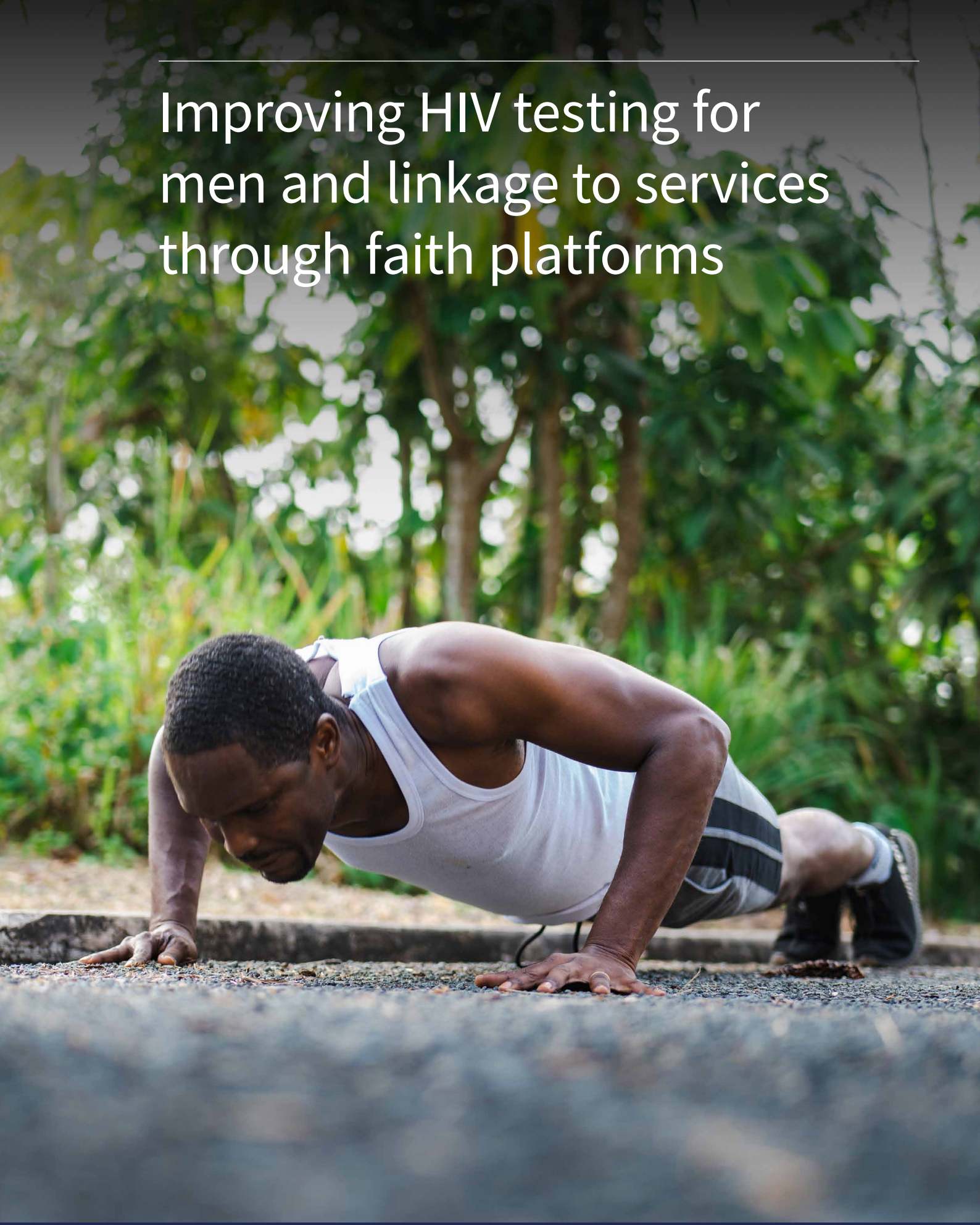
Improving HIV testing for men and linkage to services through faith platforms



World Health Organization

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Abbreviations and acronyms

ACHAP:	Africa Christian Health Association
AGYW:	Adolescent Girls and Young Women
AIDS:	Acquired Immunodeficiency Syndrome
ANC:	Antenatal Care
ART:	Antiretroviral Treatment
CDC:	Center for Diseases Control
CDC-DGHT:	Centers for Disease Control and Prevention - Division of Global HIV & Tuberculosis
CHWs:	Community Health Workers
CMMB:	Catholic Medical Mission Board
CoH:	Circle of Hope
CPs:	Faith and Community-Led Posts
COP/ROP Guidance:	Country/Regional Operational Plan Guidance
CRS:	Catholic Relief Services
DRC:	Democratic Republic of Congo
EDARP:	Eastern Deanery AIDS Relief Programme
EGPAF:	Elizabeth Glaser Pediatric AIDS Foundation
EMR:	Electronic Medical Record
FBOs:	Faith Based Organizations
FY21:	Financial Year 2021
HIV:	Human Immunodeficiency Virus
HIVST:	HIV Self-Testing
HTS:	HIV Testing Services
INERELA+:	Interfaith Network of religious Leaders living with or personally affected by HIV and AIDS
IHP:	Interfaith Health Platform
MENHT:	Global Men and HIV Technical Working Group
MCH:	Maternal and Child Health
NCD:	Non-Communicable Diseases
PEPFAR:	President's Emergency Plan for AIDS Relief
PHC:	Primary Health Care
PREP:	Pre-Exposure Prophylaxis
RECIPE:	Responsibility, Empathy, Compassion, Integrity, Passion, Ethical
RLs:	Religious Leaders
SNS:	Social Network Strategy
TLC:	The Luke Commission
UHC:	Universal Health Care
UPMB:	Uganda Protestant Medical Board
UNAIDS:	Joint United Nations Programme on HIV and AIDS
UPMB:	Uganda Protestant Medical Bureau
USAID:	United States Agency for International Development
VMMC:	Voluntary Medical Male Circumcision
WCC:	World Council of Churches
WHO:	World Health Organization
ZACH:	Zimbabwe Association of Church-related Hospitals

Introduction

Globally, adolescent boys and men aged 15 and older are less likely than women to know their HIV status, begin treatment, or achieve viral suppression *(1).* Often, their HIV diagnosis occurs at a later, more advanced stage of the disease *(2).* This delay creates immediate challenges for timely care and intervention. Even after diagnosis, due to health systems challenges, men often do not seek care or engage with healthcare services, reducing their chances to access to life-saving HIV treatment. For those who do initiate treatment, adherence remains a struggle *(3)*: men are less likely than other groups to start treatment promptly, and they are more likely to drop out of care, resulting in frequent interruptions in their treatment regimen *(4).*

Social, cultural, and structural barriers, including stigma, gender norms, financial constraints, peer-pressure and limited access to male-friendly health services, are among the factors that hinder men's engagement with testing, treatment, and care at each stage of the HIV continuum of care *(5).*

Expanding HIV service coverage for men is critical for improving population health outcomes and reaching HIV epidemic control *(6).* Recent models suggest that increasing HIV testing and treatment coverage among men could reduce HIV incidence among women by half, underscoring the broader impact of engaging men in HIV care *(7).*

Building collaborative relationships especially with communities and other stakeholders is a cornerstone of primary health care (PHC) and universal health care (UHC) and engagement of faith communities with their comparative advantages could help to identify the interests and priorities of communities and to align with broader, shared goals and actions.

This document explores and records faith-based approaches for effectively delivering services to men. It is not intended as an endorsement of any specific approach but rather serves to demonstrate and document various practices and strategies.

What are Faith-Based Platforms?

For this document, faith-based platforms encompass a range of religious entities, including faith-based programs, organizations, and places of worship such as, churches, mosques, temples, synagogues, and other religious institutions.

The Faith Based Organizations (FBO) models presented in this document integrate a range of WHO-recommended interventions, including facility- and community-based testing, HIV self-testing, provider-assisted referrals, and social network-based approaches *(8).* These interventions succeed due to five central factors: strong relationship capital that facilitates holistic service delivery; the trust and access that FBOs have within families and communities, enabling them to reach priority populations; a nuanced understanding of local cultures and dynamics to tailor effective interventions; a commitment to person-centered care and compassion, reinforced through continuous staff training; and dedicated support for caregivers, ensuring sustained motivation and engagement among volunteers and healthcare professionals.

Despite their potential, the contributions of the faith sector, through both faith-based platforms and faith community leaders, are often underutilized. This document provides considerations for better integrating and leveraging faith-based approaches to close the gap in men's HIV services, advocating for increased collaboration, research investment, and policy development to harness the strengths of the faith sector.

Approach

To support men's uptake to HIV services, the Global HIV, Hepatitis and STIs Programmed of the World Health Organization *(9),* working with the WHO and UNAIDS Global Men and HIV Technical Working Group *(10),* and following discussions with the World Council of Churches *(11)* on the potential of faith-based platforms to reach priority populations, initiated an effort to identify faith-based models that could potentially become routine strategies for delivering HIV services to men more effectively.

To collect these approaches and models, a survey – *Reaching Men through Faith-health platforms* – was launched on the Interfaith Health Platform (IHP) *(12)* in September 2022. Twenty-seven responses from 16 countries were received as of February 2023. Respondents comprised both representatives of FBOs and of other sectors collaborating with faith groups and faith leaders, mostly in demand creation activities. Survey responses included activities from 16 Countries: Burkina Faso, Cameroun, Democratic Republic of Congo (DRC), Eswatini, Guinea, Kenya, Madagascar, Mozambique, Nigeria, Philippines, Rwanda, Tanzania, Uganda, USA, Zambia, Zimbabwe.

A follow up questionnaire based on the *WHO Policy Brief: Improving Men's uptake of HIV testing and linkage to Services (13)*, was sent to all survey respondents and selected FBOs to capture details on ways in which faith platforms adopt and adapt WHO-recommended approaches for improving men uptake of HTS. Qualitative in-depth interviews and exchanges were conducted with 12 survey respondents, in addition to other FBOs and partners engaged in in leading and implementing faith initiatives on HIV (See Annex 1 for a list of all respondents and survey contributors).

A desk review of relevant policies, literature, journals, articles, case studies, AIDS conferences' abstracts and posters on the subject matter, as well as key wording web search, was undertaken to collect additional information on past and current activities by the faith sector to reach men with HIV services. Gray literature, such as PEPFAR – UNAIDS Faith Initiative reports and conference abstracts, in particular from International AIDS Conferences (2018, 2020, 2022 and 2024) provided useful data and models. This was completed by a targeted search in FBOs websites, as well as in websites of organizations funding faith initiatives on HIV and AIDS. Additionally, FBO service delivery and demand creation models which have shown promise and demonstrated success in increasing men's uptake of HIV services through faith-based structures *(14,15,16,17,18,19)* were analyzed and incorporated into this report. Extensive exchanges were conducted with developers and implementers of these FBO models, as well as with non-faith organizations that collaborate with them. These discussions provided valuable insights into the implementation, challenges, and successes of these interventions, further enriching the analysis and considerations presented in this document. Regular exchanges with a WHO steering groups and members of the Global Men HIV Technical Working Group (MENHT) allowed for the refinement of this document, further enhancing the relevance of improving ways to strategically engage with the faith sector to increase men's access to HIV services through faith-based platforms. Most of the experiences and examples shared here are based in Sub Saharan Africa.

Findings

This document highlights how faith platforms and faith community-based approaches can address some barriers that hinder men's engagement with HIV testing, treatment, and care, thanks to the scale and scope of their health care provision *(20),* their relationship capital, the trust within communities, and understanding of local cultures and practices that affect health *(21).* The findings in this document serve to highlight and document faith-based approaches and are not intended as an endorsement of any specific approach but rather serve to demonstrate and document various practices and strategies. Whilst some of the studies, findings and results are observational and report based, they may provide significant indication and show promise towards effectively delivering services to men.

From the earliest days of the HIV epidemic, FBOs were among the first to provide care to people living with and affected by HIV, largely contributing to the initial response of the crisis. Today, across sub-Saharan Africa, they remain the largest non-governmental provider of health services *(22).* In many cases, FBOs' deep-rooted connections within communities, combined with their ability to mobilize support and build trust, allow them to conduct targeted outreach and reduce the stigma associated with HIV. In most regions, especially in Africa, where up to 75% of the population regularly attends religious services *(23)*, faith leaders are valuable partners in fostering community support through a compassionate, faith-based lens. Their influence on cultural norms and policies enables them, when educated and supported *(24)*, to shape a more inclusive response to HIV, especially for men who may be hesitant to access traditional health services. By leveraging their unique structures, FBOs can navigate local dynamics and foster trust, making them effective in reaching men who face significant barriers to care. Their capacity to address both the physical and emotional dimensions of health in a culturally sensitive manner calls upon global and national health actors to recognize faith-based health platforms, which are typically locally led, as strategic partners in bridging the gap in men's engagement with HIV services.

The faith-based organization models presented in this document implement a variety of WHO-recommended strategies that enhance men's uptake of HIV testing services, such as facility-based testing, community-based testing, HIV self-testing, provider-assisted referral (assisted partner notification), and social network-based approaches. Furthermore, the examples collected shows some of the core strengths of FBO interventions along five central factors:

1. **Relationship capital:** FBOs and religious leaders cultivate strong relationships within communities, using their linkages to provide holistic, comprehensive services.
2. **Trust and unhindered access:** These organizations have built a level of trust within communities that grants them unparalleled access to households, enabling them to reach priority populations.
3. **Intricate local knowledge:** FBOs may possess a deep understanding of cultural nuances and local dynamics, allowing them to tailor their interventions in ways that resonate with and effectively serve community members.
4. **Compassion and person-centered care:** A strong emphasis is placed on person-centered care and servanthood, with compassion intentionally cultivated during the onboarding of new staff and continuously reinforced through ongoing training.
5. **Care for the Carers:** Support and care for staff, whether volunteers or healthcare professionals, are central to their outcomes. The leadership of these faith-based health platforms invest time in supporting and motivating their staff.

