues of gender-based violence which was a particularly relevant issue in these two countries. The programme was also expanded in the duration of support. Originally families were supported up to six months after delivery, but this was extended to include mainly nutritional education and support of infants up to the age of 2. Thus, the programme now covers the first 1000 days of life—from conception to age 2.

Source of funding to implement the intervention: Initially, Irish Aid was the main source of funds in Malawi (and elements in Ethiopia). UK Trust funding, mainly Souter Trust, enabled the programme to be expanded to other countries. Democratic Republic of the Congo was also supported by the Dutch Government. Tearfund remains the main ongoing funding source, with additional funding provided by Chasing Zero for use in Malawi and Nigeria.

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

- Initial funding was vital to the design, development and implementation.
- Some support, such as training, was also obtained from other organizations such as Mothers to Mothers (M2M).
- The whole basis of the programme was the presence of churches in the community. This was the base from where the community was mobilized, Mother Buddies trained and then provided support.
- The use of Android mobile phones and the software developed for IMPACT were crucial in providing guidance for the Mother Buddies and for collection of data.

Key factors constraining the implementation and scale-up of the intervention:

- De-prioritization of HIV and Health by Tearfund (from 2015).
- Lack of further funding from large donors.
- Contextual circumstances, e.g. drought in Malawi meant that Mother Buddies could not operate.
- Covid-19.

Resources available for the intervention: Guardians of our Children's Health—used for HIV components of IMPACT. IMPACT training resources and evaluation reports.

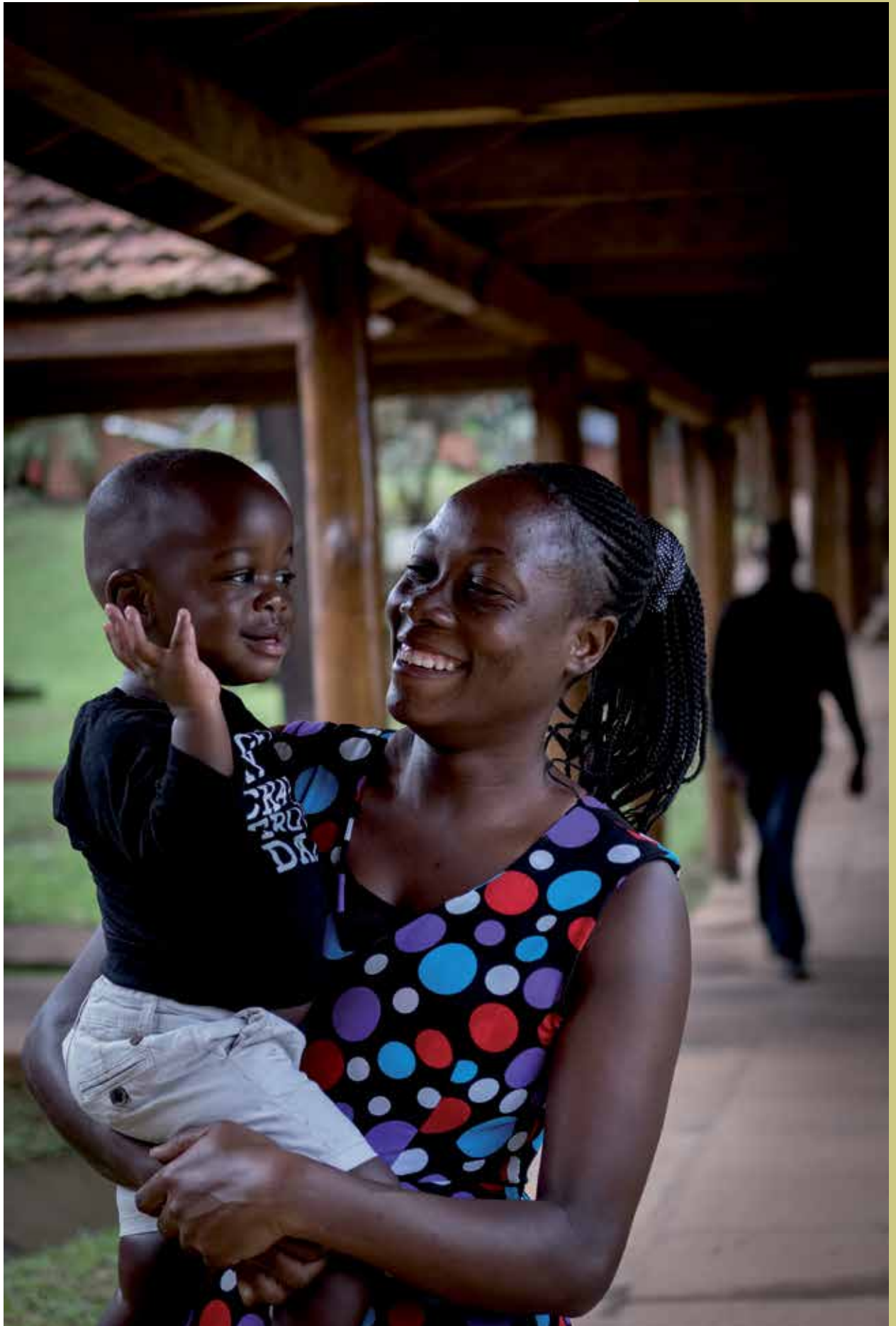
Information on the intervention:

<https://learn.tearfund.org/en/resources/footsteps/footsteps-91-100/footsteps-98/making-an-impact-tearfund-work-on-hiv>

[https://learn.tearfund.org/en/resources/footsteps/footsteps-91-100/footsteps-91/mother-buddies#:~:text=IMPACT%20\(Improving%20Parent%20and%20Child,expectant%20mothers%20in%20their%20community](https://learn.tearfund.org/en/resources/footsteps/footsteps-91-100/footsteps-91/mother-buddies#:~:text=IMPACT%20(Improving%20Parent%20and%20Child,expectant%20mothers%20in%20their%20community)

<https://www.tearfund.org/stories/2021/02/a-mother-to-many>

<https://learn.tearfund.org/-/media/learn/resources/reports/2017-tearfund-impact-and-learning-report-interactive-en.pdf>



INTERVENTION 2.4

Improving HIV outcomes for parents, children and adolescents, MALAWI

Summary

The intervention implemented by the Evangelical Association of Malawi (EAM) aims to improve HIV outcomes for parents, children and adolescents through three elements: ending HIV vertical transmission; increasing awareness about HIV prevention and life skills and increasing HIV testing; treatment and adherence by promoting PrEP, PeP and distributing self-testing kits. Religious leaders have played a prominent role in the intervention, including delivering key HIV messages about HIV prevention, treatment and tackling sexual and gender -based violence, and they have taken a lead role in distributing self-test kits in churches and mosques. The intervention's results have included: increasing the number of adolescents accessing HIV testing and treatment, reducing adolescents being lost to follow-up on treatment, decreasing the numbers of babies born with HIV to women living with HIV, and reducing the levels of stigma and discrimination faced by adolescents and children living with HIV. The participation of religious leaders in delivering HIV messages and the openness of churches and mosques to include HIV messages in their spiritual programmes have been factors highlighted as key success factors.

Keywords



ADHERENCE COUNSELLING; ADOLESCENT FRIENDLY APPROACHES; ANTIRETROVIRAL TREATMENT; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; TRACING THOSE NO LONGER ON TREATMENT; ECONOMIC EMPOWERMENT; EDUCATION FOR FAITH LEADERS; GENDER BASED VIOLENCE; HIV PREVENTION; HIV SELF-TESTING; IDENTIFICATION AND TESTING; LIFE SKILLS; MALE INVOLVEMENT; MOBILIZING FAITH COMMUNITIES; MOTHER BUDDIES; PEER MENTORS; PLACES OF WORSHIP; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; SCHOOL BASED HEALTH PROGRAMMES; STIGMA; TEEN CLUBS; TREATMENT ADHERENCE; TREATMENT BUDDIES; PREVENTION OF VERTICAL TRANSMISSION.

Name of the intervention: Improving HIV outcomes for parents, children and adolescents, Malawi

Focus of the intervention:

- Preventing vertical transmission.
- Adolescent HIV prevention and life skills training.
- Identifying and testing children and adults living with HIV not on treatment.

Faith community asset area:

- Community outreach.
- Advocacy by religious leaders.
- Using places of worship

Description of the intervention: There are three components to the intervention that has the aim of improving HIV outcomes for parents, children and adolescents. The main elements are to:

- Reduce HIV transmission from mother to child.
- Increase awareness about HIV prevention and life skills among adolescent girls, young women, boys and men.
- Increase HIV testing and promote early entry to treatment and support adherence by promoting PrEP and PeP and distributing self-testing kits

These three objectives are achieved through: community mobilization; capacity building; economic empowerment, behaviour change, digital communication, social media and campaigns.

Lead organization: Norwegian Church AID is the lead for the Adolescent Girls and Young Women (AGYW) project, the Evangelical Association of Malawi (EAM) is the direct implementor for PVT activities and is one of the subgrantees of the Palladium Group for the Faith Community Initiative (FCI).

Location: Thyolo, Phalombe, Nkhosakota, Chiladzulu and Balaka Districts of Malawi.

Where the intervention was implemented: Communities, church congregations and mosques.

Year the intervention started: 2018.



Is the intervention still being implemented: Yes?

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

Results of the intervention:

- HIV and AIDS Messages of Hope are being disseminated by religious and community leaders in communities, churches and mosques. The EAM works through 122 church congregations with a total of 153 pastors, and 15 mosques with a total of 18 sheiks.
- Religious leaders have taken the lead in distributing and providing counselling for self-test kits; 4034 self-test kits were distributed in churches and mosques between October 2018 and December 2020.
- Adolescent girls and boys have been empowered with knowledge to making informed choices.

TABLE 7.

Category		Girls	Boys
Village savings and loan (VSL)	Trained	1100	46
	Reached	1150	52
Making of reusable pads	Trained	909	
	Reached	7	
Baking	Trained	3001	
	Reached	1,150	
Chicken keeping	Trained	6	
	Reached	6	
Goat keeping	Trained	5	
	Reached	5	
Other (welding, carpentry, motorcycle, repairing, tailoring and fabrics)	Trained	260	98

- Greater number of pregnant women reached with HIV and AIDS messages, counselling and technical support. From the start in 2014 to March 2021, the project has worked with 36 female volunteers known as Mother Buddies, who were trained in digital client tracking and data collection and used a reporting tool. EAM has reached 6820 pregnant women, but between July 2020 and March 2021, EAM reached 1300 pregnant women.
- Religious and community leaders empowered in disseminating HIV and AIDS messages and reforming traditions affecting delivery of and access to HIV and AIDS related services, and those who tackle sexual and gender-based violence. EAM has trained 672 pastors and 53 sheiks to deliver messages of hope and support project activities.

Mother Buddy Approach in Malawi

The mother buddies, who are all HIV positive women who have given birth to HIV negative babies, assist neighbouring mothers to be who are at risk of passing on the virus to their children. Appointed by village leaders across communities in rural Malawi, the women are given a smartphone to log and track their clients' progress, in which they record their health details over eight visits to the mother, which start in the first three months of the pregnancy, right through to when the child is two years old.

Using a smartphone app and their training to halt the spread of HIV for the mother to child mode of transmission, the buddies inform mothers of how to avoid spreading the virus to their newborn. By providing this key information, the mother buddies serve as an essential link between the mother to be and local hospitals.

During the visits, partners are informed that they should abstain from extramarital sex and should rest during pregnancy (too much work could compromise the immune system and make it more likely for them to contract HIV during intercourse). They are also told to eat from six key food groups to ensure that they and the baby are getting the nutrients that they need.

The mother buddies also encourage the mothers to be to give birth in hospital, rather than at home. Most expectant mothers prefer to give birth at home because the health centres are so far away, but they are encouraged to give birth in hospital because it is safer.

"In the work that I'm doing, we have four key messages," says one mother buddy: "The first one is to reduce the spread of HIV. The second one is to reduce maternal death, particularly in those who are HIV positive. The third one is to reduce infant mortality, while the fourth is to increase male involvement in issues in maternal health, particularly men attending antenatal clinics".



Impact of the intervention:

- There has been an increased number of adolescent girls and boys accessing HIV testing and treatment.

TABLE 8.

HIV infection	Girls	Boys
Tested	2600	1225
On treatment	200	78
Family planning methods	5000	36 800 condoms
Sexually transmitted infections	Girls	Boys
Diagnosed	400	173
Treated	400	173
Reached with health information	155 500	122 400

- Reduced number of adolescent girls and boys no longer accessing treatment. Of the EAM target groups of boys and girls between October 2018 and December 2020, only 1.2% of boys and 0.9% of girls are no longer on treatment. EAM organizes weekly teen clubs to encourage and support boys and girls stay on treatment, which includes tracking their adherence to ART. The teen clubs also conduct home visits and provides nutritional supplements. More girls attend the teen clubs than boys. The teen club is an approach developed by the Ministry of Education as a way of reaching out to children and youth living with HIV infection, meeting at a health facility or church. These clubs enable such children to be supported to meet routinely for various activities and services, including medical check-ups, nutrition, education, treatment schedules, checking VL and socialization. This has, among other things, helped to keep children on treatment. It has also helped to improve their health and education.
- Increased access to HIV testing and treatment by expectant couples. From the start of the project, 5670 people were tested and 654 were found to be positive. Between June 2020 and March 2021, a further 1664 couples were tested of whom 109 were positive.
- Increased number of HIV negative babies born from HIV positive mothers. While the districts had different percentages of babies born free of HIV infection from their mothers, the intervention on average helped to reduce mother to child transmission from 9.3% in June 2019 to 7.9% in December 2019.
- There has been an increased number of people, especially men and boys, who feel open enough to disclose their HIV status. There has also been greater inclusion of people living with HIV infection in different leadership positions in churches regardless of their status.

Extent to which the intervention has been scaled up: The intervention is now being replicated in four more districts of Malawi (Dowa, Nkhata Bay, Mangochi and Balaka), which involves an increased number of EAM member churches and faith organizations.

Source of funding to implement the intervention: Global Fund through Action Aid UK, USAID through the Palladium Group, Tearfund UK and Tearfund Switzerland.

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

- Participation of religious leaders in reaching out to children and adolescent girl and boys with HIV and AIDS messages and other services.
- The openness of the church and mosques to accommodate issues of HIV infection and AIDS in their spiritual programmes.
- Visible results of household and individual adolescent girls' economic empowerment.
- An increased number of girls are going back to school which has been attributed to meeting their needs in several areas, including: provision of knowledge, skills and economic empowerment; provision and access to hygiene kits; bi-monthly HIV and AIDS clinics for adolescents; and emotional and psychosocial support provided by Mother Groups. These groups have been developed by the MoH and are formed by women living close to Primary and Secondary schools who are trained to support girls about sexual and reproductive health issues, menstrual hygiene, and provision of psychosocial support. They are also trained to track, trace and address issues of sexual abuse being confided by the girls.

Key factors constraining the implementation and scale-up of the intervention:

- Resource constraints to replicate and scale-up interventions to other districts.
- COVID-19 restraining community HIV testing.

Resources available for the intervention: Currently from Tearfund Switzerland for the PVT and USAID for the FCI project.

Information on the intervention: www.eaom.org; the Interfaith Health Platform: interfaith.health.platform@gmail.com

INTERVENTION 2.5

Coaching Boys into Men in the informal settlements of Nairobi, KENYA

Summary

Coaching Boys Into Men (CBIM) is an activity implemented by the Children of God Relief Institute (COGRI) in Nairobi, Kenya, and it uses faith-based community outreach approaches to increase HIV case finding, linkage and adherence to treatment, as well as safeguarding children. It is implemented and delivered through sports, especially soccer, and is based on the belief that sports coaches play an extremely influential and unique role in the lives of young men, often serving as a parent or mentor to the boys they coach. The CBIM curriculum consists of 12 15-minute card series delivered once a week in coach to athlete sessions that illustrate ways to model respect and promote healthy gender-based relationships. A total of 400 religious leaders (52 imams and 348 pastors/bishops) were trained and they in turn reached out directly to 90 000 (75%) of their congregants in churches and mosques with messages of HIV, hope, stigma reduction and GBV. The faithful then helped to distribute a further 120 000 fliers and booklets. The 95 coaches have since reached out to 2007 boys with the 12 sessions from the CBIM 12 card series and all 2007 boys signed a pledge and committed to support women and girls in ending GBV. Through these sessions (both at the place of worship and community fields) 3255 people were screened for HIV risk, of whom 1899 were found to be at risk and tested. The parents admitted that the boys were becoming more responsible and sharing the knowledge they got from the coaches with their peers. This trickledown effect led to the caregivers of the boys who were not in the programme approaching COGRI and requesting their boys too also be enrolled.



COGRI's Chief of Party, Sr. Mary Owens, interacting with a football club engaged for the CBIM activity.

Keywords



ADOLESCENT FRIENDLY APPROACHES; ANTIRETROVIRAL TREATMENT; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; EDUCATION FOR FAITH LEADERS; GENDER-BASED VIOLENCE; HIV PREVENTION; IDENTIFICATION AND TESTING; LIFE SKILLS; MALE INVOLVEMENT; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; SCHOOL BASED HEALTH PROGRAMMES; STIGMA.



Coaches implementing the CBIM activity.

© COGRI



Name of intervention: Coaching Boys into Men in the informal settlements of Nairobi, Kenya.

Focus of intervention: Adolescent HIV prevention and life skills training.

Faith community asset area:

- Community outreach.
- Places of worship.
- Advocacy by religious leaders.
- Schools.

Description of the intervention: Coaching boys into men (CBIM) is an activity implemented under priority two of the Faith and Communities Initiatives (FCI) Kenya. FCI is a PEPFAR umbrella initiative that uses faith-based community outreach approaches to increase HIV case finding, linkage and retention to treatment as well as safeguarding children. The intervention is implemented and delivered through sports, especially soccer, and is based on the belief that sports coaches play an extremely influential and unique role in the lives of young men, often serving as a parent or mentor to the boys they coach. As a result of these special relationships, coaches are uniquely placed to positively influence how young men think and behave both on and off the field. The CBIM curriculum consists of 12 15-minute card series delivered once a week in coach to athlete sessions that illustrate ways to model respect and promote healthy gender-based relationships. The CBIM card series instructs coaches on how to incorporate themes associated with teamwork, integrity, fair play and respect into their daily practice and routine. Children of God Relief Institute (COGRI) first sensitized religious leaders under priority one on their role in reaching out to their congregants with HIV information and the need to find men and children for living with HIV and to sensitize communities and community leaders to help prevent sexual violence in the community. For CBIM, the focus was prevention among 9–14-year-olds and help respond to sexual violence among all children to mitigate its negative consequences. Through these communities, 95 coaches were identified and sensitized on the CBIM tool kit and they in turn held sessions with the 2007 athletes who made a commitment to end GBV and support women and girls to be safe.



Coaches implementing the CBIM activity.

© UNAIDS

Lead organization: Children of God Relief Institute.

Location: Nairobi City, Kenya.

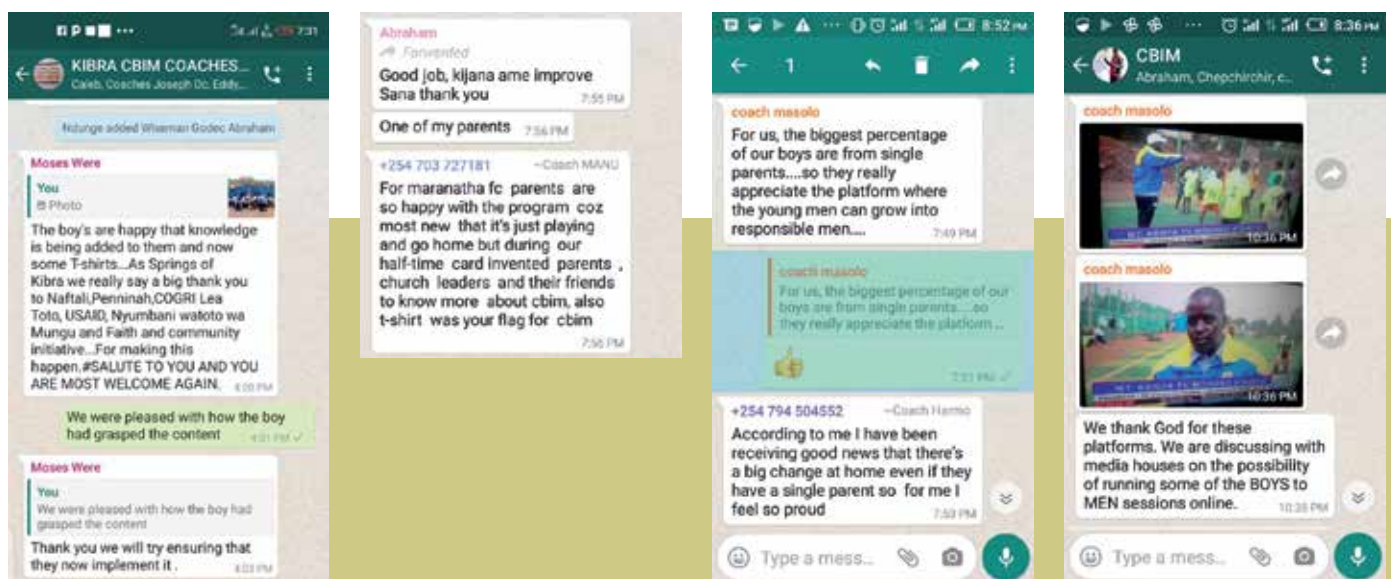
Where the intervention was implemented: In the community (sports grounds) and places of worship within the eight (Kangemi, Kawangware, Dagoretti, Kibera, Mukuru, Kariobangi, Dandora and Zimmerman) Lea Toto programme operational sites. Year the intervention started: 2020.

Is the intervention still being implemented? Yes. The CBIM intervention is still being implemented by the Lea Toto programme through schools that are based within the eight informal settlements in Nairobi. The 35 teachers who are already trained will start facilitating the CBIM tool kit when schools are back in session for 12 weeks. The school-based approach is meant to be self-sustaining after the first group's graduation since the sessions will be conducted at the same time as other games in different schools.

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

Results of intervention: COGRI trained 400 religious leaders (52 imams and 348 pastors/bishops). These in turn reached out directly to 90 000 (75%) of their congregants in churches and mosques with messages of HIV, hope, stigma reduction, and GBV. The faithful then helped to distribute a further 120 000 fliers and booklets. They also utilized social media platforms like WhatsApp groups and several sessions on local radio stations (Kwa Reuben FM and Mtaani Radio whose listenership is about 300 000 people each). With help from religious and community leaders, COGRI mapped out and trained 95 coaches from the informal settlements in Nairobi. Those coaches have since reached out to 2007 boys with the 12 sessions from the CBIM 12 card series. All signed and committed to support women and girls in ending GBV. The community coaches continue to monitor the behaviour of these boys in their respective teams. They also continue delivering card series to other boys as part of the trickledown effect in the community. These subsequent sessions are not closely monitored by COGRI as the coaches are expected to deliver this content in the rest of their professional careers wherever they are. During these sessions, the boys were also sensitized on COVID-19 prevention measures, e.g. wearing of masks, social distancing (which is strictly observed during the sessions so as to lead by example) and sanitizing/washing of hands. Through these sessions (both at places of worship and community fields) 3255 people were screened for HIV risk. Out of these, 1899 were found to be at risk and tested. Ten adults turned out to be positive and they were all referred to adult HIV comprehensive care centres.

Impact of the intervention: Most parents have appreciated how CBIM is transforming their boys. The parents admitted that the boys are becoming more responsible and sharing the knowledge they get from the coaches with their peers. This trickledown effect has led to the caregivers of the boys who were not in the programme approaching COGRI and requesting that their boys also be enrolled. The coaches on the other hand reported having noticed certain changes in the boys even in the sports itself, including increased cooperation, discipline and teamwork. Some were thinking of how they can mentor their fellow coaches online so that they can also pass it to their teams. Some of the feedback from the community is shown below.



Extent to which the intervention has been scaled up: With schools back in session, Lea Toto programme staff have mobilized teachers from 35 within the informal settlements in Nairobi in order to cascade the Coaching Boys Into Men (CBIM) programme. The 35 teachers have since been trained and they will in turn reach about 1800 boys (athletes between ages 9–14) with the CBIM tool kit when schools open to help prevent violence against women and girls. Several other actors that have shown a keen interest in the intervention include World Vision Kenya, several community football clubs in Nairobi, and local political leaders and local administration. Some have even committed to actively look for resources to enable reach out to the boys who were not reached by the intervention.

Source of funding to implement the intervention: USAID.

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

- Motivation of coaches and boys. In Phase One, coaches were given a motivation fee to drive the process. That also included a basic field kit for them and the boys. The field kits consisted of coaches' track suits, boys' jerseys and balls. Drinks for boys during some sessions were equally motivating.
- Self-driven training of trainers (ToTs) who were COGRI staff. The team received more support from the senior leadership of COGRI. This enhanced close supervision of coaches to ensure that each coach delivered correct content.
- Geographical coverage. The programme reached out for children across Nairobi's informal settlement areas where the population is greater.
- Harmonized card series sessions. To ensure that the same topic/card is covered during the same week across all the teams.
- Support and positive feedback from the parents/guardians of boys. This motivated the coaches.
- Appreciation of the program. Appreciation and good will expression by local leadership, which included chiefs, members of the county assembly, religious leaders and children's officers.
- Lessons learned from the Lea Toto programme. While working with the coaches in the first phase of the programme when children were not in school due to COVID-19, it became clear that whether it was through speeches to the team, practice sessions or even normal conversation, coaches play an important and unique role in the lives of young boys whether in school or at home.
- Gender based violence. Vulnerabilities associated with GBV in the informal settlements makes parents/caregivers more willing to give consent for the boys to participate in the programme.

