



EXECUTIVE SUMMARY

COMPENDIUM OF PROMISING PRACTICES

of African Faith Community
Interventions Against Paediatric
and Adolescent HIV

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EXECUTIVE SUMMARY

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FOREWORD

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

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

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

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



WINNIE BYANYIMA

UNAIDS Executive Director
and UN Under-Secretary-General



JOHN N. NKENGASONG

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.**

EXECUTIVE SUMMARY

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

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You can read the full report at: https://www.interfaith-health-platform.org/_files/ugd/38bdf_0e27cfc3dca472183b4e871812b9745.pdf



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