By capitalizing on these strengths (see **figure 1**), FBOs can potentially serve as useful platforms for engaging men and other priority populations in HIV services, ensuring greater demand, uptake, and retention in care.

Fig 1. Illustrative set of contributions religious communities and faith-based organizations could make *(25)*

Contributions of religious communities and faith-based organizations		Opportunities for development partnerships and programs
History and presence	⟷	Pursue common goals with communities
Trust and influence	⟷	Advance social-behavioral change and/or messaging efforts
Access and reach	⟷	Gain access, expand reach and scale programming
Social capital	⟷	Support holistic care and approaches

Outreach event for men in Kenya © INERELA+

Summary of faith-based approaches to key interventions

The approaches presented in this document, whilst not exhaustive, demonstrate strategies for reaching men in different contexts, utilizing the influence of faith leaders, FBO's, and community engagement to overcome barriers such as stigma, limited awareness, and restricted access to services.

We highlight 6 approaches. Each of these approaches is presented with a description of their approach, key strategies and operational considerations, and specific results and/or impact, highlighting common elements and effective tactics for leveraging faith-based platforms to improve health outcomes for men.

A man accessing HIV testing services in Kenya © INERELA+

Samandar holds his 3-year-old son Nazeer at a basic health unit supported by WHO, Pakistan, 2023 © WHO / Panos Pictures / Saiyna Bashir

1. **Circle of Hope, Faith- and Community-Led Posts Model, Zambia** *(26):* A faith-based model that decentralizes HIV services to community levels, establishing posts in accessible locations such as markets, transport hubs, and churches or mosques, and using local community health workers and religious leaders to increase case identification and retention in HIV treatment.

2. **Eastern Deanery AIDS Relief Programme, Kenya** *(27):* A Catholic organization that engages faith leaders in promoting HIV self-testing and linkage to care, using community outreach, person-centered services, and robust follow-up mechanisms to maintain high engagement and performance.

3. **Faith and Community Initiative** *(19):* A PEPFAR-led program aimed at reaching men and children leveraging faith structures, including increasing HIV testing services uptake by training religious leaders, expanding testing efforts, and reducing stigma in communities.

4. **Healthy Beginning Initiative (Baby Shower Model), Nigeria** *(28):* An evidence-based intervention that uses culturally tailored approaches, such as church-organized baby showers and follow-up events in places of worship, to increase HIV testing among pregnant women and their male partners, utilizing faith settings to foster male engagement.

5. **Testing Campaigns in Places of Worship, South Africa** *(29):* Collaborative efforts between Anova Health Institute *(30)* and INERELA+ *(31)* to harness the influence of religious leaders to promote HIV testing and care, particularly targeting men, gay men, and other men who have sex with men utilizing church-based campaigns.

6. **The Luke Commission, Eswatini** *(32):* A comprehensive healthcare model that provides integrated services through mobile outreach and faith leader engagement, reaching men in rural and isolated communities and creating male-friendly, stigma-free spaces for prevention and care.

1. Circle of Hope, Faith- and Community-Led Posts model

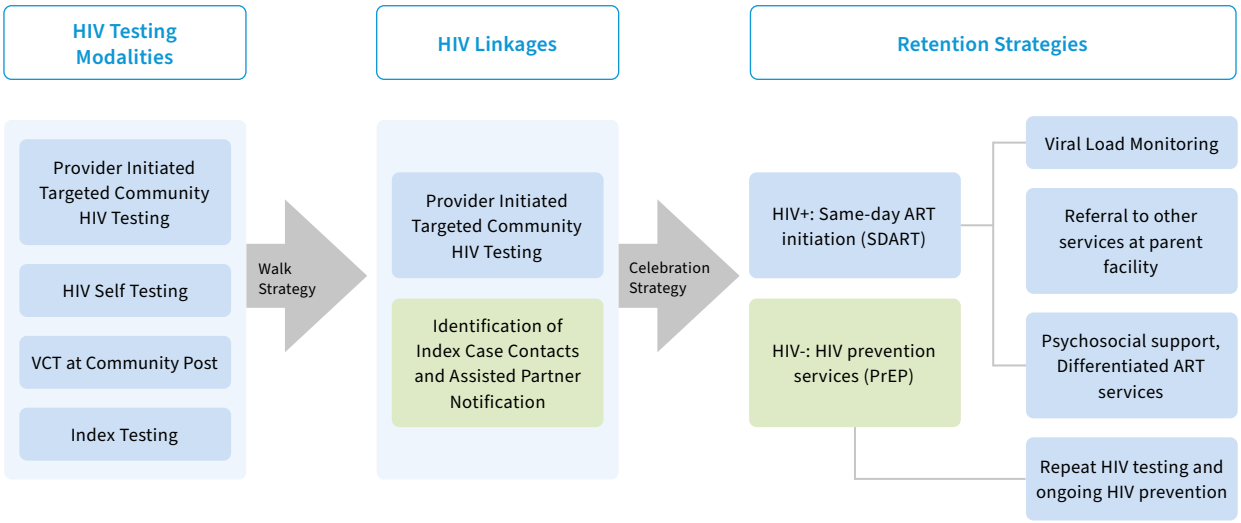
Description

Circle of Hope (COH) *(33)* is an FBO with a holistic family-centered approach to address the intersecting challenges of poverty, HIV and AIDS, and other social issues affecting people and families in Zambia. COH's focus on providing comprehensive HIV testing, treatment, and prevention services, home-based care, support for orphans and vulnerable children, and income-generating initiatives. Recognizing a gap in HIV testing and treatment access, COH developed the Faith- and Community-Led Posts (CPs) to decentralize HIV services to community levels, particularly in underserved areas, making it easier for people to access care. CP is a person-centered, community-based intervention effective to increase men's access to HIV services by addressing common barriers such as long wait times, stigma, and the need for privacy. The CP Model leverages trusted faith and community leaders to deliver holistic, stigma-free services conveniently located near where people live and work. This culturally tailored approach positions unbranded CPs in accessible, high-traffic areas, allowing men to receive care without compromising work commitments or privacy.

This approach has provided services to specific populations, including men, adolescents, and children, and has excelled in improving HIV case identification. Additionally, the model integrates other health services, such as cervical cancer screening, voluntary medical male circumcision, STI screening and management, noncommunicable disease screening and referrals, among others.

The COH Faith-and-Community-led Post (CHP) model increases case identification and retention in HIV treatment by establishing static ART community health posts in collaboration with local faith leaders. These posts are strategically located in accessible areas such as markets, bus stops, churches and mosques, reducing barriers like transportation costs and long wait times. By engaging local Community Health Workers (CHWs) and religious leaders, and by providing continuous staff training including through the use of training modules (see **figure 2, 3** and **4**), CPs ensure personalized care and fosters strong relationships between healthcare providers and the communities they serve. Evidence-informed case identification strategies include provider-initiated testing and counseling, and the application of the Social Network Strategy. This Strategy leverages trusted relationships within social networks to promote HIV testing. CHWs develop strategies, distributing self-test kits through faith leaders and local leadership to encourage testing among targeted people. People who test positive are connected to care including index care for their close networks while those who test negative and need care and follow up are counseled to retest after three months, and preventive messages on PrEP and safe sex practices, including condom use are shared. Data from the CP model in Zambia shows successful notification and same-day testing for approximately 50% of index case contacts. Through these demand creation and case identification approaches, the model creates a pool of individuals willing to access HIV testing services. While most testing occurs in the community, HIV testing services (HTS) are also available at the community post.

Fig 2. CRS, Community Posts training Module *(34)*



A display of supportive advocacy materials © INERELA+

Core Elements of CPs success in reaching men with HIV services

Overcoming Personal Stigma: This begins with staff accepting and embodying core spiritual principles, such as love and forgiveness, and practicing self-leadership. This self-acceptance enables them to deploy the RECIPE values in their interactions with clients.

Index Characteristics: Gathering information on client attributes (e.g., sex, language, marital status, employment) to ensure the best-suited CHW or counselor interacts with the client. This characterization helps with both the initial interaction and the partner notification process.

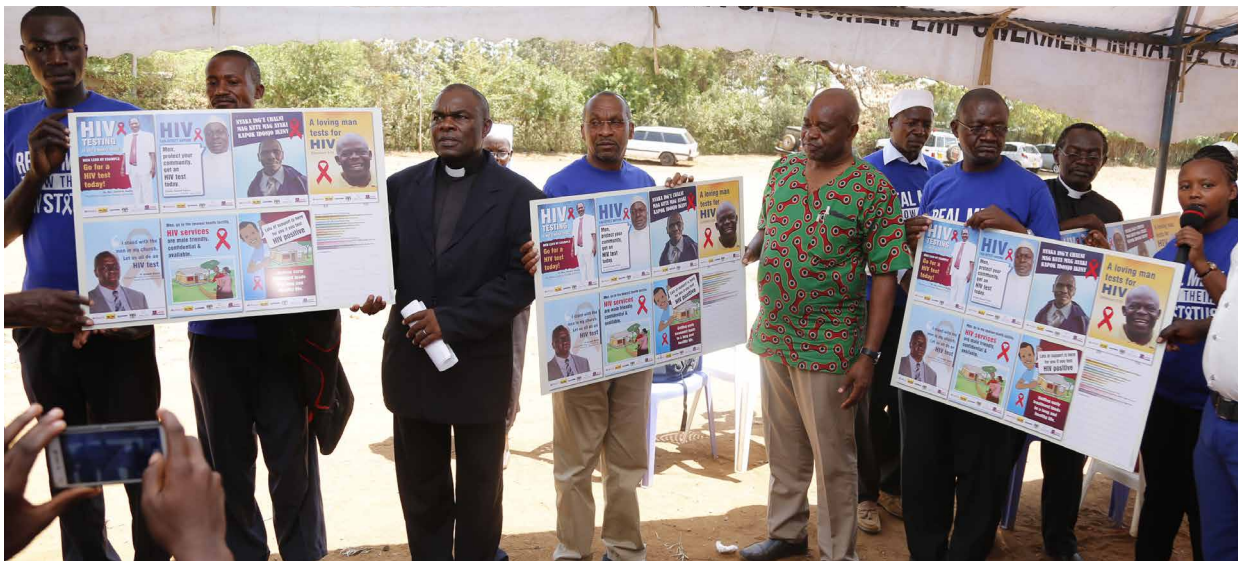
The Walk Strategy: By physically walking clients to the CP, CHWs can build rapport and discuss sensitive information like sexual partners. This is also a time to connect emotionally, socially, and spiritually, creating trust. The Walk Strategy for Index testing is the primary source of HIV testing services for the CP model, followed by targeted community testing. This strategy focuses on identifying, testing, and treating people living with HIV in the community. CHWs and PSS Counselors conduct HIV tests and gather contact information for index cases. The "Walk Strategy" involves CHWs accompanying people who test positive to the CP for confirmatory testing and same-day ART initiation. During this walk, CHWs bond with clients and collect information on additional contacts, aiming to test an index case's sexual contacts or family members on the same day. CP staff are trained in enhanced probing skills and the RECIPE core values - Responsibility, Empathy, Compassion, Integrity, Passion, Ethical - to provide holistic care and counsel clients sensitively.

The Celebration Strategy: Upon arrival at the CP, clients are welcomed warmly by the CP team, reinforcing the trust built during the walk and setting the stage for effective care and voluntary partner services including index testing, provider-assisted referral or partner notification. The Celebration Welcome Strategy is a customer-centered approach crucial at COP for promoting HIV services. The CP model uses the "Celebration Welcome Strategy" to create a warm and welcoming environment, with staff greeting clients with smiles, handshakes, and refreshments when possible. Positive experiences are key to generating word-of-mouth referrals, encouraging index cases to refer their families and communities. Staff use emotional intelligence to profile clients and handle partner notifications delicately, ensuring a comfortable and supportive experience.

The CP location promotes and facilitates access to services for men in several ways:

Strategic Location: CPs are in areas where men usually work or congregate during the day, such as markets, bus stops, taxi ranks, and places where wheelbarrow pushers wait for jobs. These locations minimize both time and cost for men to reach services.

Proximity to Work: Since services are offered near workplaces, men spend little time away from work to access HIV services.