Key factors constraining the implementation and scale-up of the intervention:

- Initially, the COVID-19 pandemic, which had hindered public/social gatherings, delayed implementation of this activity.
- There were budget limitations which hindered direct reach to other boys whose caregivers had demanded the service.
- Lack of supplementary content for girls, who often like training with boys, meant that some teams pulled out of CBIM as they perceived it as being 'gender discriminatory'.

Resources available for the intervention: Coaching Boys into Men (CBIM) Toolkit.

Information on the intervention: CBIM website: <https://www.coachescorner.org/>



CBIM leveraging the FCI platform to deal with COVID-19: The COGRI team distributing masks and sanitizers to the boys during one of the sessions.

© COGRI

INTERVENTION 2.6

Family Interventions for Adolescent HIV Prevention in Mpamba, Nkhata Bay, MALAWI

Summary

The Family Intervention for Adolescent HIV Prevention Project was implemented by the New Apostolic Church Relief Organization (NACRO) for two years from 2015. The goal was to contribute to improving sexual and reproductive health and rights information among young people aged 10–24 in Mpamba, Nkhata Bay District, Malawi, through family interventions and other campaigns to achieve a reduction in HIV infections. The project used three approaches to increase awareness of access to sexual and reproductive health and rights services by adolescents and young people in the family and target areas: the family intervention programme, school-based health programme and church based integrated health education and services.

The results indicate that there were improved family interactions for HIV prevention, with 350 adolescents and 200 parents receiving information about sex and reproductive health. In addition, 100 meetings were organized to facilitate parent–child interactions on HIV issues. There was also an increase in the number of church members engaged in HIV activities with more church leaders who mainstreamed HIV interventions into church-based activities for adolescents and women. Up to 70% of the targeted parents were motivated to challenge taboos and promote adolescent well-being. Ministry of Health data indicated that the number of new HIV infections among children and adolescents in the targeted community had dropped by 29% and the increase in the knowledge of HIV prevention had positively contributed to the demand for HIV testing and treatment. Key success factors were that the community was willing to work with a faith-based organization on HIV prevention and that the church was well positioned as an organization able to reach out because it has a clear understanding of, and good relationship with, the local communities.



Keywords

COMMUNITY EDUCATION; ECONOMIC EMPOWERMENT; EDUCATION FOR FAITH LEADERS; HIV PREVENTION; HIV SELF-TESTING; LIFE SKILLS; MOBILIZING FAITH COMMUNITIES; PEER MENTORS; SEXUAL REPRODUCTIVE HEALTH AND RIGHTS.

Name of intervention: Family Intervention for Adolescent HIV Prevention in Mpamba, Nkhata Bay, Malawi.

Focus of the intervention: Adolescent HIV prevention and life skills training.

Faith community asset area: Community outreach.



Description of the intervention: Before the project the majority of community members in Mpamba, Nkhata Bay, were still inclined to the cultural and biblical beliefs that deter many people, including adolescents, from accessing HIV services. The Family Intervention for Adolescent HIV Prevention project was implemented by the New Apostolic Church Relief Organization (NACRO) for two years from 2015. The project had the goal to contribute to improved sexual and reproductive health and rights information among young people aged 10–24 in Mpamba in Nkhata Bay District through family interventions and other campaigns to achieve a reduction in HIV infections. The project used three approaches to increase awareness of an access to sexual and reproductive health and rights services by adolescents and young people in the family and target areas:

- Family intervention programme. To reach adolescents and youth in and out of school, the project worked through family settings to provide and promote integrated sexual and reproductive health education and counselling services. The family intervention focused on supporting families to have positive perceptions and effective communication about sex and reproductive education to strengthen HIV prevention efforts. Building capacity among parents was emphasized to provide friendly messages to adolescents and young people.
- School based health programme. NACRO worked with selected primary and secondary schools with guidance and materials from the Ministry of Education to protect and promote the rights of adolescents and young people with regard to sexual and reproductive health information and services. The project provided a healthy environment and an efficient means to improve the well-being of school going boys and girls. Specific activities included: training of guidance and counselling teachers; guidance counselling sessions; identification of girls that need support (sanitary materials and school fees); and referrals to NACRO for support.
- Church based integrated health education and services. NACRO used church settings to provide integrated sexual and reproductive health education and counselling services. The project worked with church-based women and youth groups to create awareness and increase demand by adolescents and youths for integrated reproductive health education and services. This promoted voluntary abstinence, counselling and other services to sexually active youths, GBV and prevention of sexually transmitted infections. Specific activities included: training of youth peer educators (women and youth coordinators); behaviour change communication (BCC) awareness sessions targeting adolescents and young women and men with more emphasis on participation by girls, provision of sanitary materials, payment of school fees and other requisites.

Lead organization: New Apostolic Church Relief Organisation (NACRO), formerly Henwood Foundation).

Location: Mpamba, Nkhata Bay District, Malawi.

Where the intervention was implemented: The primary beneficiaries of the intervention were members of the farming community at the irrigation scheme and secondary beneficiaries were members of the Mpamba community.

Year the intervention started: 2015.

Is the intervention still being implemented? No.

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

Results of the intervention: With regard to the Improved Family Interactions for HIV Prevention project, 200 households participated in behaviour change training in parenting, protective skills and family bonding. A total of 350 adolescents (135 boys

and 215 girls) and 200 parents (160 women and 40 men) received information about sex and reproductive health and were given support about appropriate and accurate family interactions on HIV prevention. One hundred meetings were organized to facilitate parent–child interactions on HIV issues.

In addition, 82% of women and girls were engaged in income generating activities and farming activities to earn more money for their livelihoods. This reduced the dependence of women or girls on their male counterparts. The social groups increased the number of meetings and mainstreamed issues of HIV and GBV. There was also an increase in church members engaged in HIV activities. More church leaders, especially from the New Apostolic Church, have mainstreamed the HIV interventions into women and adolescent church-based activities.

Impact of the intervention: Of the targeted parents, 70% were motivated to challenge the taboos and to promote adolescent well-being. According to Ministry of Health data, the number of new HIV infections among children and adolescents in the targeted community dropped by 29%. The uptake of HIV prevention advice by adolescents and young women is demonstrated in national surveys, which recorded a reduction in HIV prevalence to about 7.3% in 2016 in Malawi North. The increase in the knowledge of HIV prevention has positively contributed to the demand for HIV testing and treatment.

While there is evidence that the project's strategies have been successful in engaging families and young people about HIV and reproductive health, more work remains to be done with some community members and religious leaders to address belief in faith healing rather than ART.

Extent to which the intervention has been scaled up: Not scaled up due to lack of continued funding for such projects.

Source of funding to implement the intervention: NAK-Karitativ, Germany.

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

- Availability of evidence-based information on HIV and reproductive health.
- A community willing to work with a faith-based organization on HIV prevention.
- Well positioned as an organization to reach out as there is clear understanding and good relationship with the local communities.

Key factors constraining the implementation and scale-up of the intervention:

- Limited financial resources that precluded the possibility of scaling up.
- Failure to attract adequate expertise within the organization due to small budgets.

Resources available for the intervention: The organization had no specific tool kits but integrated several approaches being used by other organizations in Malawi. An assessment framework used by the project is available.

Information on the intervention: The assessment framework is available by contacting the Interfaith Health Platform: interfaith.health.platform@gmail.com

INTERVENTION 2.7

Men Take Action to increase male involvement to increase prevention of vertical transmission (PVT) uptake, ZAMBIA

Summary

The Catholic Medical Mission Board (CMMB) in Zambia implemented the Men Take Action (MTA) intervention to increase male involvement to improve uptake of vertical transmission services by supporting spouses in health care and delivery, including HIV testing and treatment. Some of MTA's key activities included: training respected community leaders as champions for preventing vertical transmission and voluntary counselling and testing (VCT); and supporting the champions to organize regular behaviour change communication sessions with community members on HIV related subjects such as PVT, ART, VCT and other drivers of the epidemic. An evaluation of the MTA intervention highlighted several important results: 100% of the 4460 women who tested HIV positive accepted ARVs for PVT and HIV care compared with 70% at baseline. The intake of ARV prophylaxis for babies born from HIV positive mothers was 100%, while VCT improved dramatically, with 70% of men being tested and receiving their results compared with only 11.7% at the baseline. Couples testing and counselling among 19 177 pregnant women and their spouses improved to 70% of first ANC attendees compared with only 3% at the time of the baseline survey. The findings show that male involvement in health services increased testing and counselling among pregnant women and couples, and improved uptake of PVT services. The intervention highlights the importance of involving traditional leaders as health champions as an effective way of engaging men in HIV care and gender equity.



Keywords

ANTIRETROVIRAL TREATMENT; EARLY INFANT DIAGNOSIS (EID); GENDER-BASED VIOLENCE; HEALTH FACILITY–COMMUNITY COLLABORATION; IDENTIFICATION AND TESTING; MALE INVOLVEMENT; MOBILIZING FAITH COMMUNITIES; STIGMA; PREVENTION OF VERTICAL TRANSMISSION.



© UNAIDS/Cynthia R. Matonhodze

Focus of the intervention:

- Preventing vertical transmission.
- Capacity building for peer groups and community groups.
- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and VL suppression.

Faith community asset area: Community outreach.

Description of the intervention: According to the cultural norms and practices in Zambia, men are given more power over women as heads of the house. As family decision makers, men are central to preparations for birth and the actions needed in case of a maternal emergency. In patriarchal communities in Zambia, the influence of men is even more marked. Men in these settings control household resources and often make critical decisions that affect maternal health, including the choice of health services to be undertaken. In rural areas, where government services may be scarce, CMMB Zambia partners with traditional leadership, from paramount chiefs to village headmen and women. These individuals play a critical role in defining community norms and are often revered members of local governance structures. Collaboration and cooperation are critical to programme effectiveness, sustainability and continuity at local levels. CMMB acknowledges the critical role of men as key decision makers in increasing access to and utilization of health services.

Men Take Action (MTA) is an educational and community mobilization package involving practices, knowledge, skills and values that emphasize that married men are required to support their spouses in the area of health care and delivery. The objectives are as follows:

- Increase the uptake of HIV testing services by 95/95/95.
- Increase uptake of opt-out HIV testing from 95% of the pregnant women attending ANC at health facilities through the creation of supportive attitudes and behaviours among partners of pregnant women seeking ANC at targeted health facilities.
- Increase the participation of males in the family health, childcare, support and protection at both family and community levels.
- Improve gender, equality, equity and prevention of GBV and increase linkages and referrals of GBV victims to supporting institutions.

The key MTA approach uses adapted Participatory Learning and Action (PLA) methodologies underpinned by “Individual Stages of Change”, the “Ecological Perspective” and social behaviour change communication theories. The MTA activities involve:

- a. Orientation of key stakeholders:
 - Training revered community leaders (chiefs, headmen/women, herbalists, TBAs, etc.) as champions of PVT and VCT: four-day training curriculum based on baseline KAP survey.
 - BCC sessions held regularly by champions in general communities and in ANC settings on special days/month: aimed at men and couples
- b. The BCC sessions are participatory and iterative covering subjects such as: HIV and AIDS, elimination of vertical transmission (EVT), HIV testing and counselling, ARVs, gender and other drivers of the epidemic as needed.

Lead organization: The Catholic Medical Mission Board (CMMB) is an international NGO providing long term, cooperative medical and development aid to communities affected by poverty and unequal access to health care. For over a century, CMMB has worked to strengthen and support communities through health care programmes and initiatives, the distribution of medicines and medical supplies, and the placement of volunteers. CMMB has been working in Zambia since 1965. CMMB Zambia works with provincial and district health offices of the Ministry of Health in all ten provinces and enjoys a close relationship with the Zambian Episcopal Conference and the Churches Health Association of Zambia, the umbrella organization of Zambia’s faith-based health care institutions.

Location: CMMB implemented Men Take Action at 31 Church Health Institutions (CHIs) and associated communities in 25 Zambian districts in Central, Copperbelt, Lusaka, Northern, North-western and Western Provinces.

Where the intervention was implemented: Communities and in the following mission hospitals across Zambia:

- Central: Chipembi Mission, Nangoma Mission Hospital.
- Copperbelt: Kafulafuta Mission Hospital, Mpongwe Mission Hospital.
- Eastern: Minga Mission Hospital, Nyanje Mission Hospital, St. Paul's Mission (Katete).
- Luapula: Kawambwa Mission Hospital, St. Pauls Mission, Mambilima Mission, St. Margarete Mission, Lubwe Mission Hospital.
- Lusaka: Mumpasha Mission Hospital, Katondwe Mission Hospital.
- Northern: Mwenzo Mission Hospital, Chalabesa Mission Hospital.
- Northwestern: Manyinga Mission Hospital, Kasempa Mission Hospital, Luwi Mission Hospital.
- Southern: Chikuni Mission Hospital, Monze Mission Hospital, Macha Mission Hospital, Zimba Mission Hospital, Mtendere Mission Hospital.
- Western: Luampa Mission Hospital, Mangango Mission Hospital, Sichili.

Year the intervention started: 2009.

Is the intervention still being implemented? Yes.

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

Results of the intervention: The MTA programme was evaluated by an independent evaluator, Valentine Mwanza BA, MBA, who found the following:

- Among pregnant women who attended ANC, 92% (n = 52 225) participating in the MTA programme were tested and received their results, compared with 60% at baseline.
- All the women (n = 4460) who tested HIV positive accepted ARVs for PVT and HIV care compared with 70% at baseline.
- Intake of ARV prophylaxis for babies born from HIV positive mothers was 100% and all women who tested positive elected breastfeeding exclusively as the best option for infant feeding.
- As a result of the MTA programme, voluntary counselling and testing improved dramatically, with 70% of men being tested and receiving their results compared with only 11.7% at the baseline.
- Couples testing and counselling among 19 177 pregnant women and their spouses improved to 70% of first ANC attendees compared with only 3% at the time of the baseline survey.
- Approximately 98% of women reported some reduction in beatings by their spouses.
- Approximately 65% women said they now jointly plan together how funds earned by the male partner should be spent.



The following graphs outline the results of the MTA programme against baseline data.

CHART 2. TESTING AND RECEIVING RESULTS BY PREGNANT WOMEN IN ANC SETTING

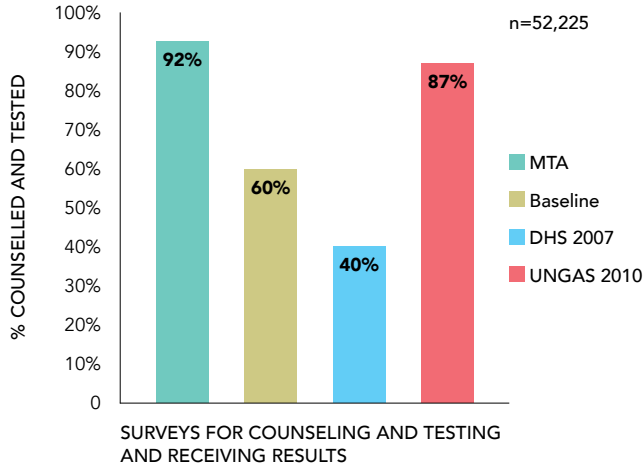


CHART 3. INTAKE OF MATERNAL ARVS FOR PMTCT

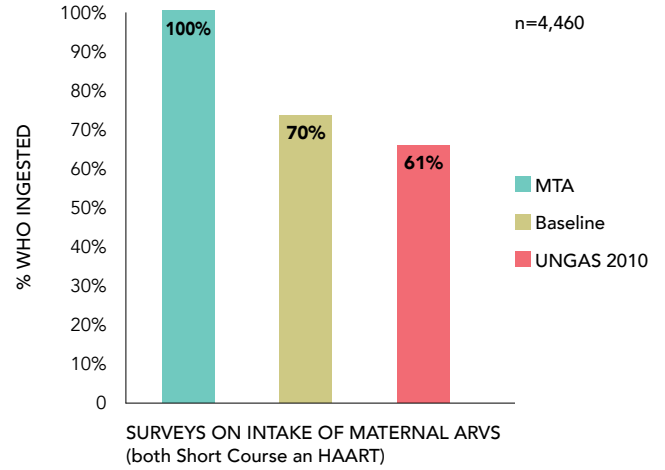


CHART 4. ARV UPTAKE: INFANTS EXPOSED TO HIV

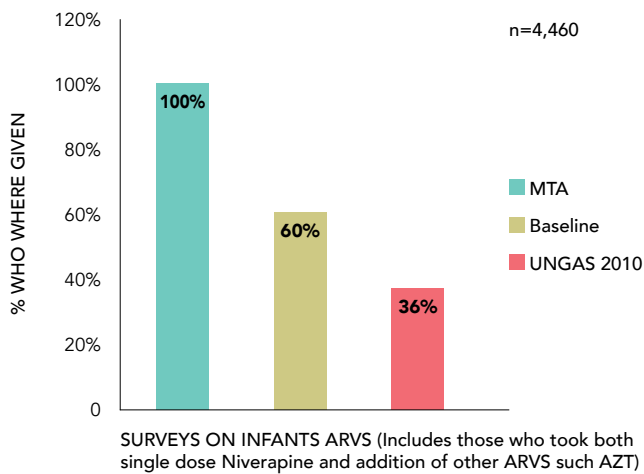


CHART 5. MEN AND COUPLES TESTING AND RECEIVING RESULTS

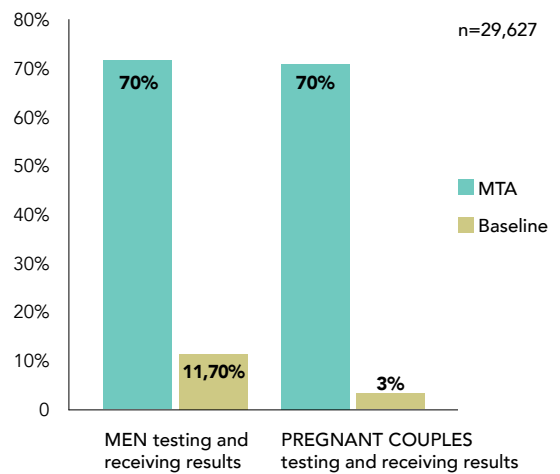


CHART 6. INFANT FEEDING OPTIONS: EXCLUSIVE BREASTFEEDING

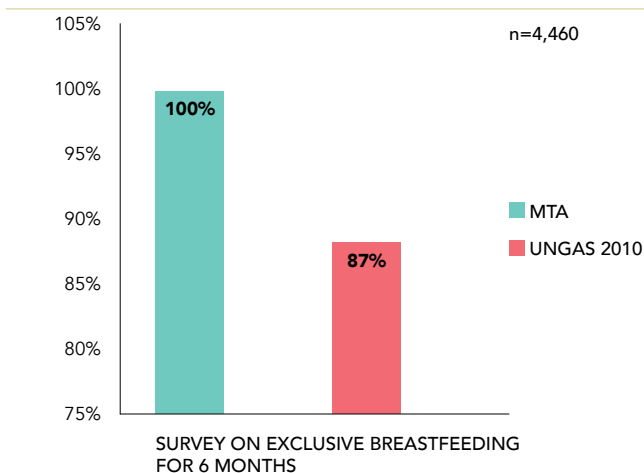
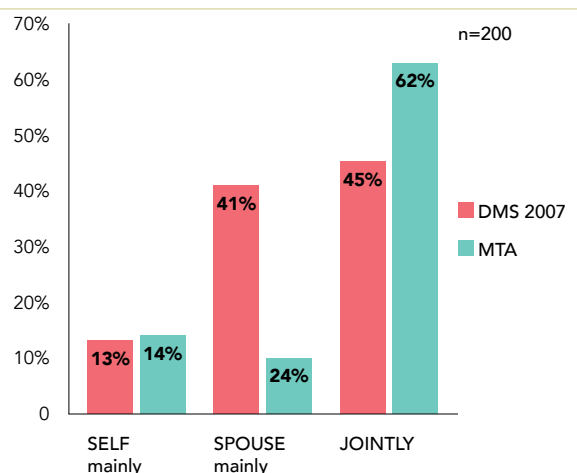


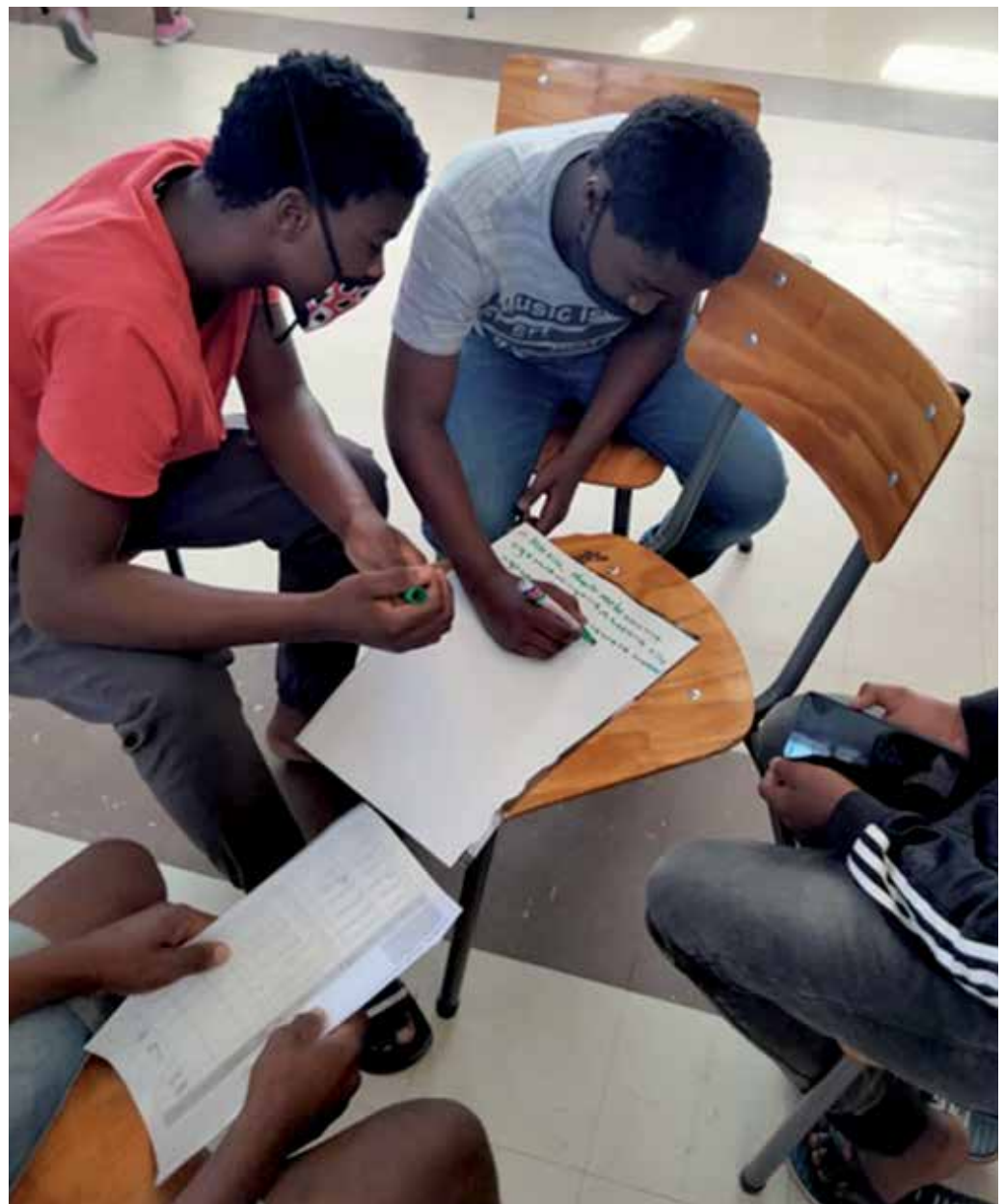
CHART 7. WHO DECIDES ON HOW MONEY EARNED BY WIFE SHOULD BE USED



Impact of the intervention:

- The findings show how male involvement in health can increase testing and counselling among pregnant women and couples, reduce stigma and improve PVT. Leveraging traditional leaders as health champions is an effective way of engaging men in HIV care and gender equity with positive behaviour change.
- It is possible to positively change cultural beliefs among men with regard to multiple female partners/polygamous marriages and sexual cleansing.
- Disclosure of HIV status by community leaders; change in policy of church health institutions (CHIs) regarding ANC/PVT services to include spouses.
- Positive response by traditional leaders in encouraging men to accompany their pregnant spouses to the ANC and lobbying CHIs to increase the frequency of ANC services at their hospitals.

Extent to which the intervention has been scaled up: Although the donor funding ended, the MTA approach has been integrated into all of CMMB Zambia programming. Currently, a manual is under development so that the approach can be implemented beyond CMMB Zambia. Other CMMB Zambia office staff, such as in Haiti and Kenya, came for a field visit in Zambia to learn the approach for replication in their respective countries.



Source of funding to implement the intervention: USAID, private foundations through CMMB, Inc. (USA).

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

- In rural areas, men are motivated to learn from other men, particularly culturally respected men, so it is important to engage traditional leaders as champions of HIV prevention.
- Although most men have heard messages on HIV and AIDS, few have clear understanding of the implications of transmission.
- Community mobilization, especially by men's groups, can lead to high uptake of health seeking behaviour, as well as PVT and VCT services.
- Minimal resources are needed to get men involved in health care. The resources that are needed include transport and lunch allowance for the men to get involved and hold sessions with their fellow men. An equivalent of \$10 per day for each volunteer covers this cost. The training cost is the usual cost of training for five days.
- Scaling up information education and change and social behaviour change communication materials for males and couples helped remove cultural barriers to male involvement in reproductive health and PVT.
- Forming male and couple support groups can be important.
- Partner and couples counselling should be offered as routine or on special days in ANC settings.

Key factors constraining the implementation and scale-up of the intervention:

- Need for a finalized CMMB MTA handbook which encompasses all programmatic areas the organization is working on currently.
- Need for frequent review of the document to accommodate changes in trends and programme implementation.

Resources available on the intervention: Yes; project specific.

Information on the intervention:

<https://childrenandhiv.org/wp-content/uploads/Sinkala-Addis-ICASA-Satellite-presentation1.pdf>

https://www.researchgate.net/publication/266787701_Men_as_partners_Preventing_HIVAIDS_and_promoting_gender_equity_with_innovative_male_involvement_in_PMTCT_and_VCT_services

Zambia Antenatal Clinic Sentinel Surveillance Report 1994–2004, Ministry of Health, 2005.

Zambian Demographic and Health Survey, Central Statistics Office, 2007.

Zambian Demographic and Health Survey, Central Statistics Office, 2001–2002.

CMMB Men Taking Action Curriculum training, 2017 (Draft).

2. COMMUNITY OUTREACH BY FAITH COMMUNITY GROUPS



INTERVENTION 2.8

Shiselweni Community Home-Based Care, ESWATINI

Summary

The Shiselweni Home Based Care (SHBC) is a faith-based organization in Eswatini that has four focal areas: home based care; early childhood development; supplying meals to orphans and vulnerable children; and supplying wheelchairs to those with disabilities. The key elements of the intervention involve community members visiting people who may be living with HIV, referring them to testing facilities and, if testing positive, supporting them to start and adhere to ART medication. Out of a total of 5500 clients, approximately 3000 are living with HIV, of whom around 300 are under the age of 19. The clients are given holistic care and support, are visited regularly and supported emotionally to adhere to their ART regime. Some 400 children also receive daily meals at one of the nutrition depots. As people were encouraged to be tested for HIV and to start on ART, the mortality rate dropped annually and although the data from a detailed study in 2014 do not prove causality, there is a trend indicating a dramatic decline in overall client mortality (71.4%), from approximately one in three (32.2%) clients in 2007 to one in ten (9.2%) in 2011. The success of SHBC has been attributed in large part to the philosophy of volunteerism of community members, which ensures commitment to, and sustainability of, the programme.

Keywords



ANTIRETROVIRAL TREATMENT; BIO-PSYCHOSOCIAL-SPIRITUAL, PATIENT CENTRED MODEL; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; COMPREHENSIVE ORPHAN AND VULNERABLE CHILDREN CARE, DIFFERENTIATED SERVICE DELIVERY; EARLY INFANT DIAGNOSIS; ECONOMIC EMPOWERMENT; HOLISTIC CARE; HOME BASED CARE; IDENTIFICATION AND TESTING; NUTRITION; TREATMENT ADHERENCE.



Name of the intervention: Shiselweni Community Home-Based Care, Eswatini.

Focus of the intervention:

- Access to comprehensive orphans and vulnerable children care and support, including nutrition, psychosocial and spiritual.
- HIV and health awareness.
- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and VL suppression.

Faith community asset area: Community outreach.

Description of the intervention: The Shiselweni Home Based Care (SHBC) intervention has four focus areas: home based care; early childhood development; supplying meals to orphans and vulnerable children; and supplying wheelchairs to those with disabilities. The key elements involve visiting people who may be living with HIV, referring them to testing facilities and, if testing positive, supporting them to start with an ART regime and ensuring that they adhere to the prescribed medication. Those children (up to the age of 16) identified as requiring extra food are invited to one of five nutrition depots where hot, balanced meals are served. In terms of caregiving, caregivers receive training in home-based care and they form caregiver groups. The caregivers are encouraged to identify people in their immediate vicinity (within walking distance of their homes) who they suspect may require assistance to cope with health issues. Although SHBC was established in 2006, mainly to assist people with HIV and AIDS, there are many other debilitating diseases that people have to cope with, such as diabetes, high blood pressure and TB. In some cases, people need physical assistance while in other cases the need may be more focused on knowledge acquisition. A plan needed to be developed whereby the needs of each individual could be accurately evaluated. This is SHBC's Client Care Plan. Central to the plan is a form where basic information on the client is noted, including a preliminary diagnosis of the client's health needs. Furthermore, the caregiver needs to indicate whether the client has been referred to determine their HIV, STI or TB status, or whether the person was referred for ART. Making use of a nine-point matrix, the condition of the client (bedridden, support needed or active) is noted as well as the client's access to support, apart from the caregiver (i.e. no access, occasional access or all the time). The client is then categorized from A to I, which determines the extent of support given by the caregiver. Depending on the category within which the client falls, the number of visits per week or month is determined as well as the special needs which have to be addressed during such a visit. Wherever possible, the family or friends of the client are encouraged to become involved with the caring of the client, so that the client will not become totally dependent upon the caregiver. A database was developed where all the information of every caregiver and their clients are recorded which enables each individual and the entire group to be monitored according to their diagnoses, gender, age groups and comorbidities such as people living with HIV and TB.

Lead organization: Shiselweni Home-Based Care (SHBC).

Location: Southern (Shiselweni) District of Eswatini.

Where the intervention was implemented: Communities within rural areas of the Shiselweni District of Eswatini.

Year the intervention started: 2006.

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: SHBC's data collection and reporting practices are very rigorous and distinguish it from many community-based initiatives. The organization has been able to track dramatic declines in client mortality, design data collection strategies to monitor and evaluate its services and develop targeted initiatives to address HIV health needs of clients and to assist its care supporters. Out of 5500 clients of which approximately 3000 are HIV positive, around 300 under the age of 19 are HIV positive (two-thirds of this group are over the age of 40). These people are given holistic care and support, are visited regularly and supported emotionally to adhere to their ART regime. Around 400 children also

receive daily meals at one of the nutrition depots. It is expected that this number will rise to over 500 once the COVID-19 restrictions in Eswatini are lifted and schools are allowed to function once again (see table below).

TABLE 9. SHBC CLIENT REPORTS: 2015–2019.

	2015	2016	2017	2018	2019
Total clients	4547	4728	4918	5449	5499
HIV positive by age group					
0–14	213	212	192	201	143
15–19	84	108	115	130	125
20–24	69	59	67	78	133
25–29	128	119	107	121	90
30–34	189	213	179	186	159
35–39	257	260	270	324	256
40+	1113	1246	1318	1709	2081
Total	2053	2217	2248	2749	2987
Referrals					
HIV testing	893	917	987	34	1084
ART	479	514	548	22	668
TB	191	202	201	18	262

Impact of the intervention: From a detailed study conducted in 2014, which reviewed data about SHBC results between 2008 and 2013, the analysis concluded that though it was not possible to establish causality, these trends appear to track in meaningful ways with a dramatic decline in overall client mortality (71.4%), from approximately one in three (32.2%) clients to one in ten (9.2%) in a six-year period¹. This reduction of 71.4% was approximately double the decline in national AIDS related mortality rates (35.4%) over roughly the same period (2007 and 2011). Thus, while the proportion of SHBC's reduced mortality attributable to the prevention of HIV related deaths is not known from these data, national AIDS related mortality rates strongly suggest that the proportion of HIV related deaths averted by SHBC care has been substantial. As people were encouraged to be tested for HIV and to start ART, the mortality rate dropped annually and is currently at 1.6%. When the nutrition programmes were implemented, many children were suffering from malnutrition and some were also identified as suffering from kwashiorkor. Not one of the children attending the nutrition depots are malnourished and it has been many years since any child with kwashiorkor in the areas where SHBC operates were noticed.

Extent to which the intervention has been scaled up: With regard to the HIV intervention programme, the work started in one rural community in 2006. As word spread about the success of the programme, community leaders in other areas contacted SHBC and asked that their community members also be trained. Before the COVID-19 pandemic, the organization was working in 50 different rural areas and

1 Reckoning HIV/AIDS care: A longitudinal study of community home-based caregivers and clients in Swaziland. <http://shbcare.org/docs/Reckoning%20HIV%20AIDS%20care.pdf>

had 1500 volunteers (who received no stipend) who have been trained and regularly visit the homes of clients. The nutrition programme also started in one area and gradually expanded to the present five areas where food is cooked daily and served to the children of the community. Attempts were made to implement the approach in three areas of South Africa (Pretoria, Bloemfontein and Cape Town), but after initial enthusiasm, the attempts in each location were unsuccessful due largely to fewer volunteers than at Shiselweni.

Source of funding to implement the intervention: The HIV intervention programme is funded solely by individuals sympathetic to the cause. The nutrition programme is funded largely by a Taiwan based organisation, the Taiwan Fund for Children and Families.

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

- HIV intervention: Because this work is done by community members, the caregivers see the lives of their friends and relatives improving and this motivates them to continue with the work of visiting and encouraging their clients.
- Nutrition programme: The people of Eswatini have a natural heart for children and seeing children suffer from malnutrition has always caused much sadness. Now that the nutrition depots are visibly making a difference in the lives of the children, mostly orphans and vulnerable children, this has become a motivating factor to persevere with the task of preparing and serving the food daily.
- General factors:
 - The success of SHBC can be attributed to the philosophy of volunteerism, which ensures commitment to, and sustainability of, the programme because it is free of the constraints of compensation in countries that are financially-constrained.
 - The ability of motivated people to acquire and apply skills necessary to change their communities cannot be underestimated regardless of their literacy level and socioeconomic status.
 - The programme started small and grew bigger. In 2009, it expanded with ten new groups—about 300 new caregivers. This called for special management and governance skills to direct the rapid expansion of SHBC.
 - Consultation with acknowledged community leaders (e.g. traditional chiefs and political leaders) was crucial for the success of the programme because of their support of the community caregivers in their areas

Key factors constraining the implementation and scale-up of the intervention:

The entire programme (which currently includes the 1500 caregivers visiting 5500 clients, 400 children receiving nutritious meals at five nutrition depots as well as 300 children enrolled in three early childhood development centres) runs on an annual budget of less than 1.2 million Eswatini Emalangeni (approximately \$80 000). This is mainly because all the board members, coordinators, as well as caregivers are volunteers without receiving any financial compensation. Nevertheless, the caregivers are often confronted with situations in homesteads where there is no food available. Part of the donations received is used to purchase food to assist people in dire need, but this is not enough for the need observed. For the past six years, the subsidy received for the nutritional depots has remained unchanged, although the number of children has increased and inflation, as well as the COVID-19 pandemic, have led to huge hikes in food prices. In effect, this means that more children have to receive less food. As mentioned above, after a year during which all the preschools remained closed, school reopenings could lead to an increasing number of children queuing for food. The programme will have to be scaled up, but without the necessary funding to implement this.

Resources available on the intervention:

Academic articles published on the work of SHBC:

- Reducing the effects of HIV/AIDS in rural communities through a holistic approach by volunteer caregivers in Shiselweni, Southern Swaziland: <http://www.shbcare.org/docs/USAID.pdf>
- On becoming the hands and feet of Christ in an AIDS-ridden community: http://shbcare.org/docs/verbum_v27_n3_a18.pdf
- Reckoning HIV/AIDS care: A longitudinal study of community home-based caregivers and clients in Swaziland: <http://shbcare.org/docs/Reckoning%20HIV%20AIDS%20care.pdf>
- Food insecurity and ART adherence in Swaziland: the case for coordinated faith-based and multi-sectoral action: <http://shbcare.org/docs/Food%20insecurity%20and%20ART%20adherence%20in%20Swaziland%20the%20case%20for%20coordinated%20faith%20based%20and%20multi%20sectoral%20action.pdf>
- A qualitative study of community home-based care and antiretroviral adherence in Swaziland: <http://shbcare.org/docs/17978-8775-1-PB.pdf>
- “We smoke the same pipe”: Religion and community home-based care for PLWH in rural Swaziland: <http://shbcare.org/docs/We%20Smoke%20the%20Same%20Pipe.pdf>
- Four video clips about Shiselweni’s work. The second explains the method used and the others provide insights into SHBC:
 - Interview with SHBC CEO prior to Courageous Leadership Award function (2008); <http://youtu.be/HrMltxg8m9M>
 - SHBC CEO speaking at Mergon Foundation (2010/10/23); <http://youtu.be/dnzTkfZYHwU>
 - Arnau van Wyngaard addressing the General Synod of the Dutch Reformed Church (2013/10/07) – https://youtu.be/PloE_MDSVZA
 - Heartbeat of SHBC (A Day in the Life of a Caregiver) – https://youtu.be/V1kfJlu_xME

Information on the intervention: www.shbcare.org;

Interfaith Health Platform: interfaith.health.platform@gmail.com



INTERVENTION 2.9

Creating HIV awareness amongst adolescents, screening and placing positives on treatment, CAMEROON

Summary

The Presbyterian Church in Cameroon has implemented this intervention in parts of Cameroon to create HIV awareness among adolescents, undertake screening and place those living with HIV on treatment. The intervention has three components: sensitizing adolescents and youth in church groups about HIV awareness, sexuality and life skills, training teachers in Presbyterian Church Schools (and other schools) to give lectures on HIV, STIs, life skills, and sexuality and conduct free screening campaigns in churches and schools to identify positive cases and support them to access treatment. The intervention increased awareness about HIV among adolescents and adults who know their HIV status—3590 youth and adults have been tested. Students who tested positive were counselled and placed on treatment with follow-up support. No cases of pregnancy were reported in the project schools in 2020 compared with 2019. Peer educators were able to support and sensitize their peers about life skills, sexuality and STIs without embarrassment. Key success factors have been the willingness of church members to give their time to get involved in the activities, the confidence given to peer mentors as a result of training and the importance of peer group discussions.

Name of the intervention: Creating HIV awareness among adolescents, screening and placing positives on treatment, Cameroon.

Focus of the intervention:

- Adolescent HIV prevention and life skills training.
- Identifying and testing children and adults living with HIV not on treatment.

Faith community asset area:

- Community outreach.
- Religious schools.
- Using places of worship to create demand for HIV services.

Keywords

ANTIRETROVIRAL TREATMENT; HIV PREVENTION; IDENTIFICATION AND TESTING; LIFE SKILLS; PEER MENTORS; PLACES OF WORSHIP; SCHOOL-BASED HEALTH PROGRAMMES.

Description of the intervention:

- Sensitizing adolescents and youth in various Presbyterian Church groups about HIV awareness, sexuality and life skills.
- Visits to Presbyterian church schools (and other schools) to train teachers to carry out lectures on HIV, STIs, life skills and sexuality.
- Conduct free screening campaigns in churches and schools to identify positive cases and support them to access treatment.

Faith communities have a major role in the intervention as they work with adolescents from the Young Presbyterians and the Christian Youth Fellowship. The pastors provide the opportunity to give health talks in church and to carry out screening. Some churches have support groups which involve people living with HIV and AIDS.

Lead organization: Health Services Department of the Presbyterian Church in Cameroon.

Location: Northwest, west, littoral, southwest and central Cameroon

Where the intervention was implemented: Places of worship, health facilities and communities.

Year the intervention started: 2020.

Is the intervention still being implemented: Yes.

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

Results of the intervention: Results for the programme are available for two regions in 2020, in Doula and the northwest:

- HIV education and sensitization and life skills, through school visits, youth group activities and World AIDS Day events: 923 young people participated. There was also qualitative information through staff feedback that the sensitization event had improved the knowledge of young people about life skills and sexuality and the maturity of the questions they asked during the counselling sessions.
- HIV testing in project schools, churches, rallies and World AIDS Day events: 3590 youths and adults were tested.

Impact of the intervention:

- Awareness about HIV among adolescents has been improved as a result of the programme activities and many more young people, as well as adults, know their HIV status.
- No cases of pregnancy were reported in the project schools in 2020, compared with 2019.
- Peer educators said they were able to support and sensitize their peers about life skills, sexuality and STIs without any embarrassment.
- Students who tested positive were counselled and placed on treatment with follow-up support.

Extent to which the intervention has been scaled up: Staff are planning to go out of Bamenda to carry out similar activities as are colleagues in other regions.

Source of funding to implement the intervention: Funds have been provided by the Presbyterian Church in Cameroon Care Programme and Presbyterian Health Centre

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

- Church members have been willing to give their time to get involved in programme activities.
- Training has given the peer mentors confidence.
- Young people have been willing to learn about HIV, especially through church youth groups and peer group discussions.

Key factors constraining the implementation and scale-up of the intervention:

- The political crisis in the northwest region has restricted programme activities in those areas
- Some support groups have been poorly attended because of the fear of stigma.
- Some people have an HIV test and then do not collect their results.
- During screening in some schools, it is mainly junior students who came for a test as the senior students are more afraid as they are sexually active.
- There have been some shortages of test kit, making it difficult to carry out more HIV screening, particularly at rallies.
- It is still not easy to persuade some positive clients to start treatment as they believe in faith healing rather than medication.
- COVID-19 has restricted programme activities.

Resources available for the intervention: Study manual, charts and pictures.

Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com



Rev. Dionne Boissiere facilitating the annual PEPFAR/UNAIDS Faith Initiative Prayer Breakfast at UNGA – © UNAIDS

INTERVENTION 2.10

HIV & AIDS Stigma Reduction & Empowerment of people living with HIV, ZIMBABWE

Summary

The Anglican Church in Zimbabwe implemented a range of activities aimed at reducing HIV related stigma and discrimination in the operational areas of the Anglican Church in Zimbabwe. The activities implemented were guided by several outputs, including: increased public engagement with people living with HIV, increased disclosure of HIV status, improved self-esteem and participation of people living with HIV, increased number of people attending VCT and fewer reported cases of stigma. The young people were sensitized about HIV stigma and discrimination by participating in a range of events: sports events that included people living with HIV and awareness raising; awareness raising activities within schools such as life skills training; talks and testimonies by young people living with HIV encouraging young people to adhere to ART; and mobilizing parents and teachers about zero tolerance of HIV stigma. In 2017 and 2018, a total of 3090 youths and young adults were direct beneficiaries of the HIV Stigma Reduction Programme, and there were a further 1200 indirect youths and young adult beneficiaries. The intervention aimed to reduce HIV stigma and discrimination levels from 65.5%, as identified in the People Living with HIV Stigma Index study in 2013–2014, to 30% and improve the well-being of people living with HIV by 2019 in the Anglican dioceses in Zimbabwe. The programme managed to reduce HIV related stigma to 21.4% in targeted areas within the Anglican Church in Zimbabwe and surrounding community areas, as measured by a mid-term and end of term programme evaluation using household questionnaires, key informant interviews and focus group discussions. A key success factor has been the strong support provided by the church leadership—with more than 75% of church leadership having been committed to the HIV activities.

Keywords

ADOLESCENT FRIENDLY APPROACHES; ANTIRETROVIRAL TREATMENT; COMMUNITY EDUCATION; DISCLOSURE; ECONOMIC EMPOWERMENT; EDUCATION FOR FAITH LEADERS; IDENTIFICATION AND TESTING; LIFE SKILLS; MOBILIZING FAITH COMMUNITIES; NUTRITION; PLACES OF WORSHIP; STIGMA; SUPPORT GROUPS.

Name of the intervention: HIV and AIDS stigma reduction and empowerment of people living with HIV, Zimbabwe.

Focus of the intervention:

- Zero stigma and discrimination.
- Adolescent HIV prevention and life skills training.

Faith community asset area:

- Community outreach.
- Using places of worship.
- Advocacy by religious leaders.

Description of the intervention: The Anglican Church in Zimbabwe implemented a range of activities aimed at reducing HIV related stigma and discrimination in the operational areas of the Anglican Church in Zimbabwe. The activities implemented were guided by ten outputs:

- Increased public engagement with people living with HIV.
- Increased disclosure of HIV status.
- Improved self-esteem and participation of people living with HIV.
- Increase in the quantity of comprehensive and accurate information on HIV related stigma and discrimination and noncommunicable diseases (NCDs).
- Improved services for people living with HIV.
- Increased number of people attending VCT.
- Fewer reported cases of stigma in institutions.
- Fewer cases of misconceptions.
- Improved food and nutritional security.
- Development of an HIV and wellness workplace policy

*Youth engagement
through sports
(Diocese of Matabeleland).*

© UNAIDS



To reach more adolescents, the Anglican Church in Zimbabwe implemented a range of activities, such as sports galas, which had a high turnout of youths. The sporting activities created a platform to share and raise awareness of HIV stigma and discrimination. On the sports day, mobile clinics were available for HIV testing. In addition, Church youth conferences, such as the Zimbabwe Anglican Youth Association, helped Anglican youths from all parts of the country come together to worship. Such platforms were used to reach out to young people and raise awareness on HIV related issues.

Awareness sessions targeted young people to promote adherence to ART by giving testimonies. Adolescents also participated in awareness raising activities. School going children undertook awareness raising through poems and songs during commemorations, such as World AIDS Day.

There has been good support provided by the Church leadership, up to 75%, as demonstrated by such activities as the Bishop's personal initiatives to speak in public meetings, and participation of priests at parish and church level. Priests actively participate by delivering sermons with messages against HIV and AIDS stigmatization. They are also playing an active role in some of the groups formed, such as wellness groups, where they come together for support, information sharing, and income generating activities such as making peanut butter, keeping nutrition gardens, bee keeping, etc.

Lead organization: Anglican Relief and Development, Zimbabwe.

Location: Diocese of Matabeleland, Harare, Masvingo, Central Zimbabwe and Diocese of Manicaland.

Where the intervention was implemented: Communities and places of worship.

Year the intervention started: 2016.

Is the intervention still being implemented? Yes.

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

Results of the intervention: In 2017 and 2018, a total of 3090 youths and young adults were direct beneficiaries of the HIV Stigma Reduction Programme; there were a further 1200 other youths and young adult who were beneficiaries. They were sensitized about HIV stigma and discrimination by participating in a range of events: sports events that included people living with HIV and awareness raising; other awareness raising activities, within schools, such as life skills training; and talks and testimonies by young people living with HIV encouraging young people to adhere to ART; and mobilizing parents and teachers about zero tolerance of HIV stigma.

Impact of the intervention: The HIV Stigma and Reduction Programme ultimately aimed to contribute to the overall reduction in HIV related stigma and discrimination. Specifically, reduce HIV stigma and discrimination from 65.5%, as identified in the People Living with HIV Stigma Index study in 2013–2014, to 30%, and improve the well-being of people living with HIV by 2019 in the Anglican dioceses in Zimbabwe. The programme managed to reduce HIV related stigma to 21.4% in targeted areas within the Anglican Church in Zimbabwe and surrounding community areas. This reduction was measured by a mid-term and end of term programme evaluation using household questionnaires, key informant interviews and focus group discussions.

Extent to which the intervention has been scaled-up: The intervention has been scaled up to other areas of the Anglican Church in phase 2 as it was only targeting a few centres due to the large areas of the dioceses. In phase 2 of the programme, more areas are being reached.

Source of funding to implement the intervention: United Societies Partners in the Gospel (USPG)

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

- Reduction of HIV related stigma in church institutions and communities.
- Increase in number of people living with HIV disclosing their status.
- Increase in number of wellness groups.
- More people living with HIV are now participating in public forums.
- HIV related messages in the Church sermons.
- Improved networking at the national and diocesan level with stakeholders and focal persons linking up with local health workers.
- Good support by the church leadership; this commitment coming from the Bishops and their personal initiative to speak in public meetings and priest participation at the parish and church levels.

Key factors constraining the implementation and scale-up of the intervention:

- Generally, the programme impacted positively on the targeted communities and church, though initially there were challenges from some who were not willing to have HIV stigma and discrimination issues discussed within the church context.
- Youth coverage in the HIV programme needed to be improved; there was a need to identify youths as focal persons.
- Clergy required continuous training in HIV counselling as the Church was receiving many referrals.
- The geographical locations of the centres were far apart as the dioceses covered large areas.
- The Covid-19 pandemic has negatively affected the programme.

Resources available for the intervention: The Anglican Church in Zimbabwe developed an HIV and Wellness Policy which guides the Church. The Diocese of Central Zimbabwe, under the Anglican Church in Zimbabwe, also developed a sermon manual for preaching. The national office is currently in the process of developing a national clergy sermon manual for the Anglican Church in Zimbabwe.

Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com

Partnering with the National AIDS Council: Interaction between Anglican youths and NAC staff.

© Anglican Relief & Development Zimbabwe



INTERVENTION 2.11

Teen Clubs, ESWATINI

Summary

The Teen Clubs intervention implemented by The Luke Commission (TLC) in Eswatini offered DSD to young people aged 8–24 living with HIV. They seek to provide a safe and welcoming space for children and young adults to gain life skills and to encourage adherence among young people living with HIV by providing a stigma-free environment for receiving ARV refills. The clubs undertake a range of activities during half-day Saturday events, held monthly for each age band, featuring: singing together, games, life skills trainings, ART refills, opportunities to meet with counsellors as needed or requested, and stepped-up adherence counselling, as needed. From small beginnings, the programme rapidly scaled up to include rosters in the following age bands (current attendance numbers as of May 2021): ages 8–14: 57, 15–19: 97 and 20–24: 19. Every attendee has the opportunity to receive medication refills and to receive life skills training, a nutritious meal and to build connections with others in a safe, nurturing and stigma free environment. There has been positive feedback provided by the young people and their carers. One TLC staff member said: “I was touched when one young man said they must all preach about the advantages of the medications. They feel free to share their positive status with friends and not be scared”. One of the key success factors has been that the comprehensive health care platform includes all ages and prioritizes building trust between staff and patients. In turn, patients refer friends and family to TLC.