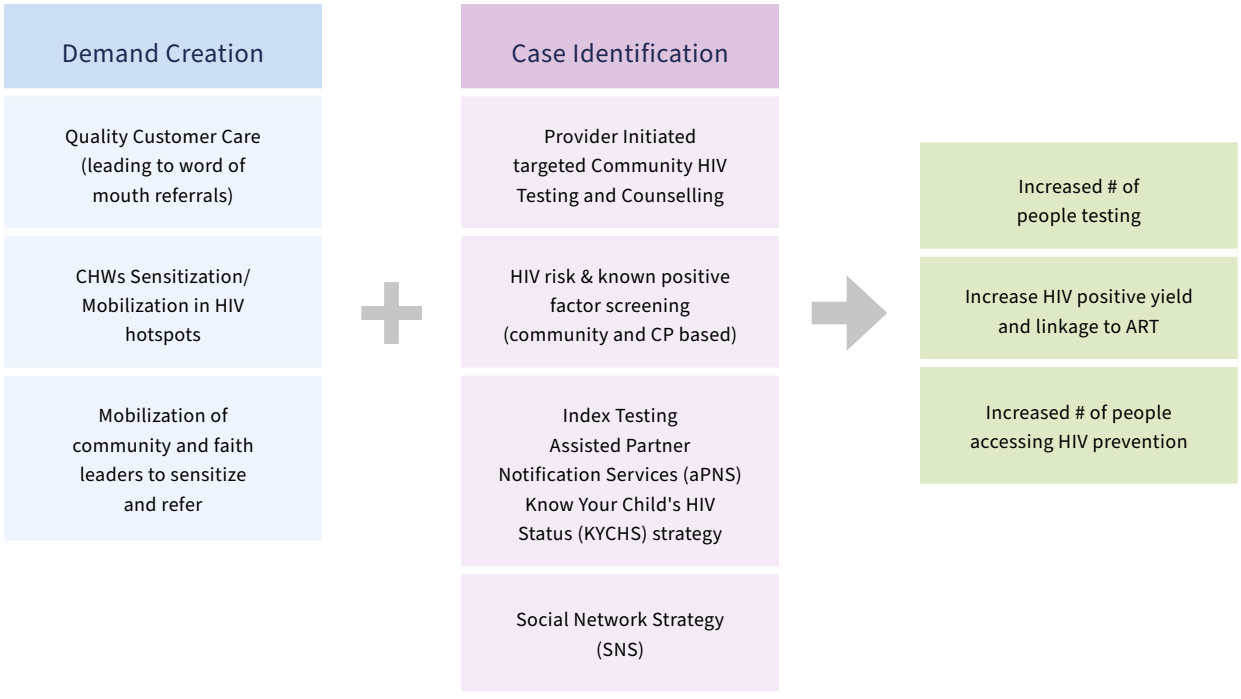


A display of communication materials for men in Kenya © INERELA+

Fig 3. CRS, Community Posts training Module: Characteristics of the CPs – Quality Customer Care and Care Service Delivery Values, the RECIPE *(34)*

Stigma-Free Access: CPs blend into their surroundings and are not marked as clinics, reducing the stigma that may come with accessing a traditional health facility.

Fig 4. CRS, Community Posts training Module *(34)*



Findings

The CP Model has shown exceptional results *(35)* in closing HIV care gaps, particularly among men, proving instrumental in identifying, enrolling, and retaining men living with HIV in treatment services, helping them maintain viral suppression even during the COVID-19 pandemic. Through the CP model, the number of men receiving ART services increased fourfold over four years, from 3,320 in 2018 to 13,579 in 2022 *(36)*. The model also demonstrated strong performance in supporting women and children.

Figure 5 and **6** *(39)* illustrates the impact of *Faith-Engaged Community Posts* on HIV case finding, linkage, and retention in Zambia, showing a substantial increase in new HIV case identification and retention, particularly among men and children. The faith-engaged CP model has led to over a **1200% increase** in new HIV case identification. It achieved high linkage and retention in treatment for men, children, and other groups. **Figure 6**, shows a consistent increase in HIV positivity among children tested over time; and indicates high positivity among men as the program progressed. Both tables highlight a significant increase in case identification when using faith-engaged CPs.

Case identification strategies

- Index testing
- Partnering with local faith leaders to enhance community trust and engagement
- Offering testing at both fixed and mobile sites to ensure accessibility

Impact highlights

- Median new HIV case identification increased
- 700% increase among men and 670% among children
- 94% retention rate for newly diagnosed clients

Figure 7 *(40)* shows a comparison of the engagement and retention in HIV services for two groups: *Men* and *Adolescent Girls and Young Women (AGYW)*, between *Faith-Engaged Community Programs (CPs)* (blue bars) and *Non-Faith-engaged CPs* (gray bars). The percentages indicate the success rates in these groups for each type of CP.

Men: Faith-Engaged CPs achieved a 32.5% engagement/retention rate among men, significantly higher than the 9.5% rate achieved by Non-Faith-engaged CPs. The p-value for this difference is less than 0.000001, indicating a statistically significant result.

Adolescent Girls and Young Women: Faith-Engaged CPs had a 31.2% engagement/retention rate for AGYW, compared to only 7.3% for Non-Faith-engaged CPs. This difference is also statistically significant, with a p-value of less than 0.000001. The difference in results (**Figure 7**) *(40)* between faith-based and non-faith settings can be attributed to the fact that the comparison posts employ only one of the three essential components of the CP Model. The three core components, fully implemented in faith-based settings, are:

- **Location:** CPs are unbranded, small, one-room community posts that ensure privacy and accessibility.
- **Value-Based Training:** Staff are trained in the R.E.C.I.P.E. model (Responsibility, Empathy, Compassion, Integrity, Passion, Ethics), ensuring high-quality, person-centered care.
- **Faith- and Community Engagement:** Local, trusted faith leaders actively participate in identifying individuals in need of HIV testing and support within the community.

In addition, from October 2021 through September 2022, Zimbabwe Association of Church-related Hospitals *(41)* implemented the same model. ZACH Faith-engaged CPs advanced closing gaps, compeered to PEPFAR-supported non-faith engaged HIV care and treatment sites for men (17.7% vs 12.1% testing positivity, p-value of less than 0.0000001) *(42)*. Overall VLS was 95% *(42).* This comprehensive approach in faith-based settings significantly enhances the effectiveness of outreach, testing, and linkage to care.

This model demonstrates the effectiveness of involving faith communities and local leaders in HIV services to overcome barriers, improve linkage to care, and retain clients in treatment, potentially contributing to broader epidemic control efforts.

Fig 5. Faith-Engaged Community Posts Expand HIV Case Finding, Treatment and Viral Load Suppression Among Men in Zambia in the Context of COVID 19, April 2018 -March 2022 *(37)*

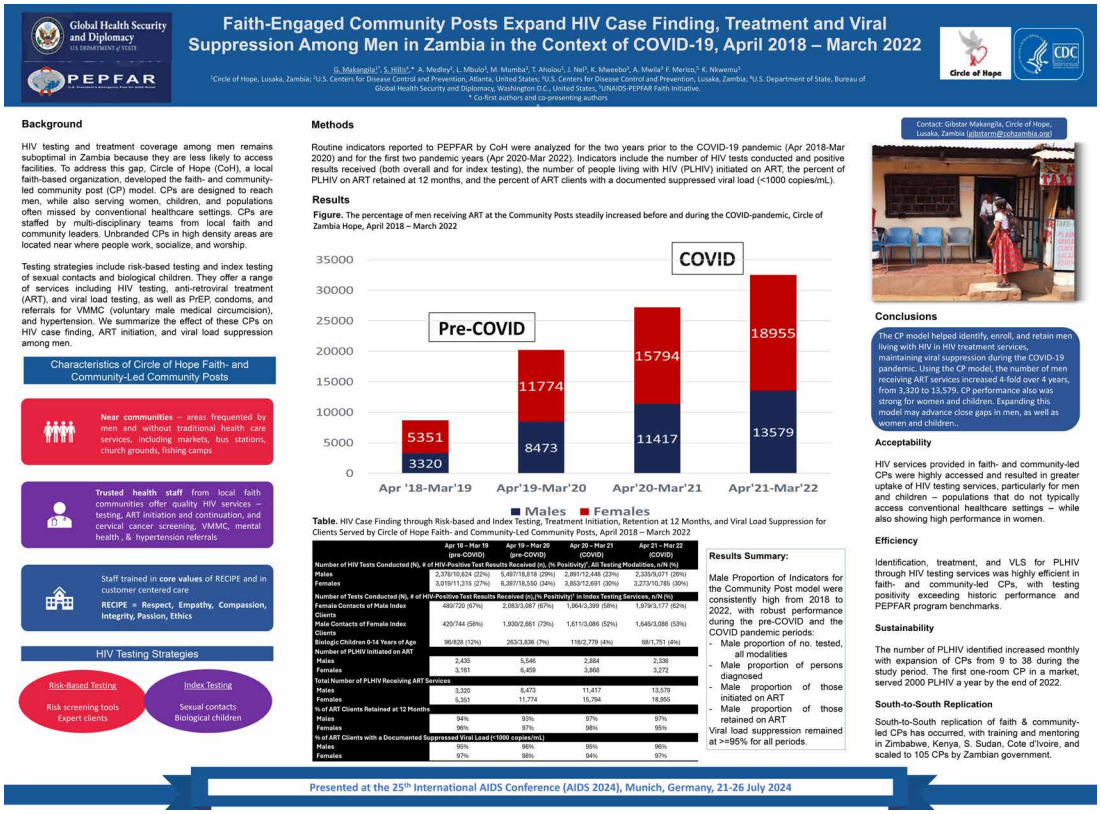


Fig 6. Faith-Engaged Community Posts Associated with Over 1200% Increase in New HIV-Case Ascertainment, with High Linkage and Retention, Zambia *(38)*

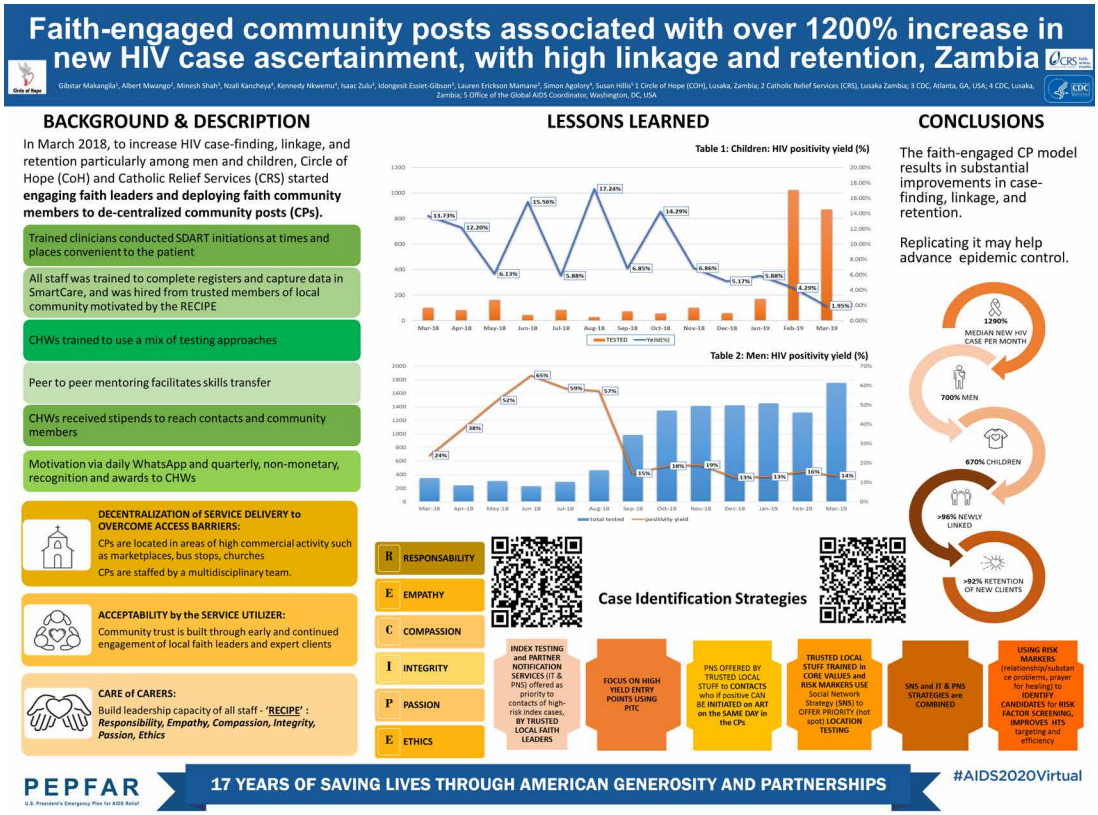
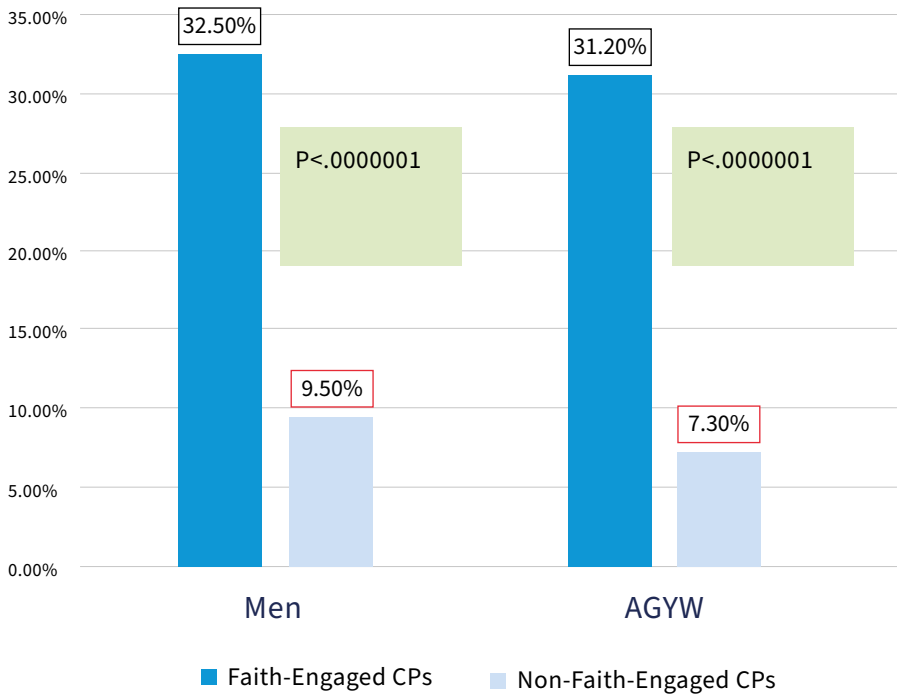


Fig 7. HIV Positivity for Faith- and Community-Led Community Posts vs Government CPs, Zambia *(42)*



Key elements of the Faith- and Community-Led Posts for reaching men

- **Decentralized Service Delivery:** Community Posts are strategically placed in locations where men live, work, worship, and socialize, such as markets, bus stops, and churches. This reduces travel time and transportation costs, making services more accessible.
- **Targeted Testing in Hotspots:** By focusing on known hotspots, the model enables targeted HIV testing that reaches men who may not visit traditional health facilities.
- **Collaboration with Local CHWs and RLs:** The integration of community and faith leaders helps build trust and encourages men to engage with health services, overcoming traditional social barriers. Local CHWs familiar with the community and its dynamics provide culturally sensitive and trusted care, encouraging men to seek testing and treatment. Faith and community leaders trained as volunteer outreach workers provide HIV testing, counseling, and linkage to care, using social network-based testing strategies to reach individuals.
- **Reduced Stigma and Access Barriers:** The proximity of services to men's daily environments, along with efforts to reduce stigma through community engagement and sensitization, helps foster a more accepting atmosphere for men to seek care.
- **Flexibility and Integration of Services:** The integration of other health services like cervical cancer screening and Voluntary Medical Male Circumcision provides an entry point for men to access broader health care while receiving HIV testing and counseling.
- **Person-Centered Service Delivery:** Through the R.E.C.I.P.E. model (Responsibility, Empathy, Compassion, Integrity, Passion, Ethics), CP staff ensure that clients receive respectful, compassionate, and confidential care.
- **Data-Driven Retention Strategies:** Continuous monitoring through data collection helps reach men who have been lost to follow-up, allowing for targeted re-engagement efforts.