Keywords

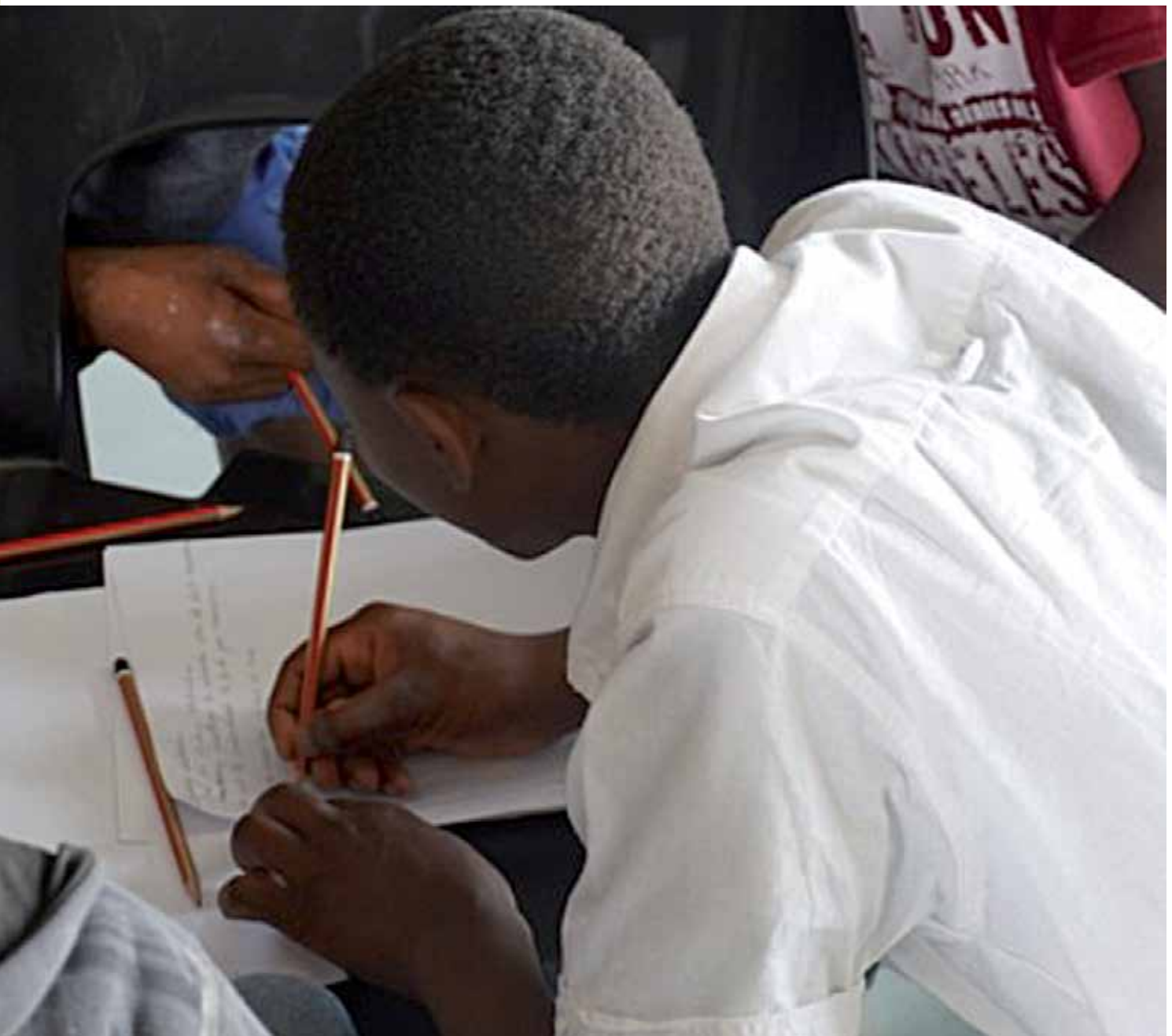
ADHERENCE COUNSELLING; ADOLESCENT-FRIENDLY APPROACHES; ANTIRETROVIRAL TREATMENT; HIV PREVENTION; LIFE SKILLS; NUTRITION; STIGMA; SUPPORT GROUPS; TEEN CLUBS; TREATMENT ADHERENCE; VIRAL LOAD SUPPRESSION.

Name of the intervention: Teen Clubs, Eswatini.

Focus of the intervention:

- Access to HIV treatment, retention and adherence and VL suppression.
- Adolescent HIV prevention and life skills training.

Faith community asset area: Community outreach; faith inspired health service provider.



Description of the intervention: Teen Clubs offer DSD to HIV positive youth aged 8–24. They have the following objectives:

- To provide a safe and welcoming space for children and young adults to gain life skills.
- To encourage adherence among HIV positive youth by providing a stigma free environment for receiving ARV refills.

The Teen Clubs undertake a range of activities related to half-day Saturday events, held monthly for each age band, featuring:

- Singing together.
- Games.
- Life skills training.
- ART refills.
- Opportunities to meet with counsellors as needed/requested, including stepped-up adherence counselling as needed.

Lead organization: The Luke Commission (TLC).

Location: Sidvokodvo, Eswatini (centrally located in the middle of Eswatini) with participants drawn from all four regions of Eswatini.

Where the intervention was implemented: The Luke Commission Miracle Campus.

Year the intervention started: August 2018.

Is the intervention still being implemented? Yes, three times a month with segmented age bands.

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

Results of the intervention: From small beginnings, the programme has rapidly scaled up to include rosters in the following age bands (current attendance numbers as of May 2021): ages 8–14: 57; 15–19: 97; 20–24: 19. Every attendee not only has the opportunity to receive medication refills, but also receive life skills training, a nutritious meal, and the possibility of building connections with others in a safe, nurturing and stigma-free environment.

Impact of the intervention: There has been a lot of positive feedback provided by the young people and their carers. One TLC staff member said: “I was touched when one young man said they must all preach about the advantages of the medications. They feel free to share their positive status with friends and not be scared”. A mother said: “I knew my status long-time, including for my daughter, but was scared to accept it, disclose to my daughter, and start treatment. When you visited my area and counselled me, I started taking medications but was still fearful for my daughter. Now we talk, and she learns from her teen club”.

Extent to which the intervention has been scaled up:

Initially, Teen Clubs were aimed at a narrower age band (8–13 years and 14–19 years). The programme has since been expanded to include an additional age band of 20–24-year-olds (who meet separately) after noticing that this age group also struggled with adherence and viral suppression. The intervention builds on a resource provided by the Eswatini Ministry of Health. Other organizations within Eswatini also use this curriculum.

Source of funding to implement the intervention: TLC funds

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

- Comprehensive health care platform that includes all ages. It prioritizes trust building between TLC and the patient. In turn, patients refer friends and family to TLC.
- Caring and committed staff who engaged energetically and enthusiastically.
- Transport sponsorship for eligible participants to defray transport costs.

Key factors constraining the implementation and scale-up of the intervention:

- Transport is a key barrier to accessing health care in Eswatini. Private donors provide funding for a transport reimbursement programme. This programme has significantly mitigated this barrier.
- While TLC does everything possible to reduce and hopefully eliminate stigma, for some participants, perceived stigma may be a possible barrier to attendance.

Resources available for the intervention:

Strengthening High-Impact Interventions for an AIDS-free Generation (AIDSFree) Project. 2016. Swaziland Integrated Teen Club Curriculum: Teen Club Instructional Material for Adolescents—Sexual and Reproductive Health and HIV Care. Arlington, VA: AIDSFree Project.

Information on the intervention:

<https://www.pathfinder.org/wp-content/uploads/2016/01/YPLHIV-Compendium.pdf>

Link to the Luke Commission newsletter with a feature about Teen Clubs: <https://www.lukecommission.org/News-Stories/articleType/ArticleView/articleId/426/>



Young people learn how to make sure they take their medications during holidays and school breaks.

INTERVENTION 2.12

HIV care and support for adolescents living with HIV, ZIMBABWE

Summary

The Community Health Care intervention, run by Windows of Hope in Zimbabwe, seeks to give HIV care and support to children and adolescents living with HIV using a variety of activities, particularly working through support groups. Children are encouraged to engage in peer-to-peer education on the importance of adherence to treatment, disclosure of HIV status, importance of good nutrition, and resisting stigma and discrimination using methods like dramas, games and songs, among other strategies. Prescribed medications are also distributed to them in their support group meetings. The adolescents are also deployed to hospital opportunistic infections departments to offer counselling to their peers who would have visited for treatment for the first time. The organization supports visits to the adolescent homes to check their living standards and to encourage them. The results show that there are three support groups each having 20 active adolescents who take it in turn to help other children and adolescents in hospitals and in the community. People are also accessing medications more easily because of support groups, and adherence to medication has improved because of encouragement from peers. All 60 members in the adolescent support groups are comfortable sharing their HIV status at any platform as a way of encouraging others to get tested. They are all healthy due to their adherence to treatment and positive living. Key success factors include: receiving support from the church which encouraged its members to be trained as volunteer caregivers who connect the peer groups to community members needing support. The church also provided free access to church buildings for meetings.



Keywords

ADHERENCE COUNSELLING; ADOLESCENT FRIENDLY APPROACHES; ANTIRETROVIRAL TREATMENT; DISCLOSURE; HIV PREVENTION; LIFE SKILLS; NUTRITION; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS; STIGMA; SUPPORT GROUPS; TEEN CLUBS; TREATMENT ADHERENCE; TREATMENT BUDDIES; VIRAL LOAD SUPPRESSION.

Name of the intervention: HIV care and support for adolescents living with HIV, Zimbabwe.

Focus of the intervention: Access to HIV treatment, retention and adherence and VL suppression; and adolescent HIV prevention and life skills training.

Faith community asset area: Community outreach.





- Description of the intervention:** Community Health Care seeks to give care and support to sick people through a variety of interventions. HIV related activities for children and adolescents working through support groups include the following:
- Children are encouraged to do peer to peer education on the importance of adherence to treatment, disclosure of HIV status, importance of good nutrition, resisting stigma and discrimination using methods like dramas, games and songs, among other strategies. The children also take turns to demonstrate how to lead others to Christ as a way of strengthening spiritual support. The adolescents are also deployed to hospital opportunistic infections departments to offer counselling to their peers, who would have visited for treatment for the first time, and to encourage them.
 - The organization supports visits to the adolescents' homes to check their living standards and to encourage them as well. Exchange visits among support groups are also organized to share experiences and ideas.
 - Sexual and reproductive health education is also offered by the organization to highlight the use of contraceptives.
 - Prescribed medications are distributed in the support group meetings.
 - Christmas parties are hosted to have lighter moments with the adolescents and to show them God's love.
 - The organization undertakes stakeholder engagement and advocacy, with cases referred to specialist organizations.

Lead organization: Windows of Hope, Zimbabwe.

Location: Mutare, Zimbabwe.

Where the intervention was implemented: Communities, churches and health clinics.

Year the intervention started: 2004.

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:

- There are three support groups, each having 20 active adolescents, and they take turns to help other children and adolescents in hospitals and in the community.
- People are obtaining medications more smoothly because of support groups. Adherence to medication has improved because of through encouragement from peers.
- The number of adolescents visiting for STI testing has increased due to reduced fear of stigma because of peer teaching and support provided by the support group members.
- All the 60 members in our adolescent support groups are comfortable to share their HIV status at any platform as a way of encouraging others to get tested. They are all healthy due to their adherence to treatment and positive living.
- Ten former adolescents from the support groups got married and gave birth to HIV negative babies because they followed the teachings of the support groups.

Impact of the intervention:

- Fewer new HIV cases in the communities because of the training. Ten adolescents supported by the support groups have got married and all their children are HIV negative.
- Reduced levels of stigma among HIV positive people; some have been given leadership positions in churches, which did not happen at the start of the pandemic.
- Improved, more positive living because of teachings accessed through support groups.

Extent to which the intervention has been scaled-up: Since people are living longer and healthier lives with HIV, they are being offered loans to do business. There is also a plan to assist orphaned children.

Source of funding to implement the intervention: Serving In Mission (SIM).

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

- The church has supported this activity by encouraging its members to be trained as volunteer caregivers in the programmes. These volunteers connect the intervention with their community since they live in the same area as the clients.
- The church has also allowed the use of church infrastructure for meetings at no cost.

Key factors constraining the implementation and scale up of the intervention:

The demand for services is high but limited funds prevent replication in other places.

Resources available for the intervention: There are toolkits and a range of forms for managing the programme, e.g. a form for medicines, activity report, attendance register, pamphlet, quarterly monitoring and evaluation.

Information on the intervention: Website: www.windowsofhopezim.org; and Facebook: windows of Hope, Zimbabwe.

INTERVENTION 2.13

Children born with HIV care and support programme—Marang Career Information Centre, SOUTH AFRICA

Summary

The Marang Career Information Centre (MCIC) intervention in South Africa was initiated by a person openly living with HIV for more than 20 years who was motivated to improve the lives of children born with HIV, many of whom were orphans living in households headed by a child and who are vulnerable like other children with chronic illnesses. The intervention has a holistic perspective of a child's needs and it includes several components: to trace those children no longer accessing antiretroviral treatment, encourage positive living, provide education about treatment literacy and adherence, refer children to relevant organizations depending on their needs, provide spiritual and pastoral care counselling, career development and child protection. In 2018 and 2019, there were four support groups for young people while in 2021 there were eight support groups. All of the young people are on treatment and they receive adherence counselling every month when they go to collect their ARV medication. Approximately 200 children and their guardians have been supported since 2018.



Keywords

ADHERENCE COUNSELLING; ADOLESCENT FRIENDLY APPROACHES; ANTIRETROVIRAL TREATMENT; CHILD PROTECTION; HOLISTIC CARE; NUTRITION; PEER MENTORS; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; SUPPORT GROUPS; TREATMENT ADHERENCE.

Name of the intervention: Children born with HIV care and support programme—Marang Career Information Centre, South Africa.

Focus of the intervention:

- Support access to HIV treatment, retention and adherence and VL suppression.
- Access to comprehensive care and support for orphans and vulnerable children, including psychosocial and spiritual.
- Capacity building for peer groups.
- Protection of children from abuse, violence and exploitation.

Faith community asset area: Community outreach



Description of the intervention: This programme was initiated by a person openly living with HIV for more than 20 years who was motivated to improve the lives of children born with HIV, many of whom were orphans living in households headed by children and who are vulnerable, like other children, with chronic illnesses. Some of the children are no longer accessing treatment, some are taking drugs and others are dropping out of school due to fear of rejection and stigma. The intervention has a holistic perspective of a child's needs and it includes several components: trace those children no longer accessing ART; encourage positive living; provide education about treatment literacy and adherence; refer children to relevant organizations depending on their needs; provide spiritual and pastoral care counselling; career development; and child protection. The children live in their homes in the community and come together as a support group every month. Viral load suppression is undertaken in conjunction with the Marang Centre making referrals to the local health care centre. Every three months, Marang hosts 'educational camps' that deal with a range of issues faced by the young people and include treatment adherence.

Lead organization: The Marang Career Information Centre (MCIC) is a not-for-profit organization with a focus on orphans and vulnerable children and child and youth care services, as well as youth development. It works closely with faith communities that provide spiritual and pastoral counselling, care and support, including food and nutritional support.

Location: John Taolo Gaetsewe District, South Africa.

Where the intervention was implemented: Community.

Year the intervention started: 2018.

Is the intervention still being implemented? Yes.

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

Results of the intervention: In 2018 and 2019, there were four support groups for young people. Currently, there are eight support groups. COVID-19 has meant that the children were sent to the Marang Centre for registration and counselling. All of the young people are on treatment and they receive adherence counselling every month when they go to collect their ARV medication.

Impact of the intervention: Observations include: maturity and growth in the well-being of the children; happy children and happy families. Approximately 200 children and their guardians have been supported since 2018.

Extent to which the intervention has been scaled up: The intervention started with nine children and increased to the current 48. This has required a large scale-up of operations, including acquiring office space, where counselling and other interventions are undertaken.

Source of funding to implement the intervention: The Marang Centre is currently not receiving funding, but the intervention is being implemented with the support of the Social Development Department.

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

- Networking and collaboration with other stakeholders.
- Support from the families of the children enrolled.

Key factors constraining the implementation and scale-up of the intervention:

- HIV stigma remains the main challenge.
- Lack of funding and other resources.

Resources available for the intervention: A range of resources, including the South African Children's Act and other HIV materials that are downloaded from the internet.
Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com



INTERVENTION 2.14

Educational Intervention on HIV prevention & lifestyle, SOUTH AFRICA

Summary

The Child and Youth Care Centre (CYCC) seeks to increase the awareness of children about HIV and AIDS and the importance of treatment adherence for those children living with HIV. The centre organizes mini workshops supported by outside speakers and also more regular in-house training. During the workshops, which use participative training methods, all of the children are told about HIV and how to take care of themselves, including the importance of adhering to treatment. Since 2018, 108 children have been trained and five children living with HIV have been supported with care and ART. Children's knowledge has increased about different HIV related issues: prevention methods; increased awareness about testing; knowing your status; adhering to ART; and the levels of care and treatment.

Keywords



ADHERENCE COUNSELLING; HIV PREVENTION; LIFE SKILLS; RETENTION; SCHOOL-BASED HEALTH PROGRAMMES; STIGMA.

Name of the intervention: Educational Intervention at the Child and Youth Care Centre, South Africa.

Focus of the intervention:

- Adolescent HIV prevention and life skills training.
- HIV and health awareness.

Faith community asset area: School and youth centre.

Description of the intervention: Teaching children at the Child and Youth Care Centre to increase their awareness about HIV and AIDS and the importance of treatment adherence for those children living with HIV. The centre organized mini workshops supported by outside speakers and also more regular in-house training. During the workshops, which use participative training methods, all of the children are told about HIV and how to take care of themselves. The children living with HIV receive counselling with the CYCC social worker as some of them do not fully understand why they were born with HIV. They are taught how to take care of themselves, including the importance of adhering to treatment.



Lead organization: Hands of Compassion.

Location: Youth Care Centre, Nietgedacht, South Africa.

Where the intervention was implemented: Child and Youth Care Centre (CYCC).

Year the intervention started: 2018.

Is the intervention still being implemented? Yes.

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

Results of intervention: Knowledge of different prevention methods for HIV and AIDS, e.g. abstaining and using a condom. Increased awareness about ART and safe practices to prevent HIV infection and the importance of getting tested and knowing your HIV status. Increasing awareness of the levels of care and treatment, whether they are living with HIV or caring for someone living with HIV. Since 2018, 108 children have been trained and five children living with HIV have been supported with care and ARV treatment.

Impact of intervention: The young people are able to take part in question and answer sessions to obtain a clear and honest answer of their concerns. Young people learn how HIV is contracted and transmitted and learn about the importance of living a healthy lifestyle, treating people with respect, and not discriminating against them.



Extent to which the intervention has been scaled up: More young people are able to go back to their families and communities with a better understanding of HIV and not with the myths that they had previously been told. More children are able to relate better to people living with HIV and AIDS without fear and stigma.

Source of funding to implement the intervention: Self-funded.

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

- Providing children with more information.
- Continuing with workshops.
- Providing young people with platforms to learn and give back what they have learned.

Key factors constraining the implementation and scale-up of the intervention:

- When the children go back to their families, the hope is that they will not be easily influenced and will be strong enough to stand their ground.
- It is not always easy to follow up on the children after they have been released from the centre.

Resources available for the intervention: Websites to find training materials.

Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com



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 intervention¹:

- 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 Champion High School, Uganda	2014–2020	2250	Ocer Champion, 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'éducation et d'écoute (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-Saharan 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 Sociax Loyola; Association of Volunteers–ABE, Burkina Faso; St. Joseph's Parish, Kenya. HIV prevention for youth and adolescents: St. Aloysius, 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'Écoute, 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



USING PLACES OF WORSHIP TO CREATE DEMAND FOR HIV SERVICES

3.





INTERVENTION 3.1

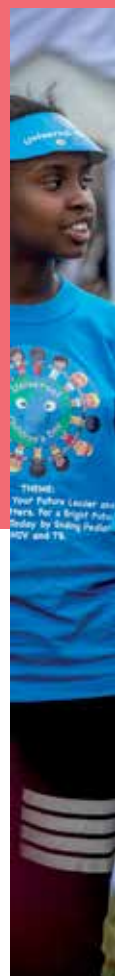
Expanding integrated health service delivery through Health Posts within places of worship, ZAMBIA

Summary

The intervention in Lusaka, Zambia, identified the important role that can be played by places of worship. It involved expanding the role of health posts, which ordinarily provide basic first aid services, to providing an integrated primary care package comprising HIV, maternal child health family planning and outpatient services that are located in faith communities, i.e. on church grounds in informal settlements, in Zambia. The objective was to expand work with faith leaders, faith communities and faith-based organizations to increase HIV understanding and community mobilization, and reach individuals with critical holistic HIV prevention and treatment interventions.

The activities included: engaging faith communities to find children living with HIV not on treatment and link them to ART, HIV care, engaging faith and non-faith male mentors to find men at high risk of HIV, offer HIV testing services, linking HIV positive men to ART, and linking HIV negative men to voluntary medical male circumcision (VMMC), pre-exposure prophylaxis (PrEP), condoms and other effective HIV prevention interventions. Also, engaging and training church leaders to mobilize church and community members for HIV prevention and treatment in a respectful, empathetic and caring manner. Overall, HIV testing yields were higher in faith community sites compared with non-faith community sites, averaging 15% and 7%, respectively, for the FY21 semi-annual period.

Although case finding was scaled up across all sites, indexing yields among children younger than 15 was higher in the faith community sites compared with non-community sites, averaging 23% and 13%, respectively, for the FY21 semi-annual period, contributing to the superior performance of faith community sites in paediatric case identification. The Ministry of Health is fully engaged and led the selection process for the new 29 faith community health posts and an additional six new non-faith-community health posts. A key success factor has been the high level of commitment provided by faith community staff to find every child not yet on ART and provide them with holistic care and support to retain them on ART and in care, including providing spiritual support, where the client and caregiver opted in.



Keywords

ADHERENCE COUNSELLING; ANTIRETROVIRAL TREATMENT; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; EDUCATION FOR FAITH LEADERS; HEALTH FACILITY; COMMUNITY COLLABORATION; HIV PREVENTION; HIV SELF-TESTING; HOLISTIC CARE; IDENTIFICATION AND TESTING; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; RETENTION; TREATMENT ADHERENCE; VIRAL LOAD SUPPRESSION.



Name of intervention: Expanding integrated health service delivery through health posts located in places of worship, Zambia.

Focus of intervention:

- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and viral load suppression.
- HIV and health awareness.

Faith community asset area:

- Using places of worship to create demand for HIV services and to host HIV services. Co-location of health posts (primary care clinics) within partner church premises, making available much-needed operational space.
- Community outreach. Programme implementation staff (faith community health workers and spiritual counsellors) in key areas, including case finding, psychosocial support, and adherence support, from a trusted, community-based entity/partner.

Description of the intervention:

Expanded integrated health service delivery through health posts (the lowest level of the health system in Zambia, ordinarily providing basic first aid services, but expanded under DISCOVER for supported sites to provide an integrated primary care package comprising HIV/MCH/FP/RH/OPD services) located in faith community church grounds in informal settlements in Zambia.

- Objective: Expand work with faith leaders, faith communities and faith-based organizations to increase HIV competency and community awareness, and reach individuals with critical holistic HIV prevention and treatment interventions.
- Activities:
 - Engage faith communities to find children living with HIV not on treatment and link them to ART, and HIV care.
 - Engage faith and non-faith male mentors to find men at high risk of HIV, offer HIV testing services, link HIV positive men to ART, and link HIV negative men to VMMC, PrEP, condoms and other effective HIV prevention interventions.
 - Engage and train church leadership to mobilize church and community members for HIV prevention and treatment in a respectful, empathetic and caring manner.
 - Offer clinical services, including ART, PrEP, PVT and VMMC through prefabricated clinics located within church grounds, under the overall oversight of the faith community initiative partner.
 - Work through the Zambian Ending AIDS campaign to engage leaders of faith communities in HIV prevention.

Lead organization: John Snow, Inc., Research and Training Institute, Inc. (JSI) through the USAID DISCOVER-Health Project.

Location: Twenty-nine partner congregations and the areas they cover in seven districts in the Lusaka and Copperbelt provinces of Zambia.

Where the intervention is implemented:

- In health posts (health service clinics) located on church grounds.
- In communities within clinic catchment areas.

Year the intervention started: 2018.

Is the intervention still being implemented: Yes.

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

The intervention built faith community technical capacities and layered intensified case finding and psychosocial support onto pre-existing service delivery clinics; built management capacities for faith community partners to manage USAID funds and prepare for handling future donor funds; and built management capacities to fully own the service delivery clinics and provide service monitoring, in collaboration with the MoH.