Operational considerations

- **Resource Requirements:** Although CPs rely on volunteer-led efforts, they also require support for training, logistics, and small stipends for community leaders. Using existing health system resources and community networks helps minimize costs.
- **Community Engagement:** Success relies heavily on the involvement of local leaders who have trust and influence within the community. Ensuring that leaders are involved in site selection, implementation, and ongoing training enhances community buy-in.
- **Monitoring and Evaluation:** CPs collect data on key metrics such as HIV case-finding, linkage to ART, and viral suppression. Quarterly community feedback sessions and periodic customer care assessments ensure alignment with community needs.
- **Scalability and Adaptation:** The CP Model has demonstrated scalability within Zambia and adaptability across different countries. Key factors for scale-up include multi-sector collaboration, standardized training, and South-to-South capacity-building support.

Future Directions

As the CP Model continues to expand, plans are in place to incorporate additional health services, engage Muslim and other non-Christian faith communities, and provide targeted services for adolescents through Youth-Centric CPs. The ongoing commitment to African-led solutions promises sustainable improvements in HIV care access for men and families across sub-Saharan Africa.

The faith- and community-led community posts' model has been successfully replicated through South-to-South initiatives in Zimbabwe, Kenya, Côte d'Ivoire, and South Sudan.

Community outreach event in Kenya © INERELA+

2. Eastern Deanery AIDS relief programme

Description

Eastern Deanery AIDS Relief Programme (EDARP) is a Catholic faith-based organization, which operates across the eastern slums of Nairobi, running 14 sites and serving approximately 29,000 people living with HIV, from the general population and key population groups. In 2018, observing a decline in new HIV case finding, the Eastern Deanery AIDS Relief Programme launched the *Faith-Engaged Highly Targeted HIV-Self-Testing in Urban Settlements Programme* to address this gap *(43)*. Through this Programme, EDARP trained all staff, health workers, and community health workers, many of whom were faith leaders, in targeted HIV self-testing, in collaboration with the Ministry of Health. The programme provided highly targeted dissemination of HIVST kits during home visits and in community settings, with a strong emphasis on person-centered partner notification services and seamless linkage to care. Each HIVST distributed was meticulously tracked and documented to ensure follow-up and support for all participants (see **figure 8**).

Findings *(39)*

After launching the program, EDARP saw a 117% increase in new HIV diagnoses among men and a 134% increase among women between May and October 2019, compared to the previous six months. Similar increases were noted in the number of individuals newly linked to treatment (See **Figure 9**) *(39).*

The testing yield for men increased from 1.2% (294 out of 22,429) to 2.8% (604 out of 21,703), and for women, from 1.7% (491 out of 28,952) to 4.1% (1,169 out of 28,321), both with statistically significant improvements ($p < 0.0001$) (**Figure 10**, AIDS2020) *(44).*

The program's success continued even during the active community transmission of COVID-19, with new case ascertainment and yield doubling. The model's comprehensive system for high linkage at the faith and community sites was key to maintaining this impact. Each HIVST kit distributed was tracked and documented to ensure accompaniment and follow-up, enhancing the model's effectiveness in linking people to care.

The targeted dissemination of HIV self-testing kits through faith leaders and community health workers by EDARP has substantially increased case-finding and linkage to care in Nairobi's urban settlements. The model's success, even amidst the challenges of COVID-19, demonstrates its potential for expansion both within and beyond Kenya to support global efforts toward epidemic control. EDARP's approach of engaging faith leaders and integrating community and clinical services proved highly effective. Key lessons included the importance of comprehensive training for CHWs and staff, the use of person-centered partner notification services, and a robust system for tracking and follow-up. Additionally, creating a supportive environment and providing emotional and spiritual support to staff helped maintain high engagement and performance.

Key elements of EDARP's faith-based approach in reaching men and operational considerations

- **Faith-Driven Community Engagement:** EDARP leveraged the trust and influence of faith leaders in Nairobi's eastern slums to drive HIV self-testing efforts. By training religious leaders in HIV and HIV self-testing, EDARP was able to engage men who might otherwise resist traditional health services. This culturally sensitive approach, rooted in community values, ensured greater acceptance and participation in HIV testing initiatives.
- **Spiritual Support Integrated with Health Services:** Recognizing the importance of addressing both physical and spiritual needs, EDARP integrated spiritual support with health services. This contributed a more holistic and welcoming environment for HIV testing and care.

Fig 8. Outcomes of the Eastern Deanery AIDS Relief's Programme: *Faith-Engaged Highly Targeted HIV-Self-Testing in Urban Settlements.* Poster presented at the International AIDS Conference 2020 *(45)*

Outcomes

Increased New Diagnoses and Linkages to Care

Improved Testing Yield

Sustained Impact During COVID-19

Comprehensive Follow-Up System

Fig 9. EDARP, Testing to Treatment Cascade 2028 – 2019 *(46)*

Increases in HIV-Positive Tests and New Linkages to Treatment (Disaggregated by Sex) Before and After the Distribution of HIV Self-Tests by Faith Leaders in Nairobi, Kenya (November 2018-October 2019)

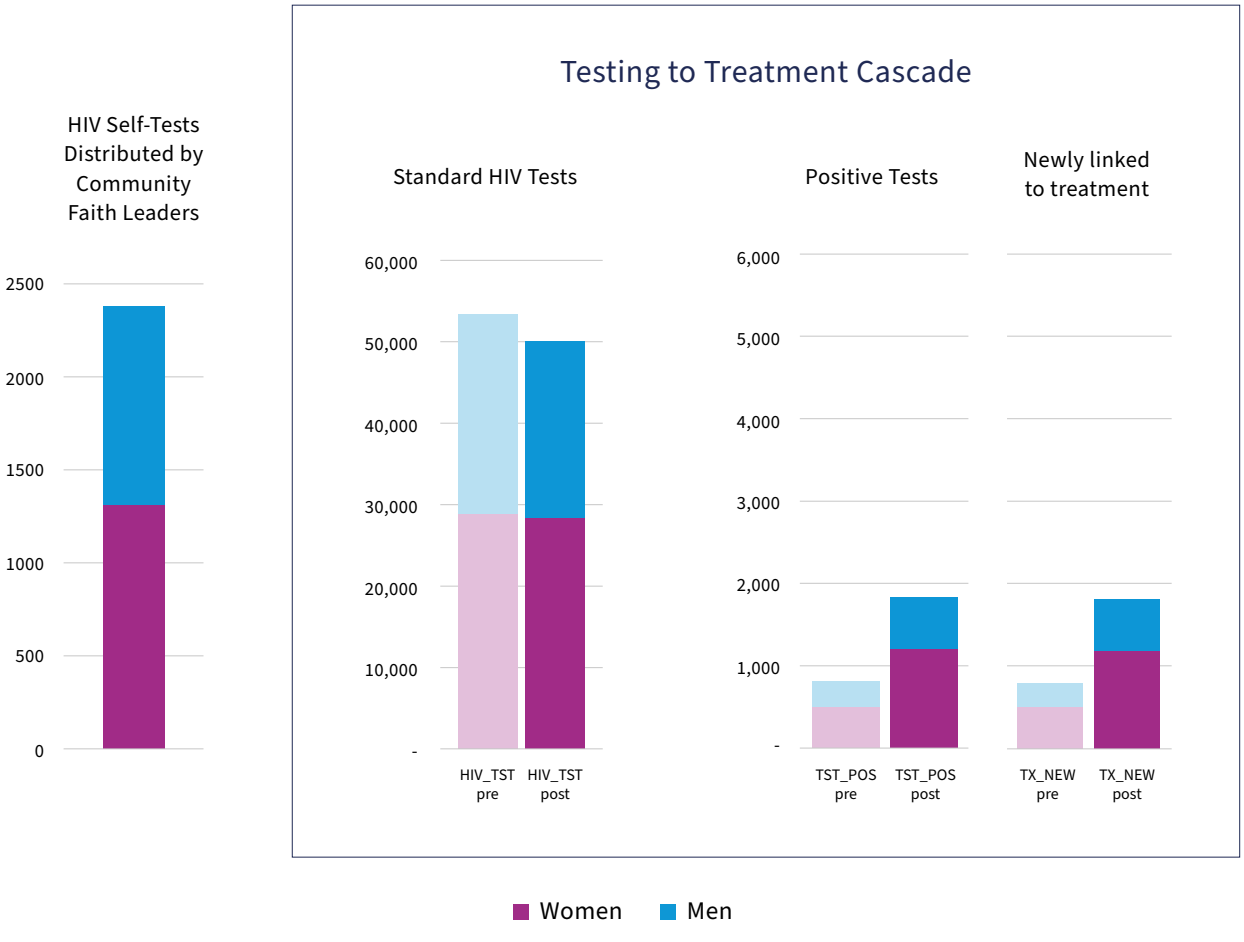
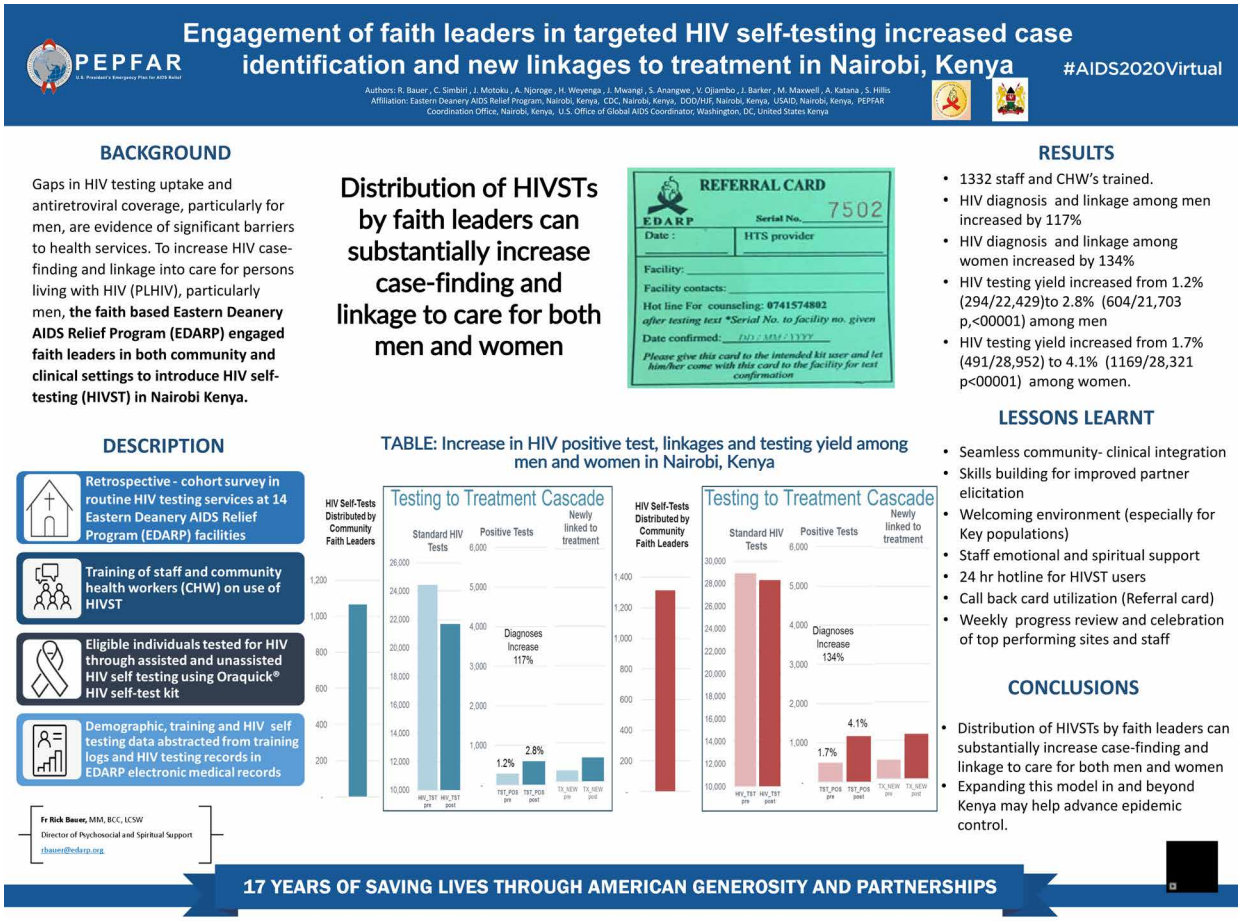


Fig 10. Engagement of Faith Leaders in Targeted HIV-self testing Increased Case Identification and New Linkage to Treatment in Nairobi, EDARP Kenya, AIDS 2020, Poster *(47)*



Faith leaders provided continuous emotional and spiritual support to people diagnosed with HIV, helping them cope and adhere to treatment. This support network was crucial in maintaining engagement in care and fostering a sense of community solidarity.