Results of the intervention:

TABLE 13. USAID DISCOVER-HEALTH FAITH COMMUNITY (FC) AND NON-FAITH-COMMUNITY FY21 Q1 AND Q2 AEDIATRIC PERFORMANCE AND CASCADE

Indicator	FC* (20 sites)			Non-FC (231 sites)			All (FC and non-FC)		
	FY21 Q1	FY21 Q2	FC semi-annual subtotal	FY21 Q1	FY21 Q2	Non-FC semi-annual subtotal	Annual target	Semiannual achievement	Per cent of annual target
HTS_TST	163	266	429	1932	2042	4403	4155	4832	116%
HTS_TST_POS	25	38	63	121	133	317	183	380	208%
HTS_INDEX	58	92	150	549	736	1435	3635	1585	44%
HTS_INDEX_POS	11	23	34	69	84	187	128	221	173%
TX_NEW	27	38	65	127	140	332	380	397	104%
TX_CURR	186	225	225	2161	2303	2303	2533	2528	100%
Cascade Performance									
HTS_Yield	15%	14%	15%	7%	7%	7%	4%	7%	163%
Index_Yield	19%	25%	23%	13%	11%	13%	4%	13%	370%
Linkage	108%	100%	103%	105%	105%	105%	95%	105%	110%
VL_Suppression	77%	81%	81%	76%	79%	79%	95%	79%	83%
Derived calculations									
TX_NET_NEW	11	39	50	28	142	170		220	
Net_New_Ratio	0.4	1	0.8	0.22	1.01	0.5		0.66	
Program growth	5%	21%	27%	1%	7%	8%		10%	
Continuity in treatment	92%	100%	94%	96%	100%	98%	92%	97%	99%

* The faith community data are from 20 health posts. Nine community health posts in Lusaka district were handed over to the MoH support in FY20 Q4. While USAID DISCOVER-Health still provides funding and technical support, the data are excluded from this analysis.

- **Footprint.** The data in the table are for FY21 Q1 and Q2 (FY21 semi-annual period). The 20 faith community facilities constituted 8% of the service delivery footprint (251 facilities) for the FY21 semi-annual period.
- **HIV testing service yields.** Overall HIV testing yields were higher in the faith community sites compared with non-faith-community sites, averaging 15% and 7%, respectively, for the FY21 semi-annual period. Although there are scaled up case findings through indexing across all sites, indexing yields among children <15 were higher in the faith community sites compared with non-faith-community sites, averaging 23% and 13%, respectively, for the FY21 semi-annual period. These results contributed to the superior performance of the faith community sites in paediatric case identification.
- **Linkage rates.** The HIV treatment across all sites is through same-day ART initiation. Faith community and non-faith-community linkage rates for under 15 children were at 103% and 105%, respectively, for the FY21 semi-annual period (linkage rates were higher than 100 because some clients were referred by other HIV testing service partners). Linkage rates from project-only HIV testing services were around 100% for both faith community and non-faith-community sites.
- **TX_NEW.** The faith community facilities consistently performed better in paediatric case identification and contribution to new HIV treatment. While they constitute 8% of the service delivery footprint, they contributed 65 (16%) to under 15 TX_NEW for the FY21 semi-annual period.
- **Continuity in treatment.** Most countries are still grappling with COVID-19 and one of the biggest concerns is interruption in treatment for paediatric clients on ART. A number of measures were therefore put in place to safeguard continuity in treatment for paediatric clients across all sites. Continuity in treatment rates are similar for faith community and non-faith-community sites, at 94% and 98%, respectively, for the FY21 semi-annual period due to project-wide client retention efforts.
- **Viral suppression.** Viral suppression rates were similar for faith community and non-faith community sites at 81% and 79%, respectively, for the FY21 semi-annual period.

Impact of the intervention: Although improvements in the HIV cascade were seen for children under 15 for all sites due to the effect of an ongoing national paediatric surge, the data show differences in performance when faith community and non-faith-community health posts are compared. Faith community facilities in this project constitute 11% of the service's delivery footprint. However, they consistently perform above their presence in terms of case identification and contribution to project's new HIV treatment, contributing 16% to under 15 TX_NEW for the FY21 semi-annual period.

Extent to which the intervention has been scaled up: Faith communities are willing to support the expansion of the faith community health post location model. However, each facility that offers HIV treatment must meet minimum national standards. The investments required to meet standards are resource-intensive and this has been the primary limiting factor for scale-up. The Ministry of Health participated in and led the selection process for the 29 new faith community health posts, and an additional six new non-faith-community health posts. The USAID DISCOVER-Health post service delivery design and model dovetails with two important MoH objectives: to add around 900 health posts and to expand the range of health services offered at health post level to provide full primary health care services. Resource limitations have hindered progress towards achievement of these objectives, with only about 60 new health posts established. The 35 new health posts (including the 29 faith community health posts) established by USAID DISCOVER-Health constitute an estimated 58% of the number of new health posts established. The MoH views all these new health posts as part of the MoH health post



complement. The project has already transitioned nine faith community health posts in Lusaka to partial MoH technical support and will transition the remaining 20 by September 2022.

Source of funding to implement the intervention: PEPFAR funding through USAID/ Zambia.

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

- The high level of commitment of the faith community initiative partner staff to find every catchment area child not yet on ART and provide holistic care and support to retain them on ART and in care, including providing spiritual support, where the client/caregiver opt-in.
- The current paediatric surge is helping keep the focus on the children living with HIV not on treatment and on the paediatric cascade leading to improvements across all sites.

Key factors constraining the implementation and scale-up of the intervention:

- A partial lockdown due to the COVID-19 epidemic curtailed community outreach activities and made community-based client follow-up challenging.
- However, activities continued to be partially implemented on church platforms and networks, with MoH approval, while ensuring COVID-19 preventive measures were followed.

Resources available for the intervention:

- Leveraged resources from ongoing project implementation delivering health services at health post level through 242 non-faith-community sites and 29 faith community sites, including case finding and psychosocial support (currently at 231 non-faith community and 20 faith community sites after planned site transitioning to MoH in Lusaka).
- Initial and annual refresher training.
- Toolkits (index case testing tools, age appropriate counselling tools/materials).
- Ongoing technical support from USAID DISCOVER-Health: mentorship and supervision.

Information on the intervention: <http://programme.aids2018.org/Abstract/Abstract/8337>

INTERVENTION 3.2

Congregation-based approach to HIV testing in pregnant women in Nigeria, NIGERIA

Summary

The Baby Shower Initiative is a church congregation-based approach developed in Enugu State, Nigeria, with the aim of increasing HIV testing among pregnant women. The church congregation-based approach started in 2013–2014 as a cluster randomized trial which found that the intervention improved HIV testing among pregnant women (with 93% linkage) and their male partners, who were 12 times more likely to know their status, compared with partners of women giving birth who had not participated in the congregation-based events. Building on the success of the trial, the Catholic Caritas Foundation of Nigeria implemented the congregational approach in Benue States to increase the uptake of PVT services. There are three typical steps in the Baby Shower approach; each has several activities: (i) couples session (early identification of pregnant women); (ii) baby shower (on-site confidential community based testing); and (iii) baby reception (follow-up of mother–infant pairs). The intervention in Benue State improved HIV testing among pregnant women (with 93% linkage to treatment) and their male partners. In a third phase running from April 2018 to March 2019, a further 22 197 children (0–15 years) were referred for HIV testing, 21 142 children were tested and 106 new HIV positive children were identified and linked to treatment. A key success factor was the use of an integrated and on-site approach to laboratory testing provided during church—by organizing baby showers participants reported substantially reduced stigma associated with the HIV-only testing approach. Also important was that religious leaders in Nigeria are knowledgeable about HIV and were able use their respected position in communities to promote for HIV prevention.

Keywords

ANTIRETROVIRAL TREATMENT; EARLY INFANT DIAGNOSIS; FAMILY-BASED INDEX TESTING; IDENTIFICATION AND TESTING; INTEGRATED, FAMILY CENTRED APPROACH; MALE INVOLVEMENT; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; RETENTION; TREATMENT ADHERENCE; PREVENTION OF VERTICAL TRANSMISSION.

Name of the intervention: Congregation based approach to HIV testing in pregnant women in Nigeria.

Focus of the intervention: Identifying and testing pregnant women and their partners, and children living with HIV not on treatment.

Faith community asset area: Places of worship.

Description of the intervention: The Baby Shower Initiative is a church congregation-based approach developed in Enugu State, Nigeria, with the aim of increasing HIV testing among pregnant women. This approach started in 2013–2014 as a cluster randomized trial which found that the intervention improved HIV testing among pregnant women (with 93% linkage) and their male partners, who were 12 times more likely to know their status compared with the partners of women giving birth who had not participated in the congregation-based events. Building on the success of the trial, the Catholic Caritas Foundation of Nigeria implemented the congregational approach in Benue States to increase the uptake of PVT services, including increasing male involvement in PVT services and early infant diagnosis. The intervention, implemented by Caritas Nigeria, also demonstrated the effectiveness of an integrated approach to HIV testing using congregational settings, in this case churches. There are three typical steps in the Baby Shower approach, and each of these has several activities:

- Couples session (early identification of pregnant women):
 - Prayer.
 - Introduce programme.
 - Register with church health advisor.
 - Obtain consent.
 - Schedule baby shower.
- Baby shower (on-site confidential community-based testing):
 - Education and counselling.
 - Fill pre-delivery questionnaire.
 - Physical examination.
 - Draw blood.
 - Specimen transport, storage and processing
- Baby reception (follow up of mother–infant pairs):
 - Early infant diagnosis.
 - Sickle cell genotype.
 - Fill post-delivery questionnaire.

Lead organization: The Catholic Caritas Foundation of Nigeria.

Location: Benue State, Nigeria.

Where the intervention was implemented: Places of worship.

Year the intervention started: 2016.

Is the intervention still being implemented? Yes, as a component of the GRAIL project being implemented by Caritas Nigeria.

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

Results of the intervention: The congregation-based approach to HIV testing in pregnant women began with a pilot project in Enugu State when HIV testing uptake increased significantly: 92% in the intervention group versus 55% in controls $p > 0.0001$. The pilot in Enugu identified 919 positives (696 (7.3%) females and 223 (4.0%) males). Of the 696 females identified, 226 (2.8%) were new positives while 470 (4.5%) were previously known. Similarly, of the 223 male positives identified, 126 (2.2%) were new positives while 97 (1.8%) were previously known. The scale-up was undertaken with 10 056 pregnant women and 6187 male partners at 74 churches between July 2016–May 2017 in Benue State, north central, Nigeria. The intervention improved HIV testing among pregnant women (with 93% linkage to treatment) and their male partners. Nearly half of female participants (44.9%) had not enrolled in ANC for the index pregnancy, with 22.3% of female and 24.8% of male participants reported they had never been tested for HIV.

The Catholic Caritas Foundation of Nigeria was reassigned to work in other States in Nigeria from October 2017. A new implementing partner started work in Benue State from October 2017. The Catholic Caritas Foundation of Nigeria continued the implementation of the congregation-based approach through the GRAIL project, which was prioritizing the paediatric population. Over this period (April 2018–March 2019), 22 197 children (0–15 years) were referred for HIV testing, 21 142 children were tested and 106 new HIV positive children were identified and linked to treatment.

TABLE 14. BABY SHOWER ACHIEVEMENTS IN BENUE STATE (JULY 2016–MAY 2017)

No. LGAs	Congregations	Baby showers	No. tested	No. of mothers tested	Partner testing	Mothers/spouses (positivity)	Naïve HIV+	Tx_New	Linkage
12	81	519	14 847	9382	61%	7% vs. 4%	164	136	82.9%

No. of hospital deliveries	No. of new born	Baby receptions	No. of early infant diagnosis
4181	4216	271	228

Impact of the intervention: The best indication of the programme's success was that when the trial ended in 2017, the communities elected to continue the programme owing to its work with pregnant women, lay health advisers and priests. The programme has subsequently been scaled up as a component of the HIV programme of Caritas Nigeria now including paediatric case finding through the GRAIL (Galvanizing Religious Actors for Identification and Linkage to Paediatric ART) project.

Extent to which the intervention has been scaled up: The congregation-based intervention is being used as a key component of the GRAIL project overseen by Caritas Nigeria, which is being implemented in 35 dioceses in Nigeria and also in Côte d'Ivoire. Through the GRAIL project, 179 religious leaders (including 89 priests) were trained from 21 states in Nigeria. They reached out to over 21 712 adults over 15 years with age-appropriate HIV messaging promoting diagnosis and treatment of children living with HIV. Over the period of implementation, 21 142 children were referred for HIV testing, with 21 130 of them tested for HIV and 106 HIV positive identified and started on ART. The congregation-based intervention for HIV testing has also been scaled up by CARITAS in Côte d'Ivoire as an intervention to increase paediatric HIV case finding.

Source of funding to implement the intervention: The organization’s own funds, PEPFAR, Caritas Internationalis and UNAIDS

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

A number of factors were identified as contributing to the magnitude of the effect, including:

- Prayer sessions that provided multiple opportunities for early identification of pregnant women as they included offering HIV counselling and testing.
- The integrated and on-site approach to laboratory testing provided during church—by organizing baby showers—were reported by participants as helping to substantially reduce stigma associated with the HIV only testing approach.
- Involvement of male partners was found to be crucial in the acceptance by pregnant women of HIV testing as it removed the preconception of a women-only intervention and presented the baby showers as a family-oriented programme.
- Participants received a ‘Mama Pack’ that was provided by the church and presented by their spouses.
- Religious leaders in Nigeria are knowledgeable about HIV and can harness their position for HIV prevention.
- The programme collaborated with faith-based organizations that already had well established social networks and were already involved in the HIV response in the selected communities;
- Most communities in Nigeria have at least one worship centre even when there are no accessible health facilities.

Key factors constraining the implementation and scale-up of the intervention:

- Funding shortages.
- Security challenges and frequent civil unrest in the hinterlands.
- High degree of variation in religious persuasion and diversity of faiths requiring model modification in some part of the country.

Resources available for the intervention:

Baby Shower Participant Log							Site ID: _____	Date: _____
S/N	Member ID	Gender	Surname	Name	Partner's Member ID	Present	Not Present	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Information on the intervention:

<https://www.thelancet.com/action/showPdf?pii=S2214-109X%2815%2900195-3>
<https://www.researchgate.net/publication/333759973> Creating Demand for HIV Testing and Treatment Services for Children through FaithBased Organizations The Caritas Nigeria Experience
<https://www.healthysunrise.org/what-we-do/>
<https://www.ahimsa-fund.com/wp-content/uploads/Caritas-Internationalis-GRAIL-Nigeria-Report-of-Activities-Apr-2019.pdf>

INTERVENTION 3.3

Health & HIV Kiosks at Faith Worship Centres in Zimbabwe, ZIMBABWE

Summary

World Vision introduced health kiosks at faith worship centres (i.e. churches) in two districts in Zimbabwe with the purpose of: increasing knowledge and literacy of HIV and health matters; improving access to services; and supporting retention in HIV care. The health kiosks disseminated HIV and health information to the congregation, mobilized congregants to access health information, and provided referrals and linkages to HIV and health services from congregation volunteers. In addition to community awareness raising, the health kiosk programme utilized safe spaces that were accessible and confidential. The kiosks engaged male and female church volunteers across generations in addition to church leadership. Many churches saw strong youth involvement among the volunteers, which led to high turnout of youth during health promotion. Topics such as condom use and STI prevention and treatment were previously a taboo in the church. However, the health kiosk programme created an opportunity for discussion of these sensitive topics, even among youth. A total of 3500 individuals requested information from the kiosks, which meant that the project recorded a 350% increase in the HIV and health information received from the health kiosks of which 34.6% of the information was received on HIV, 23.7% on maternal and child health (MCH) and 34.7% on other health matters. Forty-five per cent of those receiving information on HIV were tested for HIV and received their test results, while 5.7% of those who received the test were HIV positive. All HIV positive patients were referred to the health facility for care and treatment and followed up for adherence support. Two key success factors were: engaging faith leaders and volunteers in the design, mapping, project implementation and monitoring of the intervention, and secondly, actively engaging MoH staff and District Health Officers in the training, supervision and monitoring of the project helped to promote sustainable programming.



Keywords

ADOLESCENT FRIENDLY APPROACHES; ANTIRETROVIRAL TREATMENT; COMMUNITY VOLUNTEERS; COMMUNITY EDUCATION; COMMUNITY FAMILY DAYS; EDUCATION FOR FAITH LEADERS; HEALTH AND HIV KIOSKS; HIV PREVENTION; IDENTIFICATION AND TESTING; MALE INVOLVEMENT; MOBILISING FAITH COMMUNITIES; PLACES OF WORSHIP; RETENTION; SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS; VIRAL LOAD SUPPRESSION.

Name of the intervention: Health and HIV Kiosks at Faith Worship Centres, in Zimbabwe.

Focus of the intervention:

- HIV and health awareness.
- Identifying and testing children and adults living with HIV and not on treatment.

Faith community area: Places of worship.



Description of the intervention: Health kiosks at faith worship centres (churches) in two districts in Zimbabwe with the purpose of increasing knowledge of HIV and health matters, improving access to services, and supporting retention in HIV care. The health kiosks disseminated HIV and health information in the congregation, mobilized congregants to access health information, and provided referrals and linkages to HIV and health services from congregation volunteers. In addition to community awareness raising, the health kiosk programme utilized safe spaces that were accessible and confidential. They engaged male and female church volunteers across generations in addition to church leadership. Many churches saw strong youth involvement among the volunteers, which led to high turnout of youth during health promotion. The older volunteers could counsel and share information with their peers, and the male congregants felt comfortable talking to male volunteers. Topics such as condom use and STI prevention and treatment were previously a taboo in the church. However, the health kiosk programme created an opportunity for the discussion of these sensitive topics, even among youth.

Lead organization: World Vision Zimbabwe with Ministry of Health and Child Care.

Location: Two districts in Zimbabwe: Gwanda and Gokwe North.

Where the intervention is being implemented: Places of worship.

Year the intervention started: 2018.

Is the intervention still being implemented? Not at present. The intervention will be replicated through area programmes in Zimbabwe and elsewhere, as it is being used as part of World Vision's technical programme guidance.



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

Results of the intervention: A total of 3500 individuals requested information from health kiosks, which meant that the project recorded a 350% increase in the HIV and health information received from the kiosks, of which 34.6% of the information was received on HIV, 23.7% on maternal and child health (MCH), and 34.7% on other health matters. Forty-five per cent of those receiving information on HIV were tested for HIV and received their test results, while 5.7% of those who received the test were HIV positive. All HIV positive patients were referred to the health facility for care and treatment and followed up for adherence support.

Impact of the intervention: The health kiosk model is simple, cost-effective, sustainable and easily replicable in any faith-based setting, mobile or static.

Extent to which the intervention has been scaled-up: Limited.

To date, the intervention has only been implemented in the two districts in Zimbabwe but staff from World Vision Tanzania have been trained to implement the model. However, the model is being used for scale-up in other programme areas, particularly in grant applications, and it is included in World Vision's Technical Programme Guidance.

Source of funding to implement the intervention: WV US.

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

The main lessons learned and best practices are as follows:

- Faith-based platforms (mobile and static) are effective entry points to access integrated HIV and health services.
- Village faith leaders and volunteer-based mobilization for health services were more effective than ward based activities in increasing the uptake of health services in the participating communities.
- Engaging faith leaders and volunteers in the design, mapping, project implementation and monitoring ensures success of the project.
- Active engagement of MoH staff/district health officers in the training, supervision and monitoring of the project promotes sustainable programming.
- The use of locally available information education communication (IEC) materials approved by MoH ensured regular access to HIV/health information by the local churches.
- The health kiosk fostered closer collaboration between the MoH and childcare staff and the local faith leaders, thereby building a strong and sustainable alliance focused on improving access to health services in vulnerable communities.
- The MoH is able to tap into the great pool of highly motivated church volunteers to promote health and improve access to health services in the target districts.

Key factors constraining the implementation and scale-up of the intervention:

Funding limitations meant that the development of an implementation manual to guide scale-up was not realized.

Resources available for the intervention: None.

Information on the intervention:

Health Kiosks in Zimbabwe: https://www.worldvision.org/wp-content/uploads/2019/06/World_Vision_Health_Kiosks_overview_case_studies-1.pdf
<https://www.unaids.org/en/resources/presscentre/featurestories/2019/december/health-kiosks-expanding-hiv-services-in-zimbabwe>

INTERVENTION 3.4

Using places of worship to create demand for HIV services, KENYA

Summary

The Kenya Conference of Catholic Bishops (KCCB) worked closely with the Supreme Council of Kenya Muslims (SUPKEM) to implement an intervention that uses places of worship to create demand for HIV services. The aim of the intervention was to: use churches and mosques to orient women's groups and community point people to deliver key HIV messages to motivate young men and children to undertake HIV testing; engage volunteer male friendly HIV testing service providers and community health volunteers to distribute HIV self-test kits at places of worship; establish linkages for psychosocial support teams within the faith-based organization affiliated health facilities; and identify religious leaders willing to be HIV champions to share information about their HIV status and encourage men to undertake HIV testing and also to bring their children for testing. There was an increase in the proportion of men and children who were offered HIV testing services at places of worship and community locations. A total of 285 clients were identified, of whom 277 were linked for care and treatment at health facilities. In addition, 363 clients identified as HIV positive were enrolled in psychosocial support groups in their areas of residence. A key success factor was the strengthening of intercounty faith networks as a result of the close collaboration of religious entities who worked on the intervention.

Keywords



ANTIRETROVIRAL TREATMENT; EARLY INFANT DIAGNOSIS; EDUCATION FOR FAITH LEADERS; 'HIV INVITE BOX'; HIV SELF-TESTING; IDENTIFICATION AND TESTING; MALE INVOLVEMENT; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; PSYCHOSOCIAL AND SPIRITUAL SUPPORT; STIGMA; RETENTION; SUPPORT GROUPS.





Name of the intervention: Using places of worship to create demand for HIV services, Kenya.

Focus of the intervention:

- Identifying and testing children and adults living with HIV but not on treatment.
- Access to comprehensive psychosocial and spiritual support.

Faith community asset area: Using places of worship; advocacy by religious leaders.

Description of the intervention:

- Use of churches and mosques through existing structures to orient women's groups through their associations to influence and motivate young men and children to undertake HIV testing; this led to an increase in men with known HIV status.
- Utilize the church and community point persons in the church structures to deliver messages and mobilization for HIV testing, especially for those at risk based on the MoH HIV testing service risk categorization algorithm after detailed messages have been given by priests, pastors or imams in their sermons.
- Engagement of volunteer male friendly HIV testing service providers and community health volunteers to identify which congregants should be in the risk screening for men eligible for testing and distributing HIV self-test kits following the screening criteria at places of worship.
- Utilization of anonymous 'HIV invite box' for HIV clients who fear testing at places of worship. This involves distributing small pieces of paper where individuals write their contact information and drop them in a box which is then opened by trained health care providers who invite the contacts for a test on a specific time/day.
- Establishing linkages for psychosocial support teams in health facilities affiliated with faith-based organizations for medical and psychosocial support, and the church for spiritual and psychosocial support therapies and invitations of the International Network of Religious Leaders Living with or personally Affected by HIV Kenya Chapter (INERELA-Kenya) representatives for spiritual and motivational support.
- Use of psychosocial support groups established in churches and mosques & INERELA-Kenya religious leaders as HIV champions invited to share their HIV status and encourage men to undertake HIV testing and also to bring children for testing.

Lead organization: Kenya Conference of Catholic Bishops—Kenya AIDS Response Programme (KCCB-KARP). The intervention also worked with the Supreme Council of Kenya Muslims (SUPKEM), the umbrella body of all Muslim entities in Kenya.

Location: Kisumu County, Kenya.

Where the intervention was implemented: Places of worship, health facilities and communities.

Year the intervention started: 2019.

Is the intervention still being implemented: Yes.

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

Results of the intervention:

- There was an increase in the proportion of men and children who were offered HIV testing services at places of worship and community. The intervention identified 285 clients, with 277 of them linked for care and treatment at health facilities.
- An increase in the proportion of men and children who joined psychosocial support groups: 363 clients identified as HIV positive were enrolled in support groups in their areas of residence.

Impact of the intervention:

- A total of 75 clients were identified as HIV positive as a result of testing in the places of worship and in communities, and all were referred for ART.
- Good level of adherence was witnessed among the newly identified HIV positive individuals. All clients initiated on ART had VL tests at six months at various facilities with the catchment area.



Religious leaders attending workshop on stigma and discrimination in Kisumu County

Extent to which the intervention has been scaled up: This intervention is being implemented in nine counties of Western Kenya (Kisumu, Vihiga, Kakamega, Siaya, Migori, Kisii, Homabay, Bungoma and Busia).

Source of funding to implement the intervention: PEPFAR.

Key success factors helping the implementation and scale-up of the intervention: Intercounty faith networks were strengthened due to the inclusivity of the religious entities at all levels.

Key factors constraining the implementation and scale-up of the intervention:
Covid-19 pandemic.
Erratic supply of HIV self-test kits.

Resources available for the intervention: HIV self-testing was guided by the Kenya MoH guidelines and algorithm.

Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com



Opening remarks for the workshop on stigma and discrimination

INTERVENTION 3.5

Faith Community HIV testing for children, adolescents, and adults, ESWATINI

Summary

The Eswatini Church Forum worked with the Ministry of Health in four regions of Eswatini to disseminate new HIV 'Messages of Hope' for men and children by religious leaders using places of worship, faith communities and social media to increase demand for HIV services. The increased awareness has been used to increase HIV testing of children, adolescents and adults, including using HIV self-testing, and those people identified as HIV positive were referred for ARV treatment, as well as to other HIV services. By 2020, nearly 42 000 congregants heard messages of hope which focus on new choices (for testing), new timing (same day), new treatment (one pill), and new hope (undetectable = untransmittable). Some 34 415 HIV self-testing kits were distributed to young people, adolescents and children, with distribution highest among youth (51.5%) and adolescents (48%), with children only 0.5%. Of the 403 referred for a confirmatory test, 360 (89%) were reported to have been linked to ART. Over 57% of eligible adolescents and youth were referred for preventive services. Although there are no quantitative data, the staff reported that at the start of the project there were many discriminatory statements from the congregants and fear about disclosing their HIV status. However, as the project continued, with supportive supervision provided to the church members, there was an increase in the number of those who disclosed their HIV status and were free from self-perceived stigma and external stigma. One of the key success factors for the intervention was the training received by both faith leaders and community carers, who are selected from the churches and who receive a stipend.



Keywords

ANTIRETROVIRAL TREATMENT; COMMUNITY EDUCATION; EDUCATION FOR FAITH LEADERS; HIV SELF-TESTING; IDENTIFICATION AND TESTING; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; STIGMA; TREATMENT ADHERENCE.



Name of the intervention: Faith community HIV testing for children, adolescents and adults, Eswatini.

Focus of the intervention:

- HIV and health awareness.
- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment.

Faith community asset areas: Places of worship; advocacy by religious leaders.

Description of the intervention: New 'HIV Messages of Hope' for men and children are disseminated by religious leaders using places of worship, faith communities and social media to increase demand for HIV services. The increased awareness has been used to increase HIV testing of children, adolescents, and adults, including using HIV self-testing, and those people identified as HIV positive were referred for ART, as well as to other HIV services.

Lead organization: Eswatini Church Forum and the Ministry of Health.

Location: Four regions of Eswatini.

Where the intervention was implemented: Places of worship, communities and health facilities.

Year the intervention started: March 2020.

Is the intervention still being implemented: Yes.

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

Results of the intervention:

- By 2020, nearly 42 000 congregants heard Messages of Hope, which focus on new choices (for testing), new timing (same day), new treatment (one pill), and new hope (undetectable = untransmittable)¹.
- About 34 415 HIV self-testing kits were distributed to children aged between 2 and 14 years; adolescents 15 between 19 years; and youth 20–24 years old. Distribution was higher among youth with 51.5%, followed by adolescents at 48%, and children at (0.5%).
- Of those referred for confirmatory testing, 360/403 (89%) reported having been linked to ART.
- Of eligible adolescents and youth, 57.3% were referred for preventive services.
- Awareness about HIV was raised through the distribution of Messages of Hope to encourage HIV prevention, diagnosis, treatment adherence, and reduction of stigma and discrimination.
- An HIV self-testing screening eligibility tool was adapted to eliminate known positives.
- Standard operational procedures were produced to guide the distribution of HIV self-testing kits to children less than 16 years old.
- There are also testimonials that the Messages of Hope are very helpful in raising awareness among the youth.

Impact of intervention:

- Although there are no quantitative data, the staff report that at the start of the project there were many discriminatory statements from the congregants and fear about disclosing their HIV status. As the project continued, with supportive supervision provided to the church members, there was an increase in the numbers of those who disclosed their HIV status and were free from self-perceived stigma and external stigma. These observations have been substantiated by verbal reports from faith leaders that attitudes have changed and the stigma related to HIV was reduced.
- There are encouraging signs that HIV incidence among children, adolescents and youth will be reduced based on data about the distribution of HIV self-testing kits to these age groups and their referrals for preventive and/or curative services.
- Increased number of children tested for HIV and accessing prevention and treatment services.

1 Faith and community initiative, 2020. PEPFAR Fact Sheet. <https://www.state.gov/wp-content/uploads/2020/12/PEPFAR-Faith-and-Community-Initiative-Fact-Sheet-1.pdf>

The extent to which the intervention has been scaled up: The distribution of the Messages of Hope mainly occurs among the churches of the faith leaders that were enrolled in the faith community initiative. About 2000 faith leaders and community carers have been trained.

Source of funding to implement the intervention: PEPFAR Faith Community Initiative (FCI)

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

- Use of multiple media platforms, e.g. radio/television shows.
- Use of social media, e.g. WhatsApp groups.
- Training of both the faith leaders and community carers, who are selected from the churches and who receive a stipend.

Key factors constraining the implementation and scale-up of the intervention:

- Some faith leaders are not yet trained in sharing the Messages of Hope.
- The COVID-19 restrictions have prohibited any gathering in the country, including in churches.
- Due to funding constraints, the participation of in the FCI are limited.
- Most of the FCI support for Eswatini has focused on the Christian community, with less consideration of the other faith groups, e.g. Islamic faith, Bahais and Judaism.

Resources available for the intervention:

- Most of the resources for the FCI interventions are in the FCI monthly Technical Working Group reports, register and database for the implementation partners.
- Messages of Hope information, education and communication materials are available in both hard and soft copy.
- FCI SOPs for HIV self-testing of children under 16 years.

Information on the intervention:

https://www.facebook.com/permalink.php?story_fbid=205723687696207&id=109485090653401



INTERVENTION 3.6

Role of the church in ending HIV stigma and discrimination, ZIMBABWE

Summary

The intervention by Health Fonds Trust Zimbabwe used the church to talk about HIV, care and treatment. Three group discussions were held on HIV related issues and focused on ending stigma and discrimination for women and young people living with HIV. Of the three sessions, two were virtual and were attended by 100 people and one was in-person and attended by 25 people. The intervention's success was due in no small part to the good partnerships with local community-based organizations and with the National AIDS Council of Zimbabwe.

Keywords



ADOLESCENT FRIENDLY APPROACHES; ANTIRETROVIRAL TREATMENT; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; RETENTION.

Name of the intervention: Role of the church in ending HIV stigma and discrimination, Zimbabwe.

Focus of the intervention: HIV and health awareness; and zero stigma and discrimination.

Faith community asset area: Places of worship.

Description of the intervention: The church was used to talk about HIV, care and treatment. Three group discussions were held on HIV related issues and focused on ending stigma and discrimination for women and young people living with HIV. Of the three sessions, two were virtual and were attended by 100 people and one was in-person and attended by 25 people.

Lead organization: Health Fonds Trust Zimbabwe.

Location: Harare, Zimbabwe.

Where the intervention was implemented: Apostolic Faith Mission Church in Harare; Zimbabwe; WhatsApp groups; and live interviews.

Year the intervention started: 2019.

Is the intervention still being implemented: Yes.

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

Results of the intervention: The church has now offered three slots for services to continue lessons on HIV with congregants.

Impact of the intervention: An improvement has been seen in how the church is integrating HIV programmes into its activities.

Extent to which the intervention has been scaled up: Invitations have been received from more churches to give lessons on HIV, care and treatment.

Source of funding to implement the intervention: Personal funds and partnerships with other organizations.

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

- Partnerships with other local community-based organizations.
- Working with the National AIDS Council.

Key factors constraining the implementation and scale-up of the intervention:

Lack of funding to reach other remote faith-based communities and also gather more faith-based leaders together.

Resources available for the intervention: Heath Fonds Trust Zimbabwe Facebook and WhatsApp groups.

Information on the intervention: Heath Fonds Trust Zimbabwe Facebook: <https://www.facebook.com/Fondstrust/>





4.

ADVOCACY BY RELIGIOUS LEADERS AND FBOs



INTERVENTION 4.1

Faith Paediatric Champions, KENYA

Summary

The Christian Health Association of Kenya (CHAK), working with IMA World Health, implemented a novel approach to engage religious leaders with the goal of expanding the demand and uptake of paediatric HIV services in Nairobi. The intervention strengthened community engagement through a team of faith paediatric champions—both Christian and Muslim—specifically religious leaders, youth leaders, and CHWs. An important characteristic of the approach was that faith paediatric champions were not only pastors, but came from all areas of religious leadership, e.g. youth leaders as well as men's and women's group leaders. The intervention established a network of 20 religious leaders, 16 CHWs and 11 youth leaders as faith paediatric champions, trained them on paediatric HIV transmission and prevention, and helped them to develop action plans for community outreach, including referrals for testing. Following their training, the faith paediatric champions undertook several types of outreach activities, including: making referrals to health facilities; home visits; addressing religious gatherings in places of worship and in communities; and supporting the development of peer support groups and youth activities. Out of a total of 2998 referrals between August 2016 and May 2017, 47% were made by religious leaders, 23% by CHWs and 30% by the youth leaders. Over the same period, the faith paediatric champions provided adherence support, psychosocial support and nutritional support to 4517 children and young people between the ages of 0 and 24 years. Some religious leaders provided feedback that their standing in the community had increased because of having more knowledge about HIV and because they were able to make referrals to health facilities and give treatment advice. An important success factor for the intervention was that the faith paediatric champions were recruited from Christian and Islamic faiths.



Keywords

ANTIRETROVIRAL TREATMENT; COMMUNITY EDUCATION; EDUCATION FOR FAITH LEADERS, FAITH PAEDIATRIC CHAMPIONS; HIV PREVENTION; IDENTIFICATION AND TESTING; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; SERMON RESOURCES ON PAEDIATRIC HIV; STIGMA; SUPPORT GROUPS.

Name of the intervention: Faith paediatric champions, Kenya.

Focus of the intervention:

- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and VL suppression.
- Zero stigma and discrimination.

Faith community asset area: Advocacy by religious leaders.



Description of the intervention: IMA World Health, working with the Christian Health Association of Kenya (CHAK), implemented a novel approach to engage religious leaders to expand the demand and uptake of paediatric HIV service in Nairobi. The intervention strengthened community engagement through a team of faith paediatric champions,—both Christian and Muslim—specifically religious leaders, youth leaders and CHWs. An important characteristic of the approach was that faith paediatric champions were not only pastors and imams but came from all areas of religious leadership, e.g. youth leaders, men’s group leaders and women’s group leaders. The approach builds the capacity of religious leaders to influence community and individual behaviour towards paediatric HIV and AIDS, and to increase care and treatment services. IMA World Health established a network of 20 religious leaders, along with 16 CHWs and 11 youth leaders, as faith paediatric champions, trained them on paediatric HIV transmission and prevention, and helped them develop action plans for community outreach, including referrals for testing. The project also helped equip community religious leaders with faith-appropriate, evidence informed materials with key messages about paediatric HIV, including sermon and khutbah guides stemming from each faith group’s sacred texts. Following their training, the faith paediatric champions undertook several types of outreach activities:

- Make referrals to health facilities. They worked during training with CHWs, which enabled them to build good working relations. The champions were provided with cards and a stamp with which they would make referrals that were recognized by the staff at health facilities.
- Make home visits. The champions made home visits to provide HIV guidance and support related to issues such as couples counselling, treatment adherence counselling and spiritual counselling.
- Address religious gatherings. The champions addressed gatherings in places of worship and in communities where they would pass on HIV related messages.
- Support the development of peer support groups and youth activities.
- Monitoring of faith paediatric champions activities. This was carried out by CHAK and the International Network of Religious Leaders Living with or personally Affected by HIV Kenya Chapter (INERELA-Kenya). Monthly support guidance was provided by the health facility contact person with the supervision of the CHAK project officer. At these meetings the champions discussed issues and challenges that they had come across and were provided with guidance. They also collected data on referrals and other services offered during the month.

A related part of the project was the development of religious guides on children and HIV for use by both Christian and Islamic religious leaders. There was a multi-stakeholder and interfaith collaborative process used to develop the guides involving theologians, religious leaders and clinicians supported by INERELA-Kenya, CHAK, IMA World Health, NCCK and SUPKEM. The guides provide sermon starters for religious leaders and guidance for incorporating appropriate health practices in their religious discourse and spiritual counselling.

Lead organization: IMA World Health, working with CHAK and INERELA-Kenya.

Location: Korogocho, Nairobi, with a population of 150 200 and a 50:50 division of young people between those 24 years old and those over 24 years.

Where the intervention was implemented: Places of worship and community.

Year the intervention started: 2016.

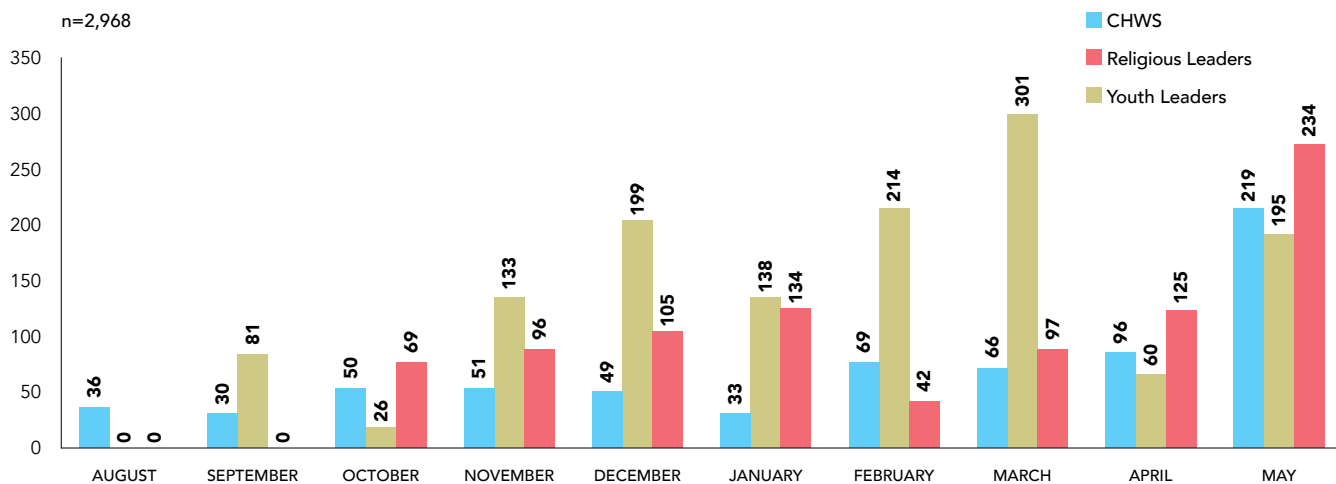
Is the intervention still being implemented? No.

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

Results of the intervention:

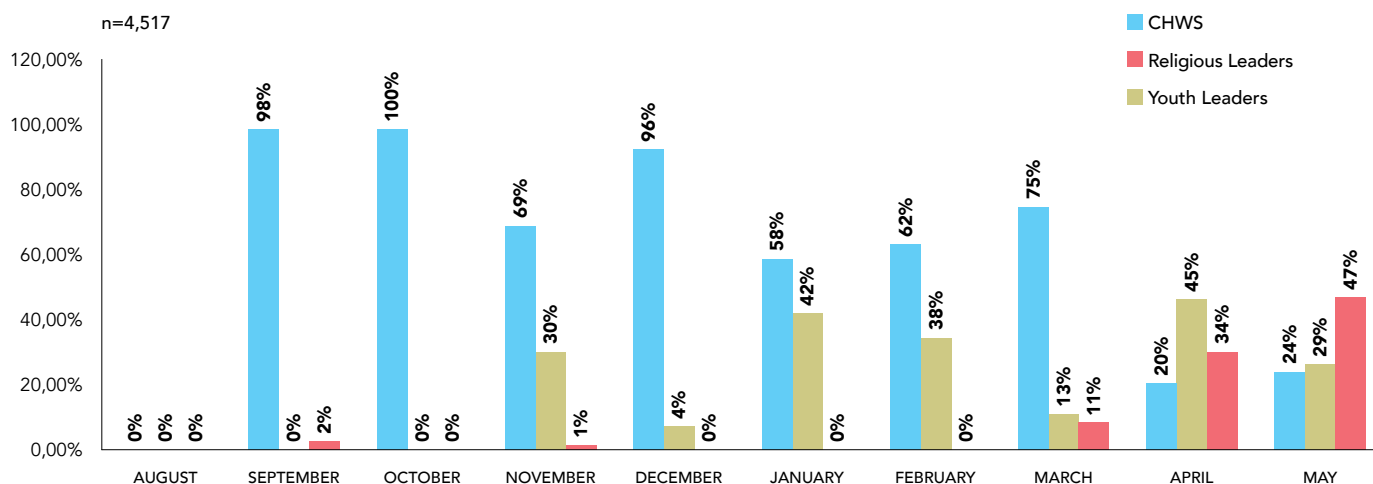
Referrals to health facilities for HIV testing by faith paediatric champions: Out of a total of 2998 referrals between August 2016 and May 2017, 1397 (47%) were made by religious leaders, compared with 699 (23% by CHWs) and 902 (30%) by the youth leaders.

CHART 8. MONTHLY REFERRALS BY PROVIDER TYPE (AUG. 2016-MAY 2017)—AGES 0-24



Provision of support services by faith paediatric champions: A range of support services were provided between August 2016 and May 2017 to 4517 children and young people aged 0–24 years. These services included adherence support, psychosocial support and nutritional support. Of these services, 2159 (48%) were provided by religious leaders, 1299 (29%) were provided by youth leaders and 1055 (23%) were provided by CHWs.

CHART 9. TOTAL SUPPORT SERVICES BY PROVIDER TYPE (AUG. 2016-MAY 2017)—AGES 0-24



Impact of the intervention:

- Communities consider religious leaders and youth leaders as trusted ‘pillars’; with the addition of knowledge and skill they can have a significant impact on stigma and people’s perceptions of others.

- Religious leaders have a regular 'captive audience' at their weekly congregations and are able to reach more people at once than can CHWs.
- Some religious leaders provided feedback that their standing and stature in the community had increased because of their increased knowledge about HIV and because they were able to make referrals to health facilities and give treatment advice. As a result, they felt empowered by their status as faith paediatric champions.
- Youth leaders also have captive audiences as they interact with their peers through football tournaments and at school (secondary and college).
- The 'peak' season for outreach for religious leaders and youth leaders is during school holidays.

Extent to which the intervention has been scaled up:

There were insufficient funds to scale the project up beyond Nairobi. However, IMA World Health undertook a similar intervention in 2018 in Dedza, Malawi, where they worked in partnership with the Malawi Network of Religious Leaders living with HIV&AIDS (MANERELA+) and the Christian Health Association of Malawi (CHAM), and mobilized a group of faith leaders to educate their community members about PVT and to encourage healthy behaviour and use of PVT services. IMA World Health identified a group of religious leaders—both Christian and Muslim—and, through a four-day workshop, educated them about HIV and PVT. Together, they developed contextually appropriate "10 key messages" on PVT and trained them on how to deliver them. The faith leaders then promoted the key messages during awareness campaigns, couples counselling, youth forums, couples symposia, mothers' group meetings, male champion group meetings, and worship services at their church or mosque, ultimately reaching a total of 11 333 people.

Source of funding to implement the intervention: USAID funded global Strengthening High Impact Interventions for an AIDS-Free Generation Project (AIDSfree).

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

- An important feature of the approach was that religious leaders—pastors and imams—were not the only members of faith communities to be faith paediatric champions. They were recruited from different religious leadership groups, e.g. youth leaders, men's groups and women's groups.
- The recruitment and training of faith paediatric champions was undertaken in close collaboration with CHWs and volunteers and this built mutual respect and strengthened the referrals made subsequently by the champions to the health facilities. During the faith paediatric champions' training they visited health facilities and that reinforced their relationship.
- It was very important that faith paediatric champions were recruited from Christian and Islam faiths and not just one faith.
- The involvement of INERELA+ Kenya and Christian Health Association of Kenya helped develop good working relationships between faith paediatric champions and staff at faith inspired health service providers.
- During the project it became clear that community members were as knowledgeable as their leaders, which means that religious leaders must have at least a basic understanding of the importance of HIV, including paediatric HIV, index-based testing and treatment adherence.
- The intervention is a relatively low-cost intervention with main costs related to training of faith paediatric champions, T-shirts, and transport for monitoring follow-up activities.
- It was important not to underestimate the time and budget required for training

Launch of the religious guides
on Children and HIV

© WCC/INERELA+ Kenya



Key factors constraining the implementation and scale-up of the intervention:

- There was initially some indifference and hesitation by some religious leaders who did not think that HIV was a topic they should be discussing. This was reflected in some cases among their congregants. Gradually, the congregations of both faiths opened up and became more supportive.
- The limited levels of understanding about HIV among religious leaders initially hindered the level of interest in the intervention.
- It was important to ensure that the policy environment was supportive for faith paediatric champions to be able to play an active role in HIV testing referrals and that donor policies are supportive.
- Ensure that there is strong collaboration between health facilities and religious leaders and that the faith inspired health service providers are well placed to facilitate such relationships.

Resources available for the intervention:

- INERELA+ Kenya, CHAK, SUPKEM, 2017. Christian Sermon Guide: Children and HIV for religious leaders: http://www.inerelakenya.org/wp-content/uploads/2017/09/2017.3.9_sermon-guide_web_tagged.pdf
- IMA's work with faith paediatric champions: <https://www.youtube.com/watch?v=cNUIINGmFENG>
- INERELA+ Kenya, SUPKEM, 2017: Islamic Khutbah Guide: Children and HIV: http://www.inerelakenya.org/wp-content/uploads/2017/09/2017.3.9_khutbah-guide_web_tagged-ilovepdf-compressed.pdf
- Empowering Faith Groups Increasing Demand for HIV Services in Nairobi, Kenya: https://www.slideshare.net/CCIH/ccih2017nkathanjerusession2b?from_action=save
- <https://imaworldhealth.org/prevent-and-treat-hiv-and-aids>
- <https://imaworldhealth.org/aidsfree-video>

Information on the intervention: Information can be found on the websites listed above. Other questions about the intervention can be provided by contacting the Interfaith Health Platform: interfaith.health.platform@gmail.com

INTERVENTION 4.2

Faith Paediatric Champions, GLOBAL AND KENYA

Summary

In June 2017, the World Council of Churches–Ecumenical Advocacy Alliance (WCC-EAA) established a group of global ‘faith paediatric HIV champions’ to be powerful agents for action on paediatric HIV in their countries and at global levels. These champions were identified in collaboration with local churches, schools and national partners, and they called on governments and other key stakeholders to reach the 2020 Prevention and Treatment Targets for Children and Adolescents. Globally, some 80 religious leaders agreed to become paediatric HIV champions, and through their efforts these champions sought to mobilize and help national leaders increase knowledge, demand, and uptake of paediatric HIV services in faith communities. A further 1000 religious leaders joined the WCC-EAA Leading by Example: Religious Leaders and HIV Testing Campaign and were encouraged to advocate for children and adolescents to be tested and treated. In Kenya, to support the implementation of the Call to Action, WCC-EAA supported the International Network of Religious Leaders Living with or Personally Affected by HIV–Kenya (INERELA-Kenya) to establish a faith-based organization steering committee in Kenya which mobilized faith advocacy activities to scale up testing and treatment for children and adolescents working closely with the National AIDS Control Council. Together they organized an event for the Day of the African Child in 2017 that mobilized 1000 children, adolescents and faith leaders from 13 congregations and seven religious schools to share information on the importance and value of testing and treatment. The intervention demonstrated the positive role that religious leaders and faith communities can play in advocacy, particularly related to paediatric and adolescent HIV testing and treatment at global and national levels.

© WCC/INERELA+ Kenya



Keywords

ANTIRETROVIRAL TREATMENT, COMMUNITY EDUCATION; EDUCATION FOR FAITH LEADERS; FAITH PAEDIATRIC CHAMPIONS; IDENTIFICATION AND TESTING; LIFE SKILLS; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; SERMON RESOURCES ON PAEDIATRIC HIV; STIGMA; TREATMENT ADHERENCE.



Name of the intervention: Faith Paediatric Champions, Global and Kenya.

Focus of the intervention:

- Identifying and testing children and adults living with HIV who are not on treatment.
- Access to HIV treatment, retention and adherence and viral load suppression.
- Adolescent HIV prevention and life skills training.
- HIV and health awareness.

Faith community asset area: Advocacy by religious leaders.

Description of the intervention: In June 2017, the World Council of Churches–Ecumenical Advocacy Alliance (WCC-EAA) established a group of ‘faith paediatric HIV champions’ to be powerful agents for action on paediatric HIV in their countries and at global levels. These champions were identified in collaboration with local churches, schools and national partners. They called on governments and other key stakeholders to reach the 2020 Prevention and Treatment Targets for Children and Adolescents. In addition, WCC-EAA issued an action alert in June 2017 calling for religious leaders to come forward as faith paediatric AIDS champions who would be engaged in making sure that all children and adolescents living with HIV would be tested and placed on treatment.

Faith paediatric HIV champions for children and adolescents living with HIV were asked to support at least one of the following tasks:

- Religious leaders to sign the WCC-EAA Call to Action: Act Now for Children and Adolescents Living with HIV and to promote it.
- Share information on children, adolescents and HIV within your faith community, including through sermons.

Young people in Kenya on march day of African Child 2017

© WCC/
INERELA+
Kenya



- Draw inspiration from the Khutbah and Sermon Guides on Children and HIV for Religious Leaders from IMA World Health, INERELA+ Kenya and AIDS Free.
- Interact with key decision-makers to address paediatric AIDS bottlenecks (government officials, pharmaceutical and generic companies, diagnostic companies, and donors) at the global level and in individual countries and set up meetings with them.
- Issue a video message on paediatric AIDS testing and treatment for adolescents.
- Organize events to raise awareness about children, adolescents and HIV, for instance during occasions such as: Universal TB Day; Universal Health Day; Universal Children Day; Universal Human Rights Day; World AIDS Day.
- Write articles, editorials for local or national newspapers and websites, or make a contribution to the WCC Pilgrimage blog and share them.
- Work with radio stations and media outlets, as well as on social media. The WCC-EAA will highlight your advocacy actions on the Live the Promise Campaign Facebook page, Twitter feed and on the WCC Pilgrimage blog.

Lead organization: World Council of Churches–Ecumenical Advocacy Alliance (WCC-EAA) in conjunction with INERELA+ Kenya.

Location: Global and Kenya.

Where the intervention was implemented: Global and Kenya.

Year the intervention started: 2017.

Is the intervention still being implemented: No.