- **Faith-Based Messaging to Reduce Stigma:** EDARP crafted its messaging to align with faith-based values, using sermons, community gatherings, and faith group meetings to promote HIV testing and reduce stigma. By framing the conversation around compassion, love, and community responsibility, EDARP created a supportive environment for men living with and affected by HIV. Churches and faith centers were used as safe spaces for discussing health concerns, including HIV. These familiar settings helped men feel more comfortable accessing testing and care services, reducing barriers to engagement.
- **Support for Staff Wellbeing:** Provide continuous support to staff to maintain high morale, engagement, and performance, which is essential for long-term program success. EDARP built strong, trust-based partnerships with staff, that facilitated deeper community engagement. This approach bridged the gap between health services and individuals who were previously lagging behind in the AIDS response.

It is important to note that FBOs highlight the challenge of limited access to HIVST kits, which constrains their ability to effectively reach and support their communities.

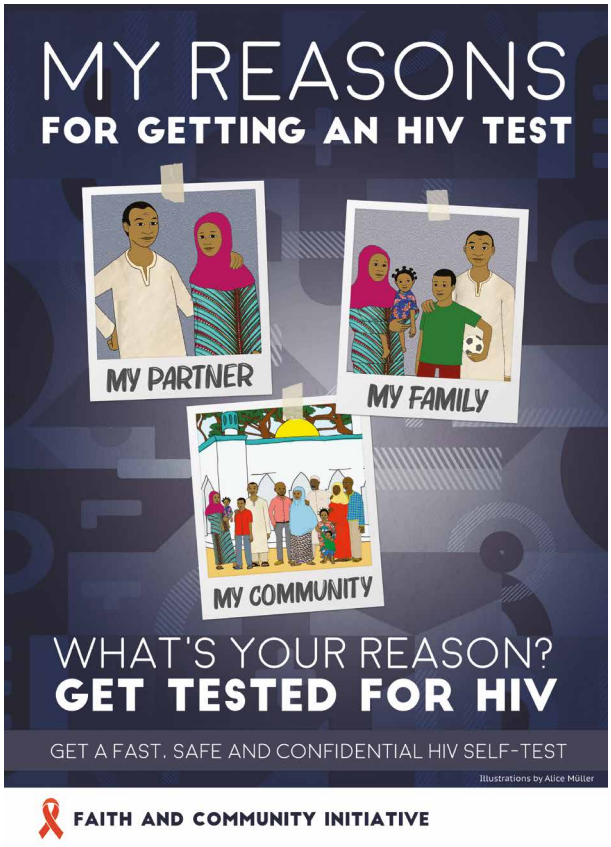
3. Faith and community initiative

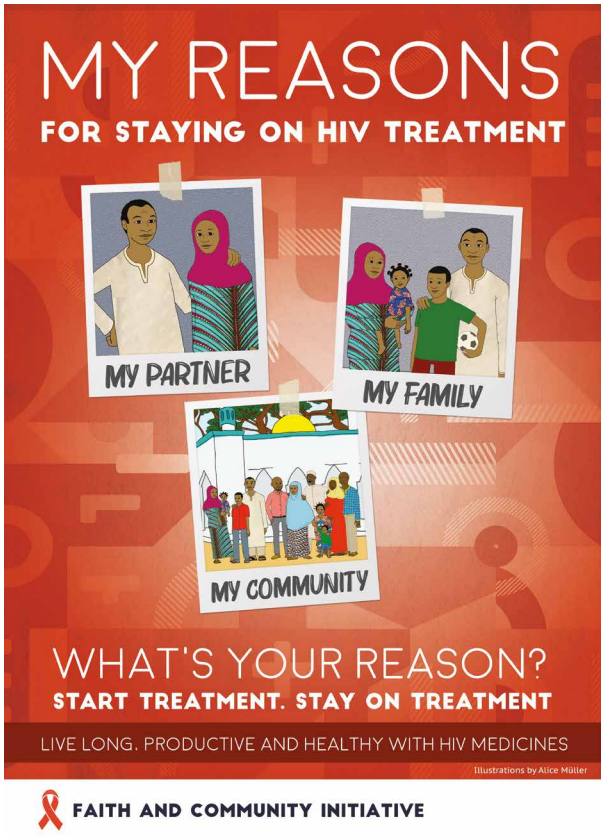
Description

Launched in 2018 and continuing through 2020, PEPFAR's Faith and Community Initiative (FCI) *(48)* addresses gaps in identifying men and children with HIV by increasing demand for HIV testing services. The FCI *(49)* focused on enhancing the uptake of optimized testing, differentiated service delivery, viral suppression, and biomedical prevention interventions such as PrEP and VMMC. This was achieved by partnering with faith communities and religious leaders to strengthen community engagement and outreach, and by leveraging faith-based structures and reach.

The FCI consists of three key activities. 1.Training Leaders and Disseminating Messages of Hope. This activity involved training RLs and disseminating HIV awareness messages through faith-based and community structures *(50)*; 2. Expanding Optimized HIV Testing and Improving Linkage to Care for men and children. The FCI promoted targeted HIV self-testing and improved linkage to treatment to ensure continuity of care. 3. Reducing Stigma and Promoting Continuity of Treatment. This activity aimed to reduce stigma around HIV, particularly in communities where faith healing is the primary approach, by fostering greater acceptance of medical treatments and supporting continuity of care (see **figure 11**).

Fig 11. FCI supporting tools for demand creation in places of worship: Guide for Muslim and Christian Religious Leaders on HIV; Posters; Messages; Hajj calendar *(51)*





NEW CHOICES.
NEW TREATMENT.
NEW TIMING.
NEW *HOPE.*

A Guide for Faith Leaders and faith communities to bridge the gaps in HIV testing, treatment, care and support for men and children.

FAITH AND COMMUNITY INITIATIVE

TRUSTED FAITH LEADERS CAN TAKE INNOVATIONS AND SOLUTIONS TO THEIR COMMUNITIES, TO ADDRESS THE CORE GAPS IN HIV TESTING AND TREATMENT

STRATEGIES TO ENGAGE MEN

The following strategies have been effective in addressing barriers that keep men from accessing HIV diagnosis and cares:

- Deliver messages of hope!
- Integrate HIV with other health care services
- Offer accompaniment and support
- Offer choices in testing

- Offer support groups for HIV-affected individuals
- Remove gender inequality, stigma and discrimination
- Engage faith leaders to encourage couple's and family testing

HIV SELF TESTING

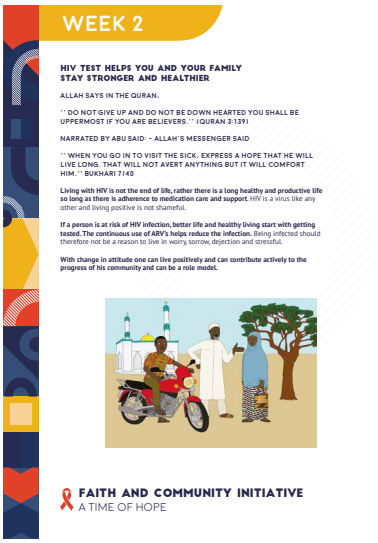
Many men avoid HIV testing because:

- Fear of discrimination, and
- Concerns about confidentiality

HIV self-testing is safe, accurate, and easy to use!

> Now, in many countries, there are tests called self-tests, that people can take in the **privacy of their own homes.**

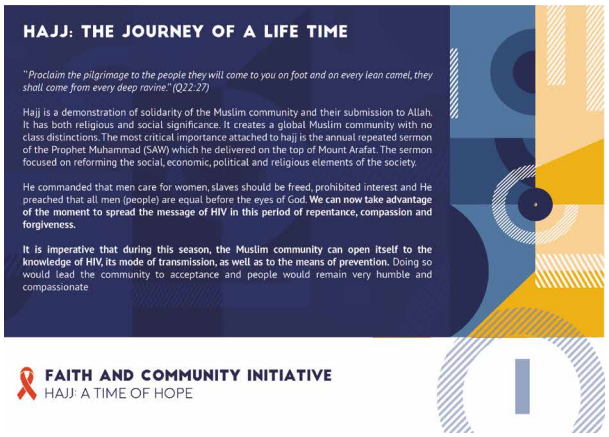
FAITH AND COMMUNITY INITIATIVE

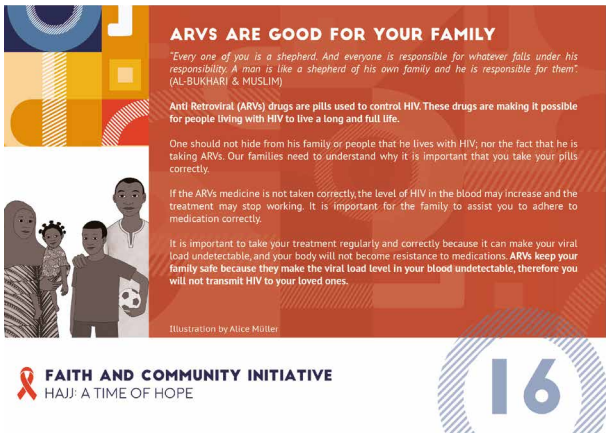


HAJJ: A TIME OF HOPE

A DEVOTIONAL RESOURCE WITH MESSAGES OF HOPE
FOR EACH DAY OF HAJJ

FAITH AND COMMUNITY INITIATIVE





Findings *(52)*

Strengthened Partnerships Between Faith and Health Sectors: The initiative strengthened collaborations between religious leaders and health facilities, improving community referrals and overall access to HIV services (*52).*

Broad Reach Across PEPFAR Countries: Initially implemented in 10 high-burden countries, the FCI models have expanded beyond these 10 to other PEPFAR countries, supporting the goals of the MenStar initiative.

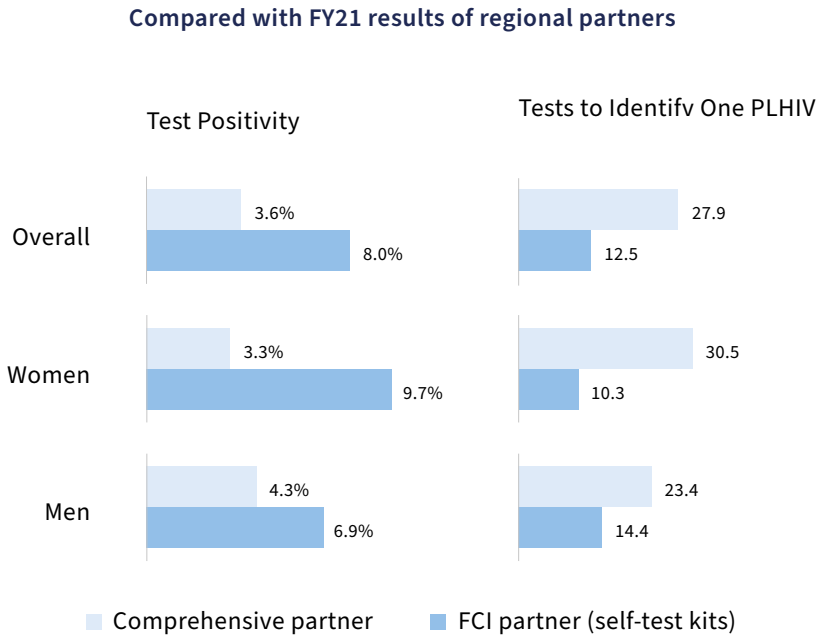
- In Eswatini, close to 42,000 congregants received *Messages of Hope*, emphasizing new options for testing, same-day services, updated treatments, and renewed optimism through the *Undetectable = Untransmittable* message. A rapid increase in PrEP uptake followed its introduction as a preventive tool for the general population and its integration into comprehensive care services *(19).*
- In Botswana, partners re-fined their FCI strategy including faith leaders providing one-on-one support, leading to a five-fold increase in yield (4% to 20%) *(19).*
- In Malawi *(53),* FCI achieved significant successes, effectively disseminating *Messages of Hope* to 1,669 congregants through faith leaders, 30,411 community members via community-based organizations, and nearly 40,000 people through mass media campaigns conducted by eight media organizations across the country. From October 2020 to March 2022, the initiative surpassed its initial targets, reaching 139.5% of the HIV testing goal, 145.5% of the new treatment goal, and achieving a 96% linkage to antiretroviral therapy (ART). In efforts to reduce stigma and improve adherence to medical treatment among those influenced by faith healing, the project targeted religious leaders and people living with HIV in five districts. It successfully returned 12,139 people living with HIV to care, including 1,148 who had left care due to faith healing, and returned 613 of them to care. Overall, the project reintegrated 7,099 people living with HIV (58% of the total) back into care. Additionally, 1,833 faith leaders were trained using the World Council of Churches Adherence Manual *(54)* and the Voices Against Stigma initiative, reaching a total of 21,687 people through their efforts.
- In Uganda, FCI has harnessed the vast social capital of FBS including through targeted distribution of HIV Self-Test kits by faith leaders. This strategy has shown to aid identification of missing HIV cases among men *(55).* The *Uganda Protestant Medical Bureau (56),* through extensive training and mobilization efforts, empowered faith leaders and community structures to promote HIV self-testing, thereby reaching individuals who might otherwise be inaccessible through traditional healthcare channels. From April to September 2021, FCI mobilized and sensitized 794 faith leaders who, in turn, counseled and screened tens of thousands of community members. This mobilization led to an increase in HIV case-finding, particularly in regions like Mubende (see **figure 12**).