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

Results of the intervention: Globally, some 80 religious leaders agreed to become paediatric HIV champions, and through their efforts these champions sought to mobilize and equip national leaders to increase knowledge, demand and uptake of paediatric HIV services in faith communities. Champions could be religious leaders, youth leaders, children and CHWs (including volunteers). They were asked to support several actions, including signing and promoting the WCC-EAA global Call to Action: Act now for Children Living with HIV and to advocate for policy makers to address paediatric HIV bottlenecks at the global level and in their country. Another 200 faith leaders took part in two prayer breakfasts related to children's access to HIV and TB testing and treatment held during the 2017 and 2018 UN General Assembly meetings in New York. A further 1000 religious leaders joined the WCC-EAA Leading by Example: Religious Leaders and HIV Testing Campaign and were encouraged to advocate for children and adolescents to be tested and treated.

To support the implementation of the Call to Action, WCC-EAA supported the Kenya chapter of INERELA+ to establish an interfaith FBO Steering Committee in Kenya which is mobilizing faith advocacy activities to scale up testing and treatment for children and adolescents, working closely with the National AIDS Control Council (NACC) in Kenya as a key partner in NACC's strategic plan for faith-based engagement. Together, they organized an event for the Day of the African Child in 2017 that mobilized 1000 children, adolescents and faith leaders from 13 congregations and seven religious schools to share information on the importance and value of testing and treatment. The global Call to Action for Faith Leaders was launched during the commemoration of the International Day of the African Child on 16 June 2017 held in Kenya. The Call to Action focused on six areas: funded national plans; early diagnosis; appropriate treatment (including support to the Global Paediatric Accelerator); access to TB drugs; eliminate stigma; and increase food security. The Global Call to Action was aligned with the Call to Action issued by religious leaders in Kenya.



Several follow-up activities were organized in Kenya lead by INERELA+ Kenya and other steering committee members, including:

- To commemorate Universal Children's Day in November 2018, several organizations conducted a series of events over two days in Nairobi with religious leaders, government representatives and civil society aimed at mobilizing faith communities to advocate for children's rights to HIV and TB testing, treatment and care. More than 100 religious leaders from different faiths, young people and other key actors participated in a series of workshops that provided information about testing and treatment for children and adolescents living with HIV and TB. Young people spoke movingly about their personal experiences of living with HIV and TB, and several of them read out letters they had written to Kenya's First Lady, government ministers and religious leaders calling on them to take action on issues such as stigma related to HIV and TB. Participants also agreed on a set of follow-up actions by religious leaders to address the challenges identified and ensure that all children and adolescents living with HIV and TB have access to prevention, testing and treatment. As part of the commemoration, more than 300 children, young people and religious leaders marched through the streets of Nairobi displaying placards promoting the welfare of children. The march concluded with speeches and prayers by religious leaders as well as performances and statements by young people. There was also an opportunity for those in attendance to have a voluntary HIV and/or TB test. One of the religious leaders said: *"It's important for religious leaders to lead by example, we are backbone of society. We must help people and empower children in their health. If we ourselves are informed we can give them direction so that they can live a better life"* (Imam Yusuf Abuhamza, SupKem Supreme Council of Kenya Muslims). One of the children spoke directly to religious leaders and requested their support: *"Join me and other children to speak out against stigma and discrimination. I hope that all places of worship can be places where everyone can feel loved and know there will be someone to help and offer support and psychological counselling also provide safe places... and hear messages of hope. I dream of a world without stigma and discrimination. Help me to end them"*. (Michelle Ng'anga—Children Against Stigma and Discrimination, Kenya)
- During 2017 and 2018, discussions were held with the MoH, INERELA+ Kenya, DNDi, NEPHAK about progress with the Kaletra pellets pilot project for paediatric treatment which had been a success. The MoH agreed to procure drugs for national coverage and Cipla agreed to supply 10 000 packs of LPV/r pellets per month to Kenya.

Impact of the intervention:

The intervention demonstrated the positive role and contribution that religious leaders and faith communities can play in advocacy, particularly related to paediatric and adolescent HIV testing and treatment at global and national levels.

Extent to which the intervention has been scaled-up: Following initial success in Kenya, Children's Investment Fund (CIFF) agreed to support some paediatric and adolescent advocacy activities in South Africa.

Source of funding to implement the intervention: Children's Investment Fund (CIFF) and PEPFAR.

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

Collaboration with many organizations and networks was essential for achieving the intervention's success. Finding reliable and dedicated project partners, especially at country-level, was critical for successful implementation of project activities. Particularly important was having good working relationships with key individuals, as well as those people having good networks of key contacts and practical experience of working on the ground.



Key factors constraining the implementation and scale-up of the intervention:

- If additional funds had been available, it would have been possible to further scale up some activities, both globally and in-country.
- Finding local partners in-country able to provide undivided attention to project activities was sometimes challenging, though quite understandable given their resource constraints.

Resources available for the intervention:

- Call to Action: Become a Champion for Children and Adolescents Living with HIV: <https://www.oikoumene.org/sites/default/files/Document/Become%20a%20Champion%20for%20Children.pdf>
- Faith communities taking action with children and youth living with HIV: <https://www.oikoumene.org/sites/default/files/File/Children-letter-writing-2018-Booklet-web.pdf>

Information on the intervention:

- <https://www.oikoumene.org/sites/default/files/Document/Become%20a%20Champion%20for%20Children.pdf>
- <https://www.oikoumene.org/sites/default/files/File/Children-letter-writing-2018-Booklet-web.pdf>

INTERVENTION 4.3

Faith-based advocacy on retention and adherence initiative in Ethiopia, ETHIOPIA

Summary

The Inter-Religious Council of Ethiopia (IRCE) implemented this faith-based advocacy intervention to improve HIV retention and adherence initiative in Ethiopia. The intervention has organized a wide range of national and subnational high-level meetings, consultative workshops, training of trainers (ToT) sessions, and briefings or religious media houses to sensitize key stakeholders about HIV testing, retention and adherence to ART and tackling stigma and discrimination. Results are limited to date as the project has only been operating for six months. However, the national and subnational high level advocacy meetings were attended by senior leaders, including: government ministers and heads of regional health bureaus, high level leaders of seven religious organizations and their respective regional heads (who collectively are followed by more than 90% of the Ethiopian population), and leadership of people living with HIV associations. All the meetings were well covered in both the secular and religious media. Posters and billboards were developed quoting the messages of the religious fathers as well as verses from the Holy scriptures, the Holy Bible and Holy Quran.

Keywords



ANTIRETROVIRAL TREATMENT; EDUCATION FOR FAITH LEADERS; IDENTIFICATION AND TESTING; MOBILIZING FAITH COMMUNITIES; SCRIPTURES AND TEACHINGS; STIGMA; TREATMENT ADHERENCE.

Name of the intervention: Faith-based advocacy on retention and adherence initiative in Ethiopia.

Focus of the intervention:

- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and VL suppression.

Faith community asset area: Advocacy by religious leaders and faith-based organizations

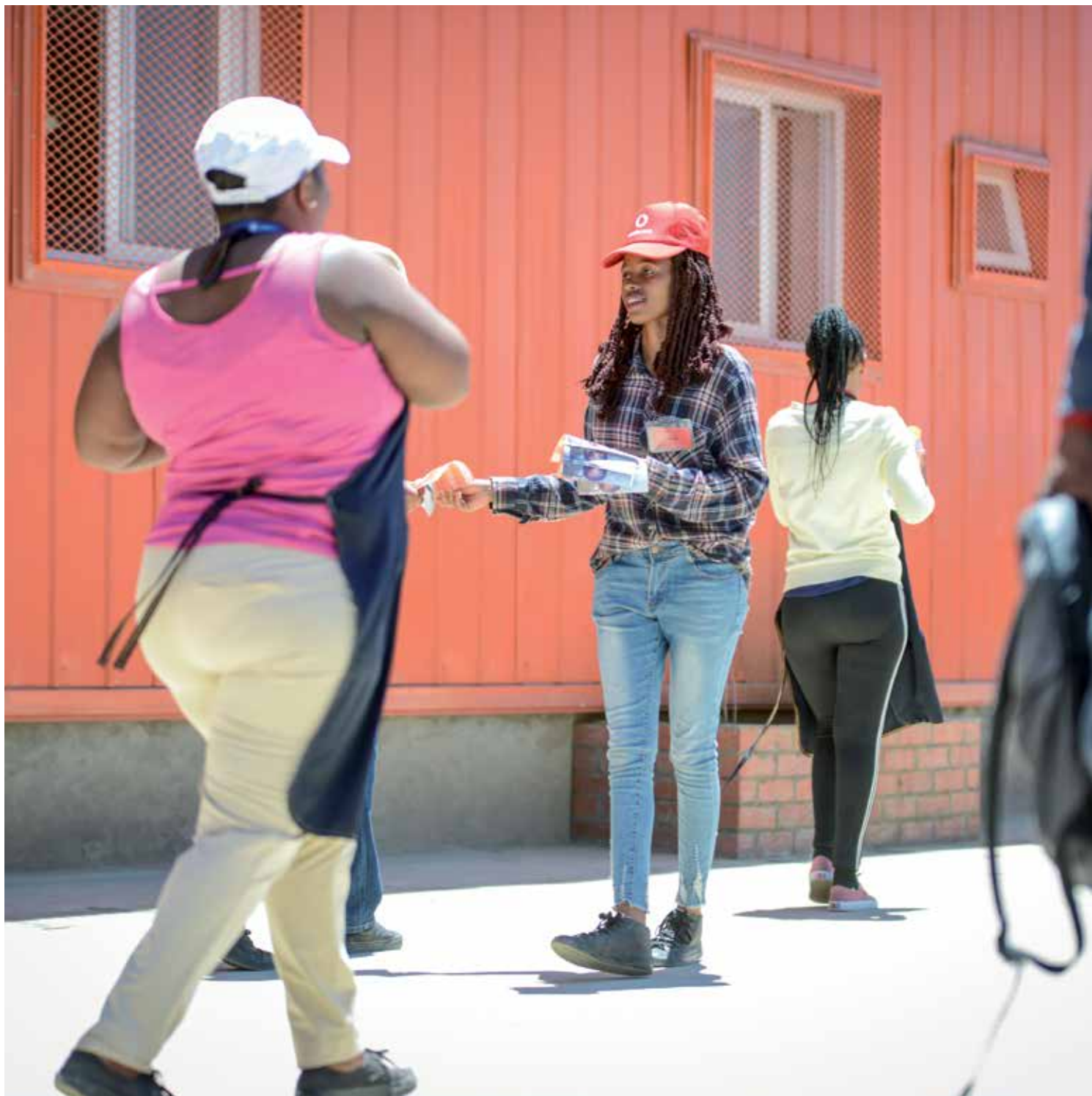
Description of the intervention: Advocacy, communication and social mobilization (ACSM).

Lead organization: Inter-Religious Council of Ethiopia (IRCE).

Location: Ethiopia.

Where the intervention was implemented: National, subnational, parish churches and mosques.

Year the intervention started: August 2020.



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: Results are limited as the project has only been operating for six months. However, since the project started, national and subnational high level advocacy meetings, consultative workshops, training of trainers, sensitization events and orientation for the media from religious media houses were conducted on HIV testing, retention and adherence to ART, as well as the compatibility of ART with spiritual therapies, the importance of tackling stigma and discrimination and of COVID-19 prevention. The national and subnational high level advocacy meetings were attended by senior leaders including: government ministers and heads of regional health bureaus, high level leaders of seven religious institutions and their respective regional heads (who it is believed are followed by more than 90% of the Ethiopian population), leadership of people living with HIV associations and other senior delegates. In addition, consultative workshops, training and sensitization events were also attended by religious scholars, spiritual healers working at Holy Water sites, churches and mosques drawn from the seven-member religious institutions of IRCE, representatives of people living with HIV associations and senior experts from government institutions. The details of those participants at these events are outlined in the table below.

TABLE 15. MEETINGS, WORKSHOPS, TRAININGS AND SENSITIZATION EVENTS HELD OVER THE LAST SIX MONTHS IN 2021

No.	Meetings/workshops/trainings	No. of meetings/workshops/trainings conducted	No. of participants attended		
			Male	Female	Total
1	Consultative workshop with religious scholars and people living with HIV community on ART retention and adherence	1	24	11	35
2	National High level Advocacy Meeting on ART Retention and Adherence with the higher leadership of member religious institutions of IRCE, Ministers	1	69	29	98
3	Conduct subnational advocacy meetings with archbishop/heads of dioceses, sheiks, pastors, bishops, reverends and government decision-makers (RHB, RHACO,) and CSOs such as people living with HIV networks, etc.	7	280	62	342
4	Message of hope designing consultative workshop with the seven member religious institutions of IRCE, people living with HIV associations and public health institutions	1	22	12	34
5	Sensitization events with spiritual healers working at holy water sites, churches and mosques to strengthen correct knowledge on HIV prevention, care and treatment, and stigma reduction	7	289	11	300
6	Training of trainers (ToT) for leadership of IRCE, regional IRC office coordinators and focal persons and theologians of the seven member religious institution of IRCE on HIV testing, treatment, compatibility of ART with spiritual therapies and the importance of tackling stigma	1	18	3	21
7	Orientation for media professionals on HIV testing, ART (retention and adherence), reduction of stigma and discrimination	2	20	5	25

Impact of the intervention: The high-level leadership of the faith institutions delivered messages of hope to their congregations on the following issues: the importance of HIV testing; and the taking of ARVs, which was deemed as being permitted by the Holy scriptures and is considered compatible with spiritual therapies. The messages also highlighted that stigma and discrimination is not allowed by God. All the meetings were well covered in both secular and non-secular media. Posters and billboards were developed quoting the messages of the religious fathers as well as verses from the Holy scriptures/Holy Bible and Holy Quran. The project is facilitating conditions to erect the billboards and post the posters at public areas and healing sites.

Extent to which the intervention has been scaled up: His Holiness Archbishop Mathias, Patriarch of the Ethiopian Orthodox Tewahido Church, delivered a message of hope to His followers on the Ethiopian Epiphany celebration celebrated on 19 January 2021, which was broadcast live by several media houses. The messages to his followers focused on ART retention, adherence and prevention of COVID-19. Recently, IRCE made other efforts to follow up on and replicate the initial high level advocacy meeting.

Source of funding to implement the intervention: PEPFAR/USAID.

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

- IRCE is an umbrella organization for seven highly popular religious institutions comprising more than 90% of Ethiopia's population. Religious institutions and leaders have a high level of acceptance in Ethiopia.
- IRCE established a separate project office to fully manage the project activities.

Key factors constraining the implementation and scale-up of the intervention:

- The high-level advocacy meetings need buy-in of other high-level officials, which may take time and hinder fast implementation.
- Low awareness level of religious leaders in rural areas may affect reduce and slow the attainment of results.

Resources available for the intervention: Not yet available.

Information on the intervention:

- Ministry of Health face book page: <https://www.facebook.com/EthiopiaFMoH/posts/1714171585420304>
- Ethiopian Broadcasting Corporate (EBC) <https://www.youtube.com/watch?v=1rlm6JgliBE..?> Ethiopian News Agency <https://www.ena.et/?p=113147>
- WALTA Communication and Media PLC (WALTA TV) <https://m.youtube.com/watch?v=FlcrlcWDX50&feature=share>
- Oromia Broadcasting Network (OBN Tv) <https://fb.watch/2Gzvdi4iKJ/>
- Addis Media Network (AMN Tv) <https://www.facebook.com/Amnaddistv/videos/212907940391893/>

INTERVENTION 4.4

Faith Community Champions, ZIMBABWE

Summary

Zvandiri implemented the Faith Community Initiative Champions (FCIC) intervention in nine districts in Zimbabwe. The intervention included religious leaders as champions who were selected and trained to disseminate Messages of Hope and to distribute HIV self-test kits. They received support through monthly FCIC coordination meetings, including how to disseminate Messages of Hope, how to target clients for testing, and how to link those testing negative to preventive services. Adolescents and young people testing HIV positive were linked and registered with Zvandiri and those older than 24 years were linked to other clinical partners. Between January and March 2021, some 50 FCIC distributed 1135 HIV self-test kits, of which 1102 were used, 86 were reactive and 67 were confirmed; all were linked to treatment and care (100% linkage rate). Faith leaders were able to disseminate 24 Messages of Hope and 8 Messages about COVID-19 which reached 55 409 and 40 444 community members, respectively. Of these, 892 were reached through sermons, 129 through men's fellowship meetings and 22 through Youth Groups. The selection of the right people to be champions is a key success factor as they are well connected, influential and have more opportunities to have an impact.

© UNAIDS/Cynthia R. Matonhodze

Keywords



ANTIRETROVIRAL TREATMENT; COMMUNITY EDUCATION; EDUCATION FOR FAITH LEADERS; FAITH PAEDIATRIC CHAMPIONS; HIV SELF-TESTING; IDENTIFICATION AND TESTING; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; SCRIPTURES AND TEACHINGS.

Name of intervention: Faith Community Initiative Champions (FCIC), Zimbabwe.

Focus of intervention:

- HIV and health awareness.
- Identifying and testing children and adults living with HIV not on treatment.



Faith community asset area: Advocacy by religious leaders and faith-based organizations.

Description of the intervention: Faith Community Initiative Champions (FCIC), including religious leaders, were selected and trained to disseminate Messages of Hope and to distribute HIV self-test kits. The FCICs then received a 2.5-day training in HIV self-test kit distribution. Thereafter, they received support through monthly FCIC coordination meetings, including how to disseminate Messages of Hope, how to target clients for testing, and how to link those that test negative with preventive services. Adolescents and young people testing HIV positive were linked and registered in Zvandiri; those older than 24 years were linked to other clinical partners.

Lead Organization: Zvandiri.

Location: Zimbabwe: Nine districts were involved:; Harare, Seke, Mazowe, Mt Darwin, Goromonzi, Zvimba, Lupane, Tsholotsho and Umuza.

Where the intervention was implemented: Health facility, community, places of worship.

Year the intervention started: 2019.

Is the intervention still being implemented: Yes.

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

Results of the intervention: Achievements January–March 2021:

- Fifty FCIC managed to distribute 1135 HIV self-test kits (516 female:619 male), of which 1102 (492 female:610 male) were used, 86 (53 female:33 male) were reactive (8% reactive rate), and 67 (42 female:25 male) were confirmed and linked to treatment and care (100% linkage rate).
- CATS, in turn, managed to distribute 66 HIV self-test kits (22 female:44 male), of which all were used, 4 (2 female:2 male) were reactive (6% reactive rate), all of whom were confirmed and linked to treatment and care (100% linkage rate).
- Faith leaders managed to disseminate 24 Messages of Hope and eight Messages of COVID-19, reaching 55 409 (29 930 female:25 479 male) and 40 444 (20 236 female:20 208 male) community members, respectively. A total of 892 (35 female:857 male) were reached through sermons, 129 through men's fellowship meetings, and 22 (5 female:17 male) through Youth Groups.



FCIC sharing information with members of an apostolic sect.

© Zvandiri



Impact of the intervention: The FCIC are successfully integrating within faith communities and hot spots and by using the Messages of Hope, are encouraging people to come forward for HIV testing. It is a very successful model of identifying new positives.

Extent to which the intervention has been scaled up: No scale-up.

Source of funding to implement the intervention: US Centers for Disease Control and Prevention (CDC) through the Zimbabwe Association of Church-Related Hospitals (ZACH).

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

- The selection of the right cadres to be trained. Those who are well connected and influential have more opportunities to have an impact.
- The FCIC were selected with the help of local stakeholders such as Ministry of Health and Child Care and community leaders. This helped to ensure that they were well connected and well positioned to infiltrate hotspots, and religious communities could spread messages of hope and offer HIV self-test kits.
- The coordination meetings assisted the FCIC to share best practices and to develop strategies to identify new HIV positive individuals.

Key factors constraining the implementation and scale-up of the intervention: COVID-19.

Resources available for the intervention: Messages of Hope training materials for HIV self-testing kit distribution

Information on the intervention: Interfaith Health Platform: interfaith.health.platform@gmail.com

MoH staff demonstrating an HIV self-testing kit during a church sermon.

© Zvandiri



INTERVENTION 4.5

The Rome Paediatric HIV & TB Dialogues and Action Plan(s): the convening power of religious leaders, GLOBAL

Summary

The Rome Paediatric HIV and TB Action Plan has been implemented by The Holy See of Rome, in conjunction with the World Health Organization, PEPFAR, key United Nations agencies and other organizations, including faith communities. The Rome Action Plan aims to reduce the morbidity and mortality among children living with HIV and co-infected with TB by addressing the persistent challenges involving access to diagnostics and treatment. The Action Plan is the result of five High-Level Dialogues that took place between 2016 and 2020 at the Vatican. The Rome Action Plan(s) and the five Dialogues led to unprecedented collaboration among pharmaceutical and diagnostics companies, regulators, donors and other key stakeholders, and has prompted several positive developments in R&D, regulatory issues, funding and pricing. Some of the most successful examples include: (a) accelerated development of new paediatric HIV formulations, including Dolutegravir (DTG) for infants and ALD; (b) increased production capacity to meet market needs for Lopinavir/Ritonavir (LPV/r) pellets and granules; (c) lower, all-inclusive prices for early infant HIV diagnosis; and (d) streamlined clinical trial system for priority HIV drugs and products. The Rome Action Plan(s) and Dialogues illustrate the convening power of faith leaders as a result of which it has been possible to achieve unprecedented collaboration with a wide range of very senior leaders in key organizations. Critical success factors have been the continued commitment and support of the Vatican for the issue of children and adolescents living with HIV and the commitment to action by CEOs and senior leadership in critical organizations.

Keywords

**ANTIRETROVIRAL TREATMENT; EARLY INFANT DIAGNOSIS;
HIV SELF-TESTING; IDENTIFICATION AND TESTING; VL SUPPRESSION.**

Name of the intervention: The Rome Paediatric HIV & TB Dialogues and Action Plan(s): The Convening Power of Religious Leaders.

Focus of the intervention:

- Identifying and testing children and adults living with HIV not on treatment.
- Access to HIV treatment, retention and adherence and VL suppression.

Faith community asset area: Advocacy by religious leaders and faith-based organizations.



Description of the intervention: The Rome Paediatric HIV and TB Action Plan is aimed at reducing the morbidity and mortality among children living with HIV and co-infected with TB by addressing the persistent challenges involving access to diagnostics and treatment. The Action Plan is the result of five High-Level Dialogues that took place between 2016 and 2020 that were held at the Vatican. The Dialogues had the following areas of concentration:

Rome 1, April 2016. Focus: (i) Conference and roadmap for the future of children living with HIV; (ii) Meeting with representatives of pharmaceutical and diagnostic industries in the Vatican.

Rome 2, May 2016. Focus: Fast-Tracking Paediatric HIV Diagnosis and Treatment.

Rome 3, November 2017. Focus: Scaling Up Early Diagnosis and Treatment. Accelerating development and introduction of optimal medicines.

Rome 4, December 2018. Focus: Addressing the remaining bottlenecks to quickly identify HIV infected children (diagnostics) and link them to optimal regimes.

Rome 5, November 2020. Focus: Paediatric HIV and TB in Children Living with HIV. Each of the Dialogues was convened by His Eminence Peter Kodwa Appia Cardinal



Turkson, Prefect of the Dicastery for the Promotion of Integral Human Development in the Vatican and was attended by high level representatives of pharmaceutical and diagnostics companies, regulators, donors and others key stakeholders. This led to unprecedented collaboration between these stakeholders and resulted in several very significant developments in R&D, regulatory issues, funding and pricing. During each Dialogue the participants put forward a variety of steps they had taken or could take on key issues, such as: expanding access to early infant diagnosis; VL testing; identifying more HIV exposed children and quickly linking them to HIV and TB testing and treatment services. They also presented additional actions that needed to be taken to accelerate the development and roll-out of priority paediatric formulations of ARVs, including streamlining regulatory processes, improving financing for the entire spectrum of paediatric formulations, development and introduction. The Rome Action Plan(s) include a broad set of commitments from partners to accelerate R&D, the regulatory process and introduction and scale-up of HIV and TB diagnostics and treatment in the country. Accountability is ensured, under the leadership of WHO and EGPAF, through the on-line tracker and quarterly reporting webinars on progress.



Lead organization: The Holy See of Rome, in conjunction with WHO, PEPFAR, UNAIDS, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), faith-based organizations and global partner organizations.

Location: The Vatican, Rome.

Where the intervention was implemented: The Dialogues were held in Rome but the focus is global.

Year the intervention started: 2016.

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:

- A key indicator of the results has been the increasing number of commitments to action made by stakeholders participating in the Dialogues. These commitments increased as follows:
 - **Rome 3:** First occasion when 41 actions were recorded in the roadmap and on treatment.
 - **Rome 4:** An additional 87 actions were agreed, related to paediatric diagnostics and 60 actions on paediatric commitment.
 - **Rome 5:** Childhood TB was included as part of the Dialogue and the stakeholders agreed to implement 130 actions on TB treatment and 77 actions on TB diagnostics as well as 73 actions on paediatric HIV treatment, 30 actions on HIV diagnostics and 11 actions on cross-cutting commitments.
- The Rome Action Plan(s) and the five Dialogues have led to unprecedented collaboration among pharmaceutical and diagnostics companies, regulators, donors and other key stakeholders, and has prompted several positive developments in R&D, regulatory issues, funding and pricing. Some of the most successful examples of this effective collaborative platform include:
 - Accelerated development of new paediatric HIV formulations, including DTG for infants and Abacavir-Lamivudine Dolutegravir (ALD).
 - Increased production capacity to meet market needs for LPV/r pellets and granules.
 - Lower, all-inclusive prices for early infant HIV diagnosis.
 - Streamlined clinical trial system for priority HIV drugs and products, including the C-reactive protein–In vitro Diagnostic (CRP–IVD).
- Progress on all of the Rome Action Plan commitments is monitored through a collaborative accountability mechanism led by the co-organizers of the Dialogues, which includes an open access on-line tracker and quarterly progress reports and webinars: <https://www.paediatrichivactionplan.org/updates>

Impact of the intervention:

The Rome Action Plan(s) and Dialogues illustrate the convening power of faith leaders through which it has been possible to achieve unprecedented collaboration with a wide range of very senior leaders in key organizations.

The partnership has set a new standard of what is achievable when stakeholders with shared values work collaboratively. For example, the timeline to develop the new paediatric dose of Dolutegravir was shortened by more than two years—becoming the fastest transition from adult to paediatric formulation ever approved by regulators.

Extent to which the intervention has been scaled up: The success of the first Dialogue resulted in four subsequent Dialogues, to cover a wider range of issues that needed in order to ensure that the morbidity and mortality among children living

with HIV and co-infected with TB were reduced. The accountability mechanism has ensured that commitments are regularly tracked and this has scaled-up the scope of the initial intervention. It is expected that future Dialogues with Action Plans will be undertaken.

Source of funding to implement the intervention: PEPFAR, UNAIDS, EGPAF.

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

- The continued commitment and support of the Vatican for the issue of children and adolescents living with HIV. Pope Francis specifically called on the meeting participants to find “new possibilities of providing greater access to life-saving diagnosis and treatment” for children.
- Support from a wide range of stakeholders, including to fund the Dialogues, helped to provide sustainability for the Dialogues and to widen the functions to include accountability and tracking.
- The commitment to action by Chief Executive Officers (CEOs) and senior leadership in critical organizations, especially pharmaceutical, diagnostics companies and regulators as well as donors, ensure that many of the actions were achieved.

Key factors constraining the implementation and scale-up of the intervention:

While many significant actions were implemented, there were others that have not been implemented.

Resources available for the intervention: The concept notes, outcomes and commitments made by stakeholders attending each of the 5 Dialogues can be found on the Rome Action Plan website, together with regular progress reports and a tracker.

Information on the intervention:

The Rome Action Plan website: <https://www.paediatricrivactionplan.org/>



INTERVENTION 4.6

Building Hope for All—Training faith communities on HIV and AIDS, NAMIBIA

Summary

Building Hope for All—Training Faith Communities on HIV and AIDS, Namibia, was implemented by The Seventh Day Adventist Church in Namibia and ADRA-Africa. The intervention included three components: (1) training for pastors, their spouses and other senior leaders in the Seventh Day Adventist Church in Namibia, as Training of Trainers and counsellors in HIV and AIDS. The aim is to improve the quality of the counselling services provided to church members, as well as improving HIV awareness raising activities in their churches and tackling stigma and discrimination within churches and communities. (2) Creating awareness about HIV and AIDS for adolescents and children aimed at increasing knowledge about HIV and AIDS to facilitate informed decision making. (3) Activities to support the formation of groups within five regions in Namibia to tackle stigma. Training was provided to 15 pastors and their spouses, 80 church elders and 120 church leaders, as well as to 480 adolescents and children who received education about HIV and AIDS. The intervention showed that religious leaders can become HIV and AIDS Champions, particularly in the context of their own religious beliefs, and that the church could provide greater access to psychosocial services for adults, youths and children infected and affected by HIV and AIDS and strengthen the resilience of youth and children to HIV and AIDS related shocks. The key success factor identified was that to be successful, people working on this type of intervention need to be familiar with the culture, values and customs of faith communities they are working with.

© UNAIDS

Keywords



COMMUNITY EDUCATION; EDUCATION FOR FAITH LEADERS; FAITH PAEDIATRIC CHAMPIONS; LIFE SKILLS; STIGMA; SUPPORT GROUPS.





Name of the intervention: Building Hope for All—Training faith communities on HIV and AIDS, Namibia.

Focus of intervention: HIV and AIDS awareness; zero stigma and discrimination.

Faith community asset area: Advocacy by religious leaders to increase awareness and tackle stigma.

Description of the intervention:

- Pastors, their spouses, Deacons and Deaconesses, principally in the Seventh Day Adventist Church in Namibia, were trained as Training of Trainers and counsellors in HIV and AIDS. The objective was to train pastors and their spouses in HIV and AIDS counselling to improve the quality of the counselling services provided to church members, as well as improving the education and awareness raising activities they undertake about HIV and AIDS in their churches. This included addressing issues of stigmatization and discrimination that occurs in churches and communities. The training also provides relevant and informed support to the support groups which are affiliated to their churches.
- There was also a component of the programme that created awareness about HIV and AIDS for adolescents and children. This training aimed to increase the knowledge of the target groups about HIV and AIDS to facilitate informed decision-making. Materials from the Bible Society, which are designed for the groups, was used. Training was done through life skills clubs at church level.
- Activities to support the formation of groups within the five regions to assist stigma reduction.

Lead organization: The Seventh Day Adventist Church in Namibia and ADRA-Africa.

Location: Pastors, spouses and church leaders from five regions in Namibia.

Where the intervention was implemented: Places of worship.

Year the intervention started: 2016.

Is the intervention still being implemented: No.

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

Results of the intervention:

- Training was provided to 15 pastors and their spouses, 80 church elders and 120 church leaders. In addition, a total of 480 adolescents and children received education about HIV and AIDS.
- Support groups which were formed as part of the counselling service have resulted in increased target group participation, sharing and engagement in their own development, including starting micro-enterprises. The support groups provide a healthy forum for engagement and reintegration into the community. Several advocacy issues have been identified and advocacy plans were successfully implemented. Therefore, counselling should always be complemented by peer support.
- Stigma reduction activities have yielded positive results such as the target groups being able to give public testimonies in churches, schools and open community forums. The target groups happily introduce themselves as persons living with HIV and AIDs and some of them use their personal experiences to counsel others. They also talk about being on ART freely and openly. Thus, counselling services should be complemented by stigma reduction activities, especially in faith communities where HIV and AIDS assume a moralistic aspect. This enhances the impact of counselling.

Impact of the intervention:

- Increased the capacity of pastors, spouses and other church members to undertake awareness raising and counselling about HIV and AIDS, especially in the SDA Church.
- Created awareness that religious leaders can become HIV and AIDS champions, particularly in the context of their own religious beliefs, and shows that there is a potential group of champions who could take this issue forward.

- Created greater access to psychosocial services for adults, youth and children infected and affected by HIV and AIDS, and increased resilience of youths and children to HIV and AIDS related shocks.

Extent to which the intervention has been scaled up: Other churches expressed interest in the training programme, but it has not been scaled up due to a lack of funds.

Source of funding to implement the intervention: ADRA–Africa.

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

To be successful, people working on this type of intervention need to be familiar with the culture, values and customs of faith communities they are working with because faith communities can be suspicious of people from outside working on sensitive issues, such as HIV.

Key factors constraining the implementation and scale-up of the intervention:

Lack of funds to carry out follow-up activities and scale-up.

Resources available for the intervention: Some resources have been produced by the Adventist AIDS International Ministry (AAIM) of the Adventist Church.

Information on the intervention:

Adventist–HIV/AIDS International Ministry website: <https://aidsministries.co/about/>



INTERVENTION 4.7

Religious leaders advocating for better identification and linkage to paediatric HIV treatment, NIGERIA

Summary

Caritas Nigeria and Caritas Internationalis supported religious leaders to advocate for better identification and linkage of children to HIV treatment in parts of Nigeria. The intervention was a conceptual progression of the congregation-based approach to HIV testing previously implemented by Caritas Nigeria (see promising practice 3.2) and aimed to train religious leaders with pastoral messages targeted at changing widespread beliefs about HIV to tackle stigma and identify and link children living with HIV to treatment. Training was a critical component of the intervention as it was the mainstay for mobilizing 'activated clergy' in which religious leaders were trained on pastoral and basic scientific considerations regarding HIV pathology. Following their training, the activated clergy provided audience appropriate HIV and AIDS prevention and stigma reduction messages to their congregations. These religious leaders provided the interface between health centres and their congregations through a team of church health advisors whose functions were to target high risk mother-and-child pairs for HIV testing and linkage of identified children living with HIV to care and treatment. Some 85 champions were identified out of a total of 179 religious leaders who underwent training to become paediatric champions. The messaging for religious communities reached a total of 43 909 people of whom 22 197 were aged between 0 and 15 years. Using this mechanism, 16 050 recurrently sick children under five years were referred for HIV testing, with 15 431 of these tested. A total of 64 children under five years were diagnosed with HIV (giving a project positivity rate of 0.4% as against the country prevalence of 0.2% for the same age group (NAIIS 2018). Of the children diagnosed as living with HIV, 62 were started on ART for an ART initiation rate of 97%. The intervention has become a key component of the strategy adopted for intensified paediatric HIV case finding in Nigeria.

© UNAIDS/Puki Ramokoatsi



Keywords

ANTIRETROVIRAL TREATMENT; COMMUNITY EDUCATION; EDUCATION FOR FAITH LEADERS; FAITH PAEDIATRIC CHAMPIONS; HEALTH FACILITY–COMMUNITY COLLABORATION; HIV SELF-TESTING; IDENTIFICATION AND TESTING; MOBILIZING FAITH COMMUNITIES; PLACES OF WORSHIP; STIGMA; TREATMENT ADHERENCE.



Name of the intervention: Religious leaders advocating for better identification and linkage to paediatric HIV treatment, Nigeria.

Focus of the intervention: Identifying and testing children and adults living with HIV not on treatment

Faith community asset area: Advocacy by religious leaders and faith-based organizations; and using places of worship.

Description of the intervention: This intervention was built on Caritas Nigeria's experience in HIV programming and the potential accorded by the Church's structure. The GRAIL Project was a conceptual progression of the congregation-based approach to HIV testing (see promising practice 3.2). It aimed specifically to train religious leaders with pastoral messages targeted at changing widespread beliefs about HIV to tackle stigma, identify and link children living with HIV to treatment as soon as possible and to generate adequate follow-up with outcomes. Training was a critical component of the intervention as it was the mainstay for the use of the 'activated clergy' strategy in which religious leaders of faith communities were trained on pastoral and basic scientific considerations regarding HIV pathology. The process of selecting the religious leaders constituted the pre-training phase of the intervention and included the following activities:

- Identification of priority geopolitical regions particularly affected by paediatric HIV related gaps and challenges.
- Identification of faith-based organizations health facilities (Catholic and others) responding to paediatric HIV in selected priority geopolitical regions through existing mappings.
- Collection of data describing the current paediatric HIV response carried out by selected faith-based organization health facilities responding to paediatric HIV.
- Identification of parishes and other religious institutions active in the selected priority region particularly affected by paediatric HIV related gaps and challenges.

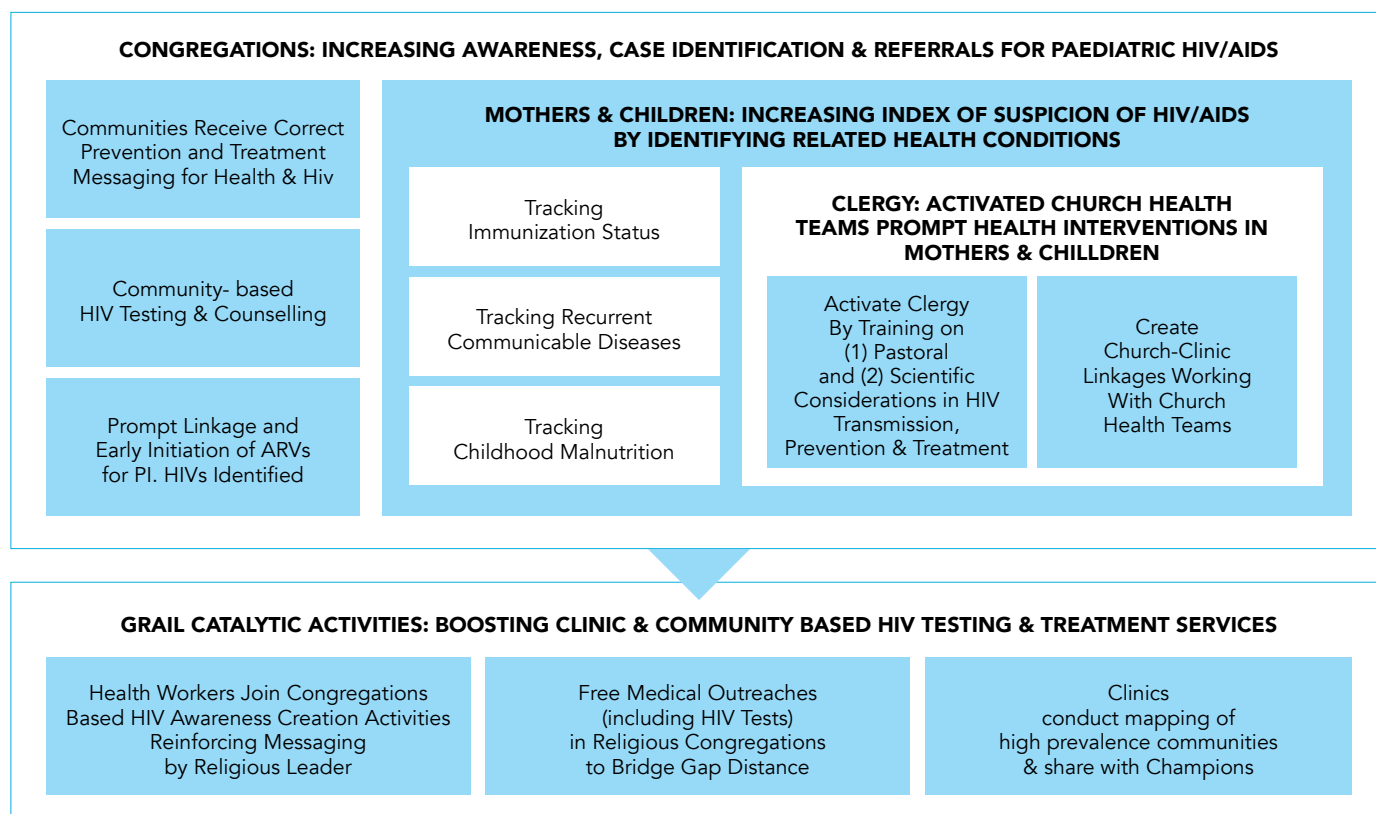
For ease of referral, each of the participating religious affiliations (Christianity—Catholics and other denominations and Islam) has corresponding staff at health facilities operated by faith-based organizations within their immediate catchment areas who were invited to participate in the training.

Following their training the activated clergy provided audience-appropriate HIV and AIDS prevention and stigma reduction messages to their congregations. These religious leaders provided the interface between health centres and their congregations through a team of church health advisors whose functions were to target high risk mother-and-child pairs for HIV testing and linkage of children diagnosed as living with HIV to care and treatment. A summary of the team responsibilities included:

- Tracking of immunization status.
- Screening for recurrent symptoms of communicable diseases such as fevers, diarrheal disease, respiratory tract infection and skin infections using the Modified Bandason Checklist.
- Referral for HIV testing and counselling and ART initiation when indicated.
- Management of and referral to health centres of co-morbid conditions diagnosed in children living with HIV.



TABLE 17. IMPLEMENTATION CHART FOR INTERVENTION



Lead organizations: Caritas Nigeria and Caritas Internationalis.

Location: 21 States plus Federal Capital Territory of the 36 States in Nigeria:

- **Southeast:** Enugu, Ebonyi, Imo, Abia, Rivers, Cross River.
- **Southwest:** Edo, Ondo, Oyo, Osun, Ogun, Lagos.
- **North-central:** Federal Capital Territory, Kaduna, Nasarawa, Benue.
- **Northeast:** Adamawa, Taraba, Bauchi, Borno, Yobe.

Where intervention was implemented: Places of worship.

Year the intervention started: April, 2018.

Is the intervention still being implemented: Yes. It is being implemented as GRAIL 3, now including Catholic Relief Service as part of the Faith-Based Action for Scaling-Up HIV Testing and Treatment for the Epidemic Response (FASTER) Project.

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

Results of the intervention: Various catalytic activities were carried out over this period, including: identification of church health advisors to drive congregational interventions; HIV messaging during homily/preaching; awareness and sensitization activities on designated days such World Day of the Sick, among others; and activation or constitution of Parish AIDS Committees and other activities. A total of 85 champions were identified out of a total of 179 religious leaders who underwent training to become paediatric champions. The outputs of the catalytic activity in terms of HIV education and stigma reduction messaging for religious communities reached a total of 43 909 persons of which 22 197 were between 0 and 15 years. Using this mechanism, 16 050 recurrently sick children under five years were referred for HIV testing, with 15 431 of these number tested. A total of 64 children under five years were diagnosed with HIV (giving a project positivity rate of 0.4% as against the country prevalence of 0.2% for the same age group (NAIIS 2018)). Of the CLHIV diagnosed, 62 were started on ART for an ART initiation rate of 97.

TABLE 16. TRAINING ACHIEVEMENTS

Training	Dates	Attendance	Participant profile		Participant affiliation		Champions identified
			Priests	Religious	Parish/Diocese	Health facility	
Southeast	23–25 April 2018	63	29	10	33	11	13
Southwest	16–17 May 2018	37	19	11	25	9	18
North–central	31 May–1 June 2018	53	20	10	23	18	31
Northeast zonal training	13–14 November 2018	26	21	2	17	3	23
Total		179	89	33	97	41	85

Impact of the intervention: The success of the intervention resulted in the approval of phases 2 and 3 of the project. In Phase 3, it became a component of the US Centers for Disease Control and Prevention funded multicountry FASTER project. It has become a key component of strategy adopted for intensified paediatric HIV case finding in the country.

Extent to which the intervention has been scaled up: Support from the FASTER project resulted in the scale-up to Benue and Rivers State, in addition to the 21 States where the intervention had been implemented previously. Caritas Internationalis also influenced the scale-up in Kenya. GRAIL 1 was implemented in the Democratic Republic of the Congo at the same time as Nigeria and it has also been implemented in Côte d'Ivoire.

Source of funding to implement the intervention: Caritas Nigeria funds. PEPFAR, Caritas Internationalis and UNAIDS.

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

- A key success factor in the intervention was the introduction of children focused, free medical outreach intended to boost the testing of recurrently sick children by addressing several challenges, including: cases of long distances from religious communities to the clinics; the unavailability of HIV test kits in the referral clinics; the cases of small communities that needed additional exposure (by offering free medical care) to encounter more sick children; and support champions who had challenges reporting referrals and HIV testing they had initiated.
- Three medical outreaches were conducted in the Nigeria project, with 1390 adults and children being clinically assessed and treated for various health conditions including testing and referral for HIV. A total of 1329 beneficiaries of the outreach were tested for HIV and 12 persons were diagnosed HIV positive. Two tested HIV positive of 431 tested in the age group of 0 to 5 years (the original target group), while three tested HIV positive of the 515 beneficiaries aged 6–10 years. About 670 adolescents, men and women aged 10 years and above also received clinical evaluation (including blood pressure checks for hypertension, random blood sugar estimates for diabetes, as well as HIV tests).

Key factors constraining the implementation and scale-up of the intervention:

The implementation team documented an unintended negative project result, which was resistance from some communities due to fears of being labelled as HIV friendly churches as well as stigma transference (with associated reduced attendance or monetary support from members).

On a positive note, some champions targeted children under 15 years with age-appropriate messaging which had a positive impact and led to the children passing messages to their family and peers and even correcting some myths about HIV.

Resources available for the intervention:

Screening Questions For Referring Children to HIV Testing Services
 Modified Bandason Tool

INSTRUCTIONS:
 Use one form for one child. Counselor is to ask the child's care giver (parent) by asking the questions listed below, holding appropriate responses for each question. Counselor is to sum up all marks for "YES", "NO" and "I DON'T KNOW". If "TOTAL MARKS" for which the response received was "YES", Counselor is to refer the child for medical investigation that includes an age-appropriate test for HIV.

Question Sequence	Question	Please Mark The Response As Received		
		YES	NO	I DON'T KNOW
STEP 1: ASK...	Has the child been admitted to hospital before?			
STEP 2: ASK...	Does the child have recurring skin problems?			
STEP 3: ASK...	Are one or both parents of the child deceased?			
STEP 4: ASK...	Has the child had poor health in the last 3 months?			
STEP 5: ASK...	Is any of the child's siblings deceased?			
STEP 6: ASK...	Does the child have any chronically ill parent or House Hold member (including persons diagnosed with tuberculosis)?			
STEP 7: ASK...	Is the child a year or more older than expected for his/her grade in school?			
STEP 8: ASK...	Does the child have any discharge or sores on the private parts?			
TOTAL MARKS				

Information on the intervention:

Bandason T. et al. Validation of a screening tool to identify older children living with HIV in primary care facilities in high HIV prevalence settings. Bethesda, MD: National Library of Medicine; 2016.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4937807/>

© UNAIDS/Puki Ramokoatsi



APPENDIX



FIG. 4. KEY FINDINGS ON PROMISING PRACTICES OF FAITH COMMUNITIES (FREQUENCY BY FAITH ASSET)

1.	Increase the identification, testing, and linkage of children and adolescents living with HIV not on 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]
2.	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]
3.	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]
4.	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]
5.	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]
6.	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]
7.	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]
8.	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]
9.	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) [14]
10.	Mobilizing faith leaders and communities through awareness and sensitization can prevent 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]
11.	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]
12.	Support HIV-self testing (1.11, 2.4, 2.6, 3.1, 3.4, 3.5, 4.4, 4.5, 4.7) [9]
13.	Facilitate peer support groups that provide comprehensive care and support to children and adolescents living with HIV (1.3, 1.8, 1.9, 1.10, 1.11, 2.2, 2.13) [7]
14.	Mobilizing faith leaders and communities can increase male involvement in HIV programming, including prevention of vertical transmission (2.2, 2.3, 2.4, 2.5, 2.7, 3.1, 3.2, 3.4) [8]
15.	Use a comprehensive care and support approach for orphans and vulnerable children (1.2, 1.3, 1.7, 1.9, 1.10, 2.8) [6]
16.	Facilitate approaches to increase HIV disclosure (1.3, 1.7, 1.9, 1.12, 2.10, 2.12) [6]
17.	Increase adolescent awareness about HIV and gender based violence, HIV prevention messages (2.3, 2.4, 2.5, 2.6, 2.7, 2.15) [6]
18.	Faith paediatric champions identified from within different faith communities can speak authoritatively to increase knowledge, demand and uptake of paediatric HIV services, including referrals for testing and treatment (4.1, 4.2, 4.4, 4.6, 4.7) [5]
19.	Improve antiretroviral treatment regimen optimization for children and adolescents living with HIV (1.1, 1.4, 1.5, 4.2, 4.5) [5]
20.	Utilize a case management approach to improve children and adolescents living with HIV retention in treatment and improve viral load suppression (1.2, 1.3, 1.9) [3]
21.	Faith paediatric champions can advocate with governments to set ambitious targets for paediatric HIV and hold governments to account for their commitments (4.2, 4.3, 4.5) [3]
22.	Using point-of-care devices to improve early infant diagnosis, that reduce testing turnaround time and increases access to antiretroviral treatment (1.6, 4.5) [2]
23.	Utilise a differentiated service delivery approach to increase antiretroviral adherence and increased viral load suppression (1.7, 2.1) [2]
24.	Use an integrated family-centred approach to HIV testing, treatment care and support (1.13, 3.2) [2]
25.	Use faith engaged community posts and health posts that increase case finding of children and adolescents living with HIV and increase access and retention in antiretroviral treatment coverage (2.1, 3.1) [2]
26.	Use sporting events and coaches to increase adolescent awareness about HIV and gender based violence, HIV prevention messages, and identify children and adolescents living with HIV (2.5, 2.10) [2]
27.	Religious schools and youth centre-based programmes can increase awareness about HIV, highlight the importance of prevention, treatment and need for tackling stigma (2.1, 2.15) [2]
28.	Utilize continuous quality improvement (CQI) approaches to increase antiretroviral treatment (ART) optimization for children and adolescents living with HIV (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. 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

© UNAIDS/Gregoire de Fombelle



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 facilities¹. FIHPs play an important role in providing health care services in many countries in Africa². 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 crises³, there is evidence that contests the view that FIHPs have a preferential option for poor and marginalized people compared with public health providers⁴. 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, 2019⁵). 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 infection⁶.

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.

- 1 President's Emergency Plan for AIDS Relief. A firm foundation: the PEPFAR consultation on the role of faith-based organizations in sustaining community and country leadership in the response to HIV/AIDS. Washington, DC: Department of State; 2012.
- 2 Olivier J, et al. Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction, faith-based health care 1. *Lancet*. 2015; 386:1765–1775.
- 3 Widmer M, et al. The role of faith-based organizations in maternal and newborn health care in Africa. *Int J Gynecol Obstet*. 2011; 114:218–222.
- 4 Olivier J, et al. Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction, faith-based health care 1. *Lancet*, 2015; 386:1765–1775.
- 5 Common vision: faith-based partnerships to sustain progress against HIV. Geneva: UNAIDS, 2019.
- 6 Vitillo RJ, ed. Ending AIDS as a public health threat: faith-based organisations as key stakeholders, Caritas Internationalis, UNAIDS and Catholic HIV & AIDs Network, 2016

UNAIDS ACKNOWLEDGES THE CONTRIBUTION
OF DR. STUART KEAN TO THE DEVELOPMENT OF
THIS REPORT.



UNAIDS
Joint United Nations
Programme on HIV/AIDS

20 Avenue Appia
1211 Geneva 27
Switzerland

+41 22 791 3666

unaids.org