Key outcomes demonstrated the efficacy of FCI's faith-based model:

- **Higher Test Positivity *(57)*:**
  - **Overall Test Positivity:** Faith community partners achieved an 8.0% test positivity, surpassing the 1.6% rate of other regional partners. This difference suggests that the FCI model may be more effective in reaching individuals who are less likely to be diagnosed through traditional means.
  - **Women:** Among women, FCI partners saw a 9.7% positivity, in contrast to the 3.1% rate from other partners.
  - **Men:** For men, FCI's test positivity reached 6.9%, higher than the 4.3% identified by comprehensive partners. This improvement highlights the potential of FCI approaches to address gender-specific testing barriers.
- **Efficient Case Identification *(58)*:** FCI partners required fewer tests to identify one person living with HIV, illustrating the efficiency of community-driven self-testing approaches:
  - For the **overall population**, FCI required 12.5 tests to identify one PLHIV, fewer than the 27.9 tests needed by other partners.
  - Among **women**, the FCI model required 10.3 tests compared to 30.5 tests by regional partners.
  - For **men**, FCI needed 14.4 tests per identification, a substantial improvement from the 23.4 tests needed by other partners.

These results underscore the potential of faith communities to bridge public health gaps, enabling cost-effective and scalable HIV case-finding interventions. FCI's model not only leverages trusted community networks but also aligns with Uganda's broader health system goals by working alongside government and medical institutions to strengthen linkage to treatment and care. By fostering trust and accessibility, the Uganda Faith and Community Initiative has demonstrated the value of community-driven solutions in achieving national and global HIV targets.

Fig 12. Uganda FCI, HIV Case Finding in Mubende, Faith Community Partners Leverage Social Capital to Close Gaps, Higher HIV-Self Test Yield at Lower Costs for All *(55)*



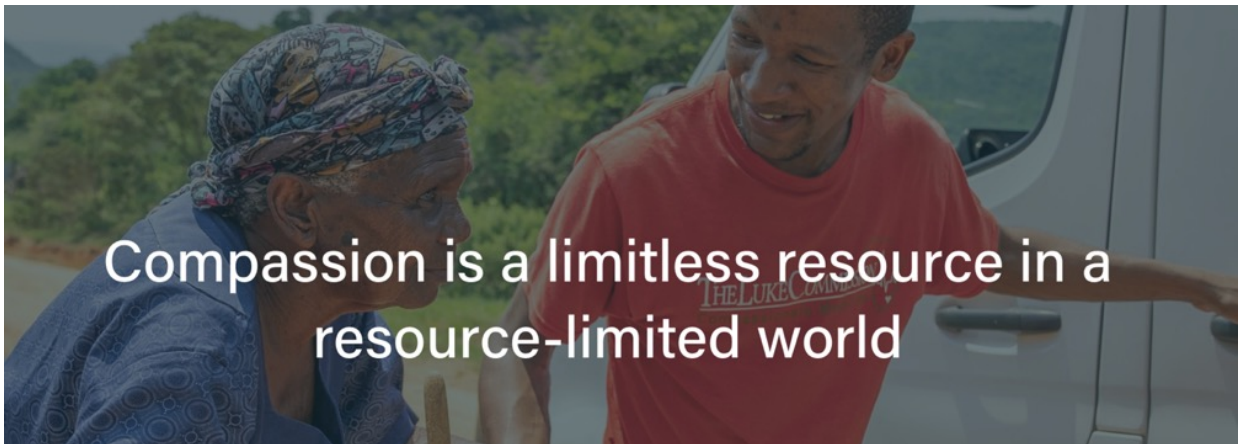
Key elements of the FCI approach in reaching men and operational considerations

- Establishing “safe spaces” and “health windows” within faith settings provided men with comfortable and familiar environments for health discussions and testing. This approach addressed men’s hesitancy to engage with healthcare services by integrating them into familiar community activities. FCI engaged faith leaders, including pastors, catechists, and community health workers, as trusted figures who could effectively reach men in the community. Faith leaders used sermons, announcements, and gatherings specific to men, such as the Men’s Guild meetings, to promote HIV awareness and testing, reducing stigma and creating a supportive environment.
- FCI implemented HIV self-testing, allowing men to take control of their health in a private and dignified manner. This approach empowered men who may be reluctant or unable to visit healthcare facilities or face stigma in testing settings. Self-testing was often assisted by trained faith leaders or health workers to support linkage to confirmatory testing and treatment if necessary.
- FCI utilized faith community radio programs, WhatsApp groups, and media campaigns to reach men where they are. Messaging was tailored to resonate with men’s concerns, facilitating engagement. Local religious radio stations, DJ mentions, and other low-cost media were key in disseminating information, especially during COVID-19 lockdowns.
- FCI involved male peer counselors and lay leaders who could relate to the men they were reaching, creating a sense of shared experience and reducing barriers to engagement. Peer-led counseling and guidance encouraged men to seek testing and treatment, showing the effectiveness of relatable role models in healthcare outreach.
- Ensure consistent access to HIVST kits, PrEP, and VMMC resources to support community outreach effectively.
- Provide ongoing training for faith leaders and community health workers to support effective HIV messaging, testing, and care.
- Adapt HIV messaging to cultural and religious contexts to promote testing acceptance.
- Involve faith leaders in stigma-reduction efforts, especially in communities influenced by faith-only-healing.
- Strengthen referral systems between health facilities and faith communities, and vice versa, for better linkage to care.
- Coordinate with national health ministries for scaling successful FCI practices in new contexts.
- Refine strategies based on outcomes, as seen in Botswana's adaptations.
- Support efforts to reconnect with people who have fallen out of care, following the model in Malawi.

4. The Luke Commission

Description

Since 2005, The Luke Commission (TLC) provides free, comprehensive healthcare to Eswatini's most isolated and underserved communities, in a country with the highest HIV prevalence in the world. Through its Miracle Campus and a vast mobile outreach network, TLC covers over 300,000 visits annually, offering compassionate care, digital health solutions, and leadership development with a local staff of over 700. Reaching all four regions of Eswatini, TLC brings healthcare to homes, churches, schools, and community centers. People living with HIV needing care move through various service stations, tracked via a scannable token in a custom electronic medical record system. Routine screenings, including blood pressure, blood sugar, and HIV testing, inform treatment plans, with immediate counseling and antiretroviral therapy offered to people who test positive (see **figure 13**).



Providing compassionate care © The Luke Commission

Findings

Fig 13. Progress in HIV prevention and treatment efforts among men in Eswatini *(60)*

Indicator	Instructions	FY24Q1	FY24Q2	FY24Q3	FY24Q4
Same day initiation rate	% Males 20-49 initiated on ART same day as testing HIV positive	77%	72%	91%	50%
HIV Positivity	Number of males 20-49 testing positive divided by number of males 20-49 who tested	4.89%	3.11%	3.17%	2.03%
PrEP Uptake	Number of men 20-49 initiating PrEP	215	300	210	489
PrEP Retention - ED PrEP	Percent of males 20-49 initiated on ED-PrEP who came for 1 month refill	7%	9%	10%	6%
PrEP Retention - Daily PrEP	Percent of males 20-49 initiated on Daily PrEP who came for 1 month refill	7%	3%	5%	2%

Data source: The Luke Commission. The data (source, The Luke Commission, September 2024) reflect both progress and challenges in HIV prevention and treatment efforts among males aged 20-49, with limited financial support influencing several key outcomes *(60)*.

Key elements of TLC's approach in reaching men and operational considerations

TLC's model addresses the barriers to reaching men by providing accessible, compassionate, and non-stigmatizing services that reach men where they are and integrate seamlessly into wider health services (see **figure 14**). This model, combined with training and partnership with faith leaders, enhances trust and encourages men's engagement in HIV care. Key Elements of TLC's Approach in Reaching Men include:

- **Comprehensive Care Model and Integrated Service Delivery:** TLC integrates a wide range of health services, alongside conducting health services such as blood pressure and blood sugar checks, avoiding labeling or stigmatizing spaces that might deter men from seeking testing or treatment, making HIV care less stigmatized and more accessible.
- **Mobile Health Services:** By taking healthcare to homes, churches, schools, and community centers across Eswatini, TLC eliminates the need for men to visit formal health facilities, which can be intimidating, costly or inconvenient.
- **Male-Friendly Spaces:** Offering male-friendly environments, including the option to choose male healthcare workers and providing small incentives like Wi-Fi vouchers, encourages men to engage with health services.
- **Faith Leader Engagement:** TLC trains faith leaders from various communities to use faith platforms to build trust and disseminate evidence-based health information . These leaders are trained in practical, sustainable community settings over one to three days. HIV 101 is introduced at every training, covering HIV prevention, testing, self-testing kits, PrEP, PEP, and antiretroviral treatment. This strategy allows TLC to extend its impact beyond its facilities, empowering faith leaders to support HIV care in their communities.
- **Person Centered Approach:** Treating all persons as important and addressing emotional or past negative healthcare experiences ensures men feel valued and respected when seeking care. In every interaction, TLC considers what brought the person to the facility, offering additional services alongside addressing their primary healthcare needs. This comprehensive model includes over 45 essential services, enabling TLC to deliver prevention, care, and treatment holistically. The comprehensive person-centered approach is especially effective in identifying people with advanced HIV.
- **Compassion at the core of The Luke Commission's culture:** Compassion is at the heart of every aspect of its operations, with staff trained to treat every person like family, with dignity and care. Guided by the motto "Every Last One," no person is turned away, regardless of condition. Through a strong emphasis on person centred care and servanthood, compassion is cultivated during the onboarding of new staff and reinforced through ongoing training. Each staff member is guided by core values of seeking solutions, and promoting unity. New employees undergo a 10-week, full-time onboarding experience called *Base Camp*, where they learn the importance of compassion in support and care. Healthcare at TLC is seen as a joy and privilege, with staff embodying values of love, service, and respect. The staff's humility and spiritual dedication are evident in the everyday practice, from worship music filling the wards to prayers offering emotional support, creating an environment where healthcare is deeply intertwined with faith and community.

Fig 14. TLC solutions to address key challenges to reaching men: Elements of Tender Loving Care *(62)*

Challenges to Reaching Men	TLC's Solutions	TLC Success Enablers Elements of Tender Loving Care
Men reluctant to seek services	• Male-friendly spaces, including Wi-Fi voucher • Choice of male HCW • Comprehensive medical services available 24/7	Compassionate Care: Every person is treated as a father, mother, brother, sister or child Comprehensive care: Begin with what motivated the person to come for services, then connect to a platform of more than 45 essential services Committed care: Unify care through secure, digital platforms to maximize efficiency and effectiveness
Men sense they are a burden or carry emotional wounds from mistreatment at other health facilities	• Refer to all persons as important persons • Integrate feedback into every clinic visit to quickly address any lapses in compassionate service delivery	
Low uptake of preventative services	• Integrate preventative services into comprehensive platform • Provide additional counseling for preventative services	
Men reluctant to enter a space labeled with name of medical service	• Integrated approach (no ART department or HIV testing room) • HIV testing conducted alongside vitals, NCD screening, other testing) • ART, PrEP, and other chronic services all conducted in the same space	

Addressing emotional or past negative healthcare experiences ensures men feelvalued and respected when seeking care © The Luke Commission

5. The Healthy Beginning Initiative – The Baby Shower model

Description

The Healthy Beginning Initiative *(63)*, also known as the Baby Shower model, is an evidence-based, faith community-driven intervention aimed at increasing HIV testing among pregnant women and their male partners *(64)*. First implemented in Nigeria as a randomized control trial in Enugu State, the program was then piloted programmatically by Caritas Nigeria in Benue State. Following its success, it was scaled up and is now being implemented nationwide by CDC-DGHT-supported partners. HBI is a sustainable, culturally tailored program led by trained lay health workers embedded within the faith community. The HCWs collaborate with trained religious leaders to identify pregnant women, provide health interventions, and facilitate access to healthcare services for women and their families. The Baby Shower Toolkit *(65)* guides the implementation of this model.

The initiative operates through three key moments (see **figure 15**):

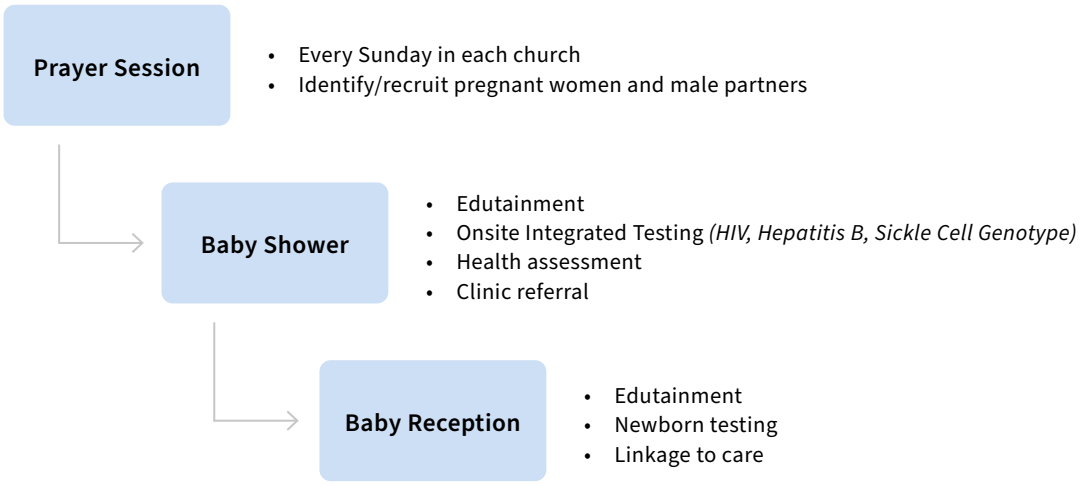
1. **Sunday prayer sessions** during church services, which are used to identify pregnant women and their male partners. During the Sunday service, the priest invites pregnant women and their partners to approach the altar to pray for a healthy pregnancy and successful delivery. Then, he encourages pregnant women to seek antenatal care at a health facility.
2. **Baby showers:** pregnant women and their partners are invited to church-organized *baby showers,* during which trained lay health workers offer health education, counseling and free onsite integrated laboratory screening for HIV, hepatitis B virus, and sickle cell genotype. Health assessments such as weight, height, and blood pressure are also carried out. This strategy replaced the HIV-only testing approach which can lead to stigma. Participating couples receive a "Mama Pack" *(67),* which includes essentials for a hospital or home birth, and immediate postnatal periods.
3. **Baby receptions** are held 6–8 weeks after birth. They allow for post-delivery follow-up and enhance referral for early infant diagnosis for HIV-exposed infants. Additionally, missed male partners who are not present during the baby showers are offered HIV testing during the baby receptions. Caritas Nigeria program staff ensured HBI participants who tested positive for HIV received appropriate HIV prevention, treatment, and care services through referrals to health facilities within the state.

Findings

Studies *(63)* on this initiative conducted in Nigeria have shown improvements in HIV case-finding and linkage among pregnant women, and improved case-finding among their male partners. Male partners of pregnant women living with HIV who participated in HBI had an HIV seropositivity approximately nine times higher than the general male study population. This approach illustrates how faith settings can be important allies in targeted testing resulting in increased uptake of HIV testing by reaching male partners of pregnant women living with HIV who may otherwise not be reached in a healthcare setting (e.g., ANC).

Figure 16 *(67)* and **17** *(70)* shows that: 10,056 pregnant women and 6,187 male partners participated in Baby Shower events between 2016 and 2017 in Benue State; 61.5% of women attended with a male partner; Nearly half of female participants (n = 4515, 44.9%) were not enrolled in ANC for the current pregnancy; 22.3% (n = 2,241) of female and 24.8% (n = 1,532) of male participants reported they had never been tested for HIV; Over 99% (n = 16,240) of participants had their HIV status ascertained, with 7.2% of females (n = 724) and 4.0% of males (n = 249) testing HIV+; 2.9% of females (n = 274) and 2.3% of males (n = 138) receiving new HIV-positive diagnoses and 93.0% (673/724) were linked to ART.

Fig 15. The Baby Shower Framework, Ezeanoloue et al. (2013). Implementation Science *(66)*



Ezeanolue et al. (2013). Implementation Science.

Fig 16. Baby Shower Initiative: Participants at Baby Shower Events, including a prayer ceremony, group education, music, gifting of a "mama pack" with safe delivery supplies, and HIV testing with ART linkage support for pregnant women living with HIV, were conducted in eighty sites in Benue State, Nigeria, between July 2016 and October 2017 *(68)*

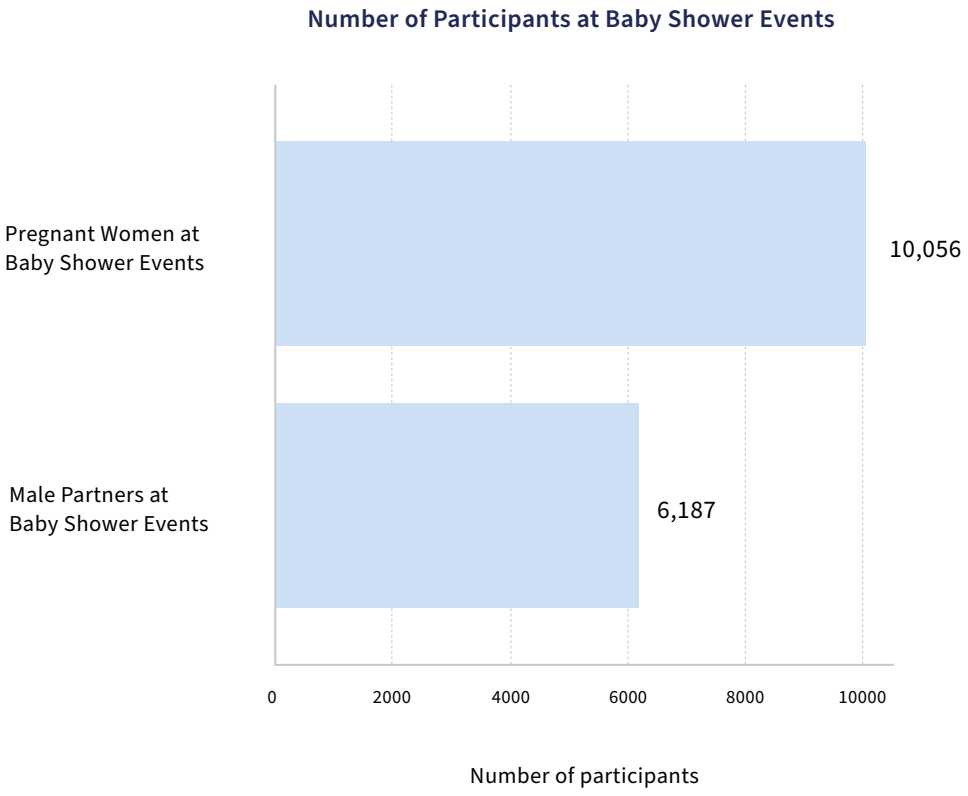
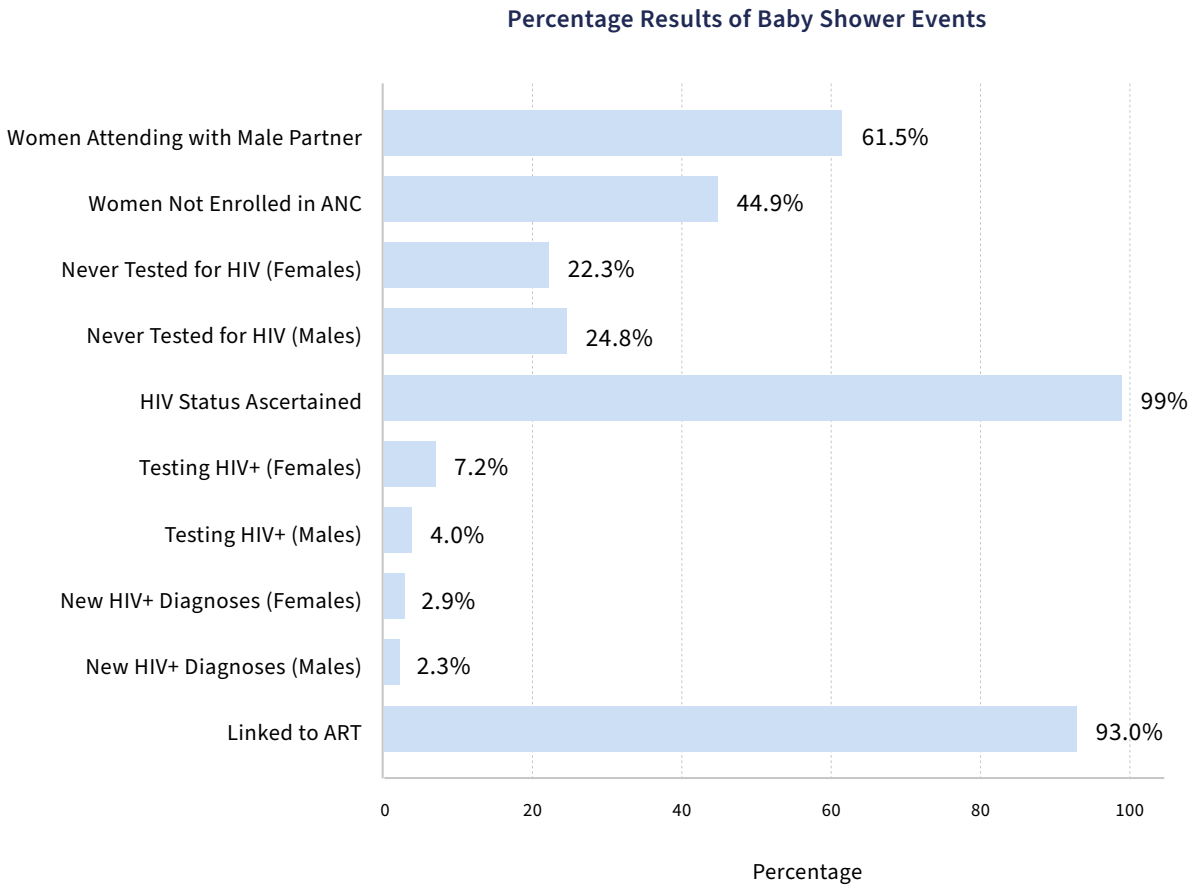


Fig 17. Baby Shower Initiative, Percentage Results, Benue State, Nigeria, between July 2016 and October 2017 *(69)*



Partner services at work © INERELA+

Key elements of the Healthy Beginning Initiative in reaching men

HBI addresses the barriers that hinder access to men's uptake of HIV services by offering a faith-integrated, culturally sensitive, and non-stigmatizing platform that encourages male engagement in HIV services, particularly by reaching male partners of pregnant women.

- **Faith-Based Setting:** By embedding HIV testing within religious services, such as Sunday prayers and baby showers, HBI leverages trusted faith environments to reach male partners of pregnant women. This approach minimizes stigma and encourages male participation. HBI engages religious leaders early in the planning process to gain their support and ensure that the intervention aligns with the faith community's values and practices. Regular meetings and training for these leaders are essential.
- **Culturally Adapted Engagement:** The initiative uses culturally familiar practices, such as prayers and baby showers, to naturally integrate health education, counseling, and HIV testing. These gatherings create welcoming environments that reduce the focus on HIV testing alone, fostering broader health awareness.
- **Comprehensive Screening:** HBI replaced HIV-only testing with integrated health screenings (HIV, hepatitis B, sickle cell, etc.), reducing stigma while encouraging comprehensive care for both men and women.
- **Male Partner Testing:** HBI successfully increases male partner HIV testing by targeting male partners of pregnant women, often through faith community-organized events like baby receptions, which also facilitate early infant HIV diagnosis.
- **Sustainable Lay Worker Model:** The initiative trains lay health workers from within the faith community to deliver health interventions and link families to health services, fostering sustainability and trust within the community.
- **Follow-Up and Continuity:** HBI continues to engage men after their child's birth through follow-up services, ensuring that men who missed testing earlier are provided with opportunities during baby receptions.

Operational considerations

These interventions, already implemented in Nigeria through the support of CDC, can be strengthen with:

- Clear referral pathways with local health facilities to ensure that participants who test positive for HIV or other conditions receive appropriate care and follow-up.
- Engage community members, especially men, to promote the initiative, share testimonials, and act as champions for male engagement in HIV services.
- Develop robust monitoring and evaluation systems to track participation, HIV case-finding, linkage to care, and other health outcomes.
- Establish clear protocols for maintaining confidentiality and privacy and emphasize the broader health benefits of the intervention (e.g., testing for hepatitis B, sickle cell, etc.) to further reduce the stigma associated with HIV testing.
- A structured follow-up plan for continued engagement of both male and female participants after childbirth, including repeat testing opportunities and access to other health services, must be in place.
- Create men support groups or peer networks within the faith community to maintain engagement and provide ongoing encouragement for men living with HIV and their families.

6. Testing campaigns in places of worship

Description

Testing campaigns in places of worship can be a good way of reaching men in high-burden settings or areas with low coverage of HIV testing services. These faith-based events have the potential to promote the linkage to prevention, treatment, care, and support, while simultaneously addressing HIV-related stigma and discrimination.

An example of these interventions is the partnership *(71)* between the Anova Health Institute *(30)* and the International Network of Religious Leaders Living with or Affected by HIV and AIDS in South Africa *(71)*. Through a three-phase intervention involving 47 churches, the partnership harnessed the influence of religious leaders to integrate health information into their sermons and encourage HIV testing among male congregants, including gay men and men who have sex with men. Over three years, Anova managed HTS and linkage to care, while INERELA+ mobilized and trained RLs to increase HTS uptake and connect male church members to necessary care and support. This partnership demonstrated the power of collaboration with faith-based initiatives to bridge the gap in HIV testing and care among men.

Portrait of a grandfather who receives regular home visits from a family nurse based at Rudaki District Primary Health Centre, Tajikistan, 2023
© WHO / Mukhsin Abidzhanov

Findings

- The program saw a total of 1,971 people attend church services on designated HTS campaign days, with 555 men (28%) and 1,416 women (72%) participating *(71).*
- The uptake of HIV testing was 52% among men, significantly higher than the 40% among women, highlighting the program's effectiveness in reaching men ($P < 0.001$) *(72).*
- A substantial proportion of men (35%) who tested during the intervention were first-time testers, underscoring the approach's success in reaching men who had previously not accessed HIV services *(73).*
- The overall testing yield was similar for both men and women, demonstrating the approach's effectiveness in identifying new HIV infections.
- By integrating these elements, the partnership effectively reached men and addressed HIV-related stigma and discrimination, demonstrating the potential for faith-based interventions to close the HIV testing gap among men.

Another example of Testing Campaign mobilizing RLs and places of worship is the *Leading by Examples: Religious Leaders and HIV Testing Campaign* of the World Council of Churches *(74).* From December 2016 to January 2019, WCC-EAA launched the interfaith *Campaign Leading by Example: Religious Leaders and HIV Testing*, leveraging the influence of RLs to address barriers to HIV testing, by setting a personal example of being tested to demonstrate that having an HIV test is not a statement on morality, but a health practice that people should adopt. In addition, the RLs utilized their religious facilities, spaces, services and reach, and the media, to increase HIV awareness and to foster demand creation for testing and to facilitate post-test linkage to on-going treatment, care and support. Testing events in churches and mosques were help as part of the intervention. RLs noted a positive increase in the numbers of persons seeking HIV testing and linkage to appropriate treatment, care and support. A better understanding of HIV testing services and their importance was also reported. Most RLs experienced an increase in people seeking information on the full range of HIV issues, and HIV testing and treatment services. Improved understanding is also reflected in the substantial increase in numbers seen to be accessing HIV testing services.

INERELA+ Kenya *(75)* actively engages men to support their uptake of HIV services by leveraging the trust and collaboration of religious leaders. Over the years, INERELA+ Kenya has empowered over 2.000 religious leaders and reached more than 5 million congregants within faith communities with key messages focused on stigma reduction. The organization works through community and congregational platforms to engage, mobilize, and empower communities, using faith-based networks to advocate for a range of issues, including sexual and gender-based violence, gender justice, meaningful male engagement, pediatric HIV and TB treatment, and economic empowerment through agribusiness. By addressing these interconnected factors that contribute to vulnerability, INERELA+ Kenya aims to reduce the spread of HIV and transform communities through the faith sector *(76).*

Input session for communication materials © INERELA+

A faith leader speaking at an event for men © INERELA+

Key elements of the testing campaigns in places of worship for reaching men and operational considerations

- **Leveraging Religious Leaders' Influence:** The interventions capitalized on the influence of RLs within their congregations. By integrating health information into their sermons and using biblical references, RLs were able to create a supportive environment that encouraged men, including MSM, to participate in HIV testing services. This approach helped reduce stigma and promoted openness to HIV testing among male congregants.
- **Targeted Training for Religious Leaders and Ongoing Mentorship and Support:** Trainings were conducted to improve RLs' knowledge about HIV transmission, their communication skills on HIV topics, and their attitudes toward people living with HIV. The training also focused on enhancing their project planning skills to organize and implement HTS campaigns effectively. This training empowered RLs to speak confidently about HIV and encouraged their congregants to get tested. After initial training, RLs continued to receive mentorship from INERELA+ and Anova project staff. This sustained support helped RLs maintain their engagement in promoting HTS and addressing HIV stigma.
- **Community Engagement Through "Champions":** The recruitment of two community "champions" was a critical strategy for raising awareness about HIV testing among men. These champions worked alongside healthcare workers to actively promote testing within the local community, further strengthening the outreach efforts.
- **Church-Based HTS Campaigns:** HTS campaigns were organized at churches, where RLs actively encouraged members to participate. By embedding HTS into church activities, the intervention utilized familiar and trusted environments to reduce stigma and facilitate access to testing. This method proved effective, with 35% of men being first-time testers, demonstrating the approach's success in reaching men.
- **Addressing Stigma through Familiar Settings and Trusted Figures:** By utilizing churches as testing sites and religious leaders as advocates, the intervention reduced the stigma associated with HIV testing. The involvement of RLs in promoting HTS through sermons and church events created a sense of normalcy around testing, encouraging men to come forward without fear of judgment.
- **Integration of Faith and Health Messaging:** The use of faith-based messaging, framed within the context of religious teachings and values, helped to normalize conversations about HIV and encourage testing among men while fostering an environment of compassion and support.

Limitations

Most of the approaches submitted through the IHP survey required additional data and information. The survey received input from a diverse range of participants, including religious leaders, staff from faith-based organizations, community workers, members of non-faith NGOs, representatives from international organizations and the private sector, journalists, people living with HIV, professors, and researchers. This broad participation reflects a widespread recognition of the value and potential of the faith sector's contribution in reaching and supporting priority populations.

Several contributions could not be included in this document, due to the lack of data. Results included are from observational data, and do not account for confounding factors that may affect program results. While some of the studies, findings and results are observational and report based, they may provide significant indication and show promise towards effectively delivering services to men.

Men in their diversity was not addressed and it would be important to see good practices of how faith based platforms support men in their diversity including men from key populations.

The survey that informed the case examples used in this document were launched on the IHP, however, many of the examples were sourced through PEPFAR Faith Community Initiatives and therefore do not include the full breath of community-led faith sector interventions.

The findings reflect experiences from Sub Saharan Africa, with most of the inputs submitted in English, and only a few in French. This highlights the need to enhance outreach efforts and invest in collecting examples of faith-based interventions from a broader range of Francophone, Lusophone, and other HIV priority countries.

While there is significant potential and positive impact in faith-based collaborations, it is also important to acknowledge some of the challenges associated with faith engagement in HIV services. Despite a strong willingness to contribute and good intentions, faith-based organizations and religious leaders often face limitations in their capacity to effectively support outreach and deliver comprehensive HIV services. Several interventions highlighted through the survey, that informed this document, showed good potential but lacked adequate monitoring and evaluation systems, as well as up-to-date scientific knowledge. Additionally, well-intentioned efforts may sometimes have unintended negative consequences, such as the perpetuation of voluntary or involuntary stigma. To address these challenges, regular and sustained training and mentoring for religious leaders and FBOs, coupled with ongoing support and exchanges, is necessary for ensuring positive and effective outcomes. Finally, it was noted that many faith based models still use outdated terms that may have the unintended potential of stigmatizing people.

In the end, many faith based interventions are not well documented, these findings therefore serves only to highlight and document faith-based approaches and the potential that they hold towards effectively delivering services to men.

The use of terms like patient, high-risk and other terms still seem pervasive and conscious efforts should be made to move towards more empowering terms and in line with best practice and as supported by communities of people living with HIV.

Conclusion

The faith-based approaches outlined present several common elements that contribute to increasing the uptake of HIV services among men. These interventions build upon the unique position of faith communities and leaders to address barriers such as stigma, lack of awareness, and limited access to services.

A recurring strategy is to collaborate with faith leaders who can influence their communities. This approach helps normalize HIV testing and reduce stigma, encouraging men to participate in HIV services. Several FBO programs integrate faith-based messaging with healthcare delivery, showing that embedding health services within trusted religious settings is effective in reaching male partners who might otherwise avoid conventional health facilities. Often faith-platforms collaborate with local leaders to create demand for HIV testing through events, campaigns, and targeted messages. Mobile outreach in community hotspots, such as drinking dens, workplaces, and places of worship, further extends reach. These strategies target men in their daily environments, making it easier for them to access services without disrupting their routines.

Most faith-based models examined emphasize a holistic approach that addresses not only the physical but also the psychosocial and emotional needs of clients and some FBOs integrate these with health services, offering a welcoming, compassionate environment that fosters trust and engagement. These programs also provide additional health services, such as cervical cancer screenings and voluntary medical male circumcision, to encourage broader uptake among men. The positive outcomes reported from these interventions underscore the potential of faith-based platforms to enhance the uptake of HIV services among men.

The faith-based organization models presented in this document implement a variety of WHO-recommended approaches that enhance men's uptake of HIV testing services, such as facility- and community-based testing, HIV self-testing, provider-assisted referral (assisted partner notification), and social network-based approaches. By capitalizing on these strengths, FBOs may create a powerful platform for engaging men and other priority populations in HIV services, ensuring greater demand, uptake and retention in care.

There remains the need for more studies and data on the impact of faith-based platforms in delivering HIV services. Research could explore both tangible and intangible contributions, such as the role of trust, community relationships, and spiritual support in increasing men's uptake of HIV testing, treatment, and care.

Language influences the way we think, react, and behave. Many faith based models still use outdated terms that have the unintended potential of stigmatizing people. The use of terms like patient, high-risk and other terms still seem pervasive, and conscious efforts should be made to revise them towards more empowering terms and in line with best practice and as supported by communities of people living with HIV. Consideration for the use of person centered language can help diminish stigma and discrimination and increase support and understanding for individuals and communities living with HIV.

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Annex*

Survey Respondents: Beatrice Maina, Bearing Point Consultancy (Kenya); Brian Otieno, Alfajiri Network (Kenya); Carlin Vese Pinzi, Reaseau des Hommes Engagés pour l'Egalité de genre, RHEEG-RDC (DRC); Catherine Mwauyakufa. INERELA+ (Zimbabwe); Charles Sako, CIHEB (Kenya); Ejimole Fidelia Onwuekwe, World Youth Peace Organization (Nigeria); Hilary Muzyamba, MOE (Zambia); Ikenna Nwakamma, NINERELLA+ (Nigeria); Innocent Ntagara, Barakabaho Foundation (Rwanda); Jeffrey Haskins, Philadelphia Fight Community Health Center (USA); Jean Munongo, Caritas Congo Asbl (DRC); Dr. Joseph Kiyimba, ABA Foundation (Uganda); Loyd Brendon Norella, Pilipinas Shell Foundation, inc (Philippines); Maricel Aguilar, Dr Paulino J. Gracia Memorial Research and Medical Center (Philippines); Mduduzi B. Dlamini, Medicines Sans Frontieres (Eswatini); Sister Mila Grace Silab, SPC, Philippine Catholic HIV and AIDS Network (Philippines); Monica Namnaba, ACHAP (Kenya); Mmadou samba Dioum, Plan International (Guinea); Naomi Thompson, Caritas Nigeria (Nigeria); Randriamanantena Vololona, INERELA+ (Madagascar); Rogers Nkeh Ngwayi, GBCHS (Cameroon); Saida Mukhi, Tanzania Faith and Community for Health, TFCH (Tanzania); Tatiana Pinto, Fundaçao Ariel Glaser (Mozambique); Tobia John, NACA (Nigeria). Respondents comprised both representatives of FBOs and of other sectors collaborating with faith groups and faith leaders, mostly in demand creation activities. Survey responses included activities from 16 Countries: Burkina Faso, Cameroun, DRC, Eswatini, Guinea, Kenya, Madagascar, Mozambique, Nigeria, Philippines, Rwanda, Tanzania, Uganda, USA, Zambia, Zimbabwe.

Contributors to follow up questionnaire: Alice Njoroje, EDARP (Kenya); Amy Ostermayr, The Luke Commission (Eswatini); Andrea Uehling, EGPAF (USA); Claudia Illante, Catholic Medical Mission Board (USA); Colin Moody, The Luke Commission (Eswatini); Echo and Harry Vanderwall, The Luke Commission (Eswatini); Emily Coard, PEPFAR (USA); Francheskie Velez (PEPFAR, Zambia); Gibstar Makangila, Circle of Hope (Zambia); Rev Jane Ng'ang'a, INERELA+ (Kenya); John Motoku, EDARP (Kenya); Loyd Brendon Norella, Pilipinas Shell Foundation, inc (Philippines); Lycias Zembe, UNAIDS (Switzerland); Sister Mila Grace Silab, SPC, Philippine Catholic HIV and AIDS Network (Philippines); Fr Richard Bauer, George Washington University Institute for Spirituality and Health, School of Medicine & Health Sciences, Washington DC (USA); Susan Hillis, PEPFAR (USA); Tatiana Pinto, Fundaçao Ariel Glaser (Mozambique); Tiffiany Michelle Aholou, CDC (USA); Victor Kabwe (PEPFAR, Zambia); Vuyelwa T S.Chitimbire, Christian Health Association of Zimbabwe (Zimbabwe).

Additional Interviews/exchanges: Alice Njoroje, EDARP (Kenya); Amy Ostermayr, The Luke Commission (Eswatini); Andrea Uehling, EGPAF (USA); Claudia Illante, Catholic Medical Mission Board; Colin Moody, The Luke Commission (Eswatini); Echo and Harry Vanderwall, The Luke Commission (Eswatini); Emily Coard, PEPFAR (USA); Emily Doogue and Tom Fenn, Catholic Relief Services, CRS (USA); Gibstar Makangila, Circle of Hope (Zambia); Rev Jane Ng'ang'a, INERELA+ (Kenya); John Motoku, EDARP (Kenya); Lycias Zembe, UNAIDS (Switzerland); Manoj Kurian, World Council of Churches (Switzerland); Fr Richard Bauer, George Washington University Institute for Spirituality and Health, School of Medicine & Health Sciences, Washington DC (USA); Vuyelwa T S.Chitimbire, Christian Health Association of Zimbabwe (Zimbabwe).

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