Galvanizing Religious Leaders' Voice and Action on Stigma Reduction through HIV Prevention Research Advocacy
FOREWORD

Kenya continues to contribute to the high rates of HIV infection in the world today. This is unacceptable, from a progressive nation like Kenya. All stakeholders need to play their part in forestalling new HIV infections, so as to bring the new infections to zero.

As religious leaders, we have a call to save lives. We have a unique role in the well-being of the people we minister to every week. As we discuss the issues of faith, it is paramount that we discuss social issues that affect our congregants. If our congregations are not healthy, then our ministry to them cannot be effective.

As the Board Chair of INERELA +, I bought into the idea of the survey, with the big picture of the benefit that the outcome would have on our congregations. I therefore urge you, as fellow religious leaders, to learn about these new prevention technologies, and add them to the array of methods that we are familiar with, so as to save lives.

I commend the secretariat of INERELA+ for constantly keeping us abreast with the new information in the field of HIV and AIDS. I pledge our continued support in the process of developing an advocacy agenda and strategies that align to our faith principles to contribute to the fight against HIV and AIDS

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Board Chairman INERELA+ Kenya


ACKNOWLEDGEMENTS

We are deeply indebted to the many people who have contributed to the success of this Knowledge Attitude & Practice (KAP) Survey on new prevention technologies (NPTs) within the faith communities. We were able to visit different faith communities, key faith community leaders and groups, and to have discussions with them. We want to appreciate all the 286 people who participated in this survey, whose names we have not listed in order to maintain the anonymity that was promised at the on-set of the research. We acknowledge all of you and we have given a broad list of the groups that participated in the annex.

We wish to give special thanks to IAVI for funding this work. Without your financial support, this survey would not have been possible. Special thanks to the Board of INERELA+ Kenya and the Secretariat, who saw the worth of this survey, and put in the time and efforts to bring it to fruition. This survey will help the network and the broader faith community to advocate for better strategies around the new prevention technologies and research, and greatly contribute to the elimination of new HIV infections in our beloved Country, Kenya.

We are grateful to Ms. Catherine Theuri, the consultant who carried out this KAP Survey, developing the tools, organising the research team and putting together the report. We appreciate all the religious leaders that allowed and trusted their representatives to participate in this survey. Without your support, the respondents would not have participated in this survey.

We thank each and every one who participated in one way or another, and pray that the results and outcomes of this survey will be well worth your time and effort.

Jane Ng’ang’a

National Coordinator
INERELA+ Kenya
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ACRONYMS

AIDS                  Acquired Immune Deficiency Syndrome
ART                  Anti-Retroviral Therapy
CBO                  Community-based Organisation
FGDs                 Focus Group Discussions
HBC                  Home Based Care
HIV                  Human Immunodeficiency Virus
IAVI                 International AIDS Vaccine Initiative
IEC                  Information, Education, and Communication
IGA                  Income Generating Activities
INERELA+             International Network of Religious Leaders Living with or Personally Affected by HIV
KAIS                 Kenya AIDS Indicator Survey
KII                  Key Informant Interviews
M&E                  Monitoring and Evaluation
MOT                  Modes of Transmission
MSM                  Men who have Sex with Men
NGO                  Non-governmental Organisation
NPTs                 New Prevention Technologies
OVC                  Orphans and Vulnerable Children
PC                   Palliative Care
PEP                  Post Exposure Prophylaxis
PLHIV                People Living with HIV
PrEP                 Pre-exposure Prophylaxis
RLs                  Religious Leaders
SAQ                  Self-Administered Questionnaires
SAVE                 Safer sex practices; Access to treatment; VCT and Empowerment
SSDDIM               Stigma, Shame, Denial, Discrimination, Inaction and Mis-action
SWs                  Sex Workers
TasP                 Treatment as Prevention
TB                   Tuberculosis
UNAIDS               Joint United Nations Programme on HIV/AIDS
VCT                  Voluntary Counselling and Testing
VMMC                 Voluntary Medical Male Circumcision
EXECUTIVE SUMMARY

The negative impact of HIV continues to be felt throughout the world, with 76 million people infected with HIV and 34 million deaths as a result of AIDS since the beginning of the epidemic. Sub-Saharan Africa is hardest hit, calling for urgent interventions to avert any new HIV infections. Kenya remains among the countries that account for 89% of new HIV infections in the world, with the fourth largest epidemic in the world. In order to address this, the national AIDS response in Kenya aims at reducing new HIV infections by 75% by 2019 as stated in the Kenya AIDS Strategic Framework 2014/15-2018/19. The religious leaders and their faith communities have an opportunity to contribute to the reduction of new HIV infections in Kenya, as over 97% of Kenyans ascribe to a religious affiliation and are therefore within their reach.

The development of vaccines and other new prevention technologies (NPTs) to prevent HIV infection offers one of the best hopes for slowing down the HIV epidemic. In 2010-2011, new HIV prevention technologies began to show great promise. Several large efficacy trials recently demonstrated proof-of-concept for a HIV vaccine, microbicides, or established efficacy for pre-exposure prophylaxis, treatment-as-prevention (TasP), and Adult Voluntary Medical Male Circumcision (VMMC), and have now been added to the arsenal of prevention options. As trusted and respected leaders of influence, religious leaders can collectively, arrest HIV related stigma towards new HIV prevention technologies.

This KAP survey undertaken by INERELA+ Kenya in collaboration with IAVI. A consultant was assigned the task of data collection, report writing and providing feedback. It was undertaken in 11 of the 47 counties in Kenya and had a total of 286 participants from different faith communities. The survey applied both qualitative and quantitative methodologies of data collection and information gathering, and made use of both primary and secondary data. The data collection methods included a desk review, focus group discussions targeting PLHIV who gave their views as the recipients of the programmes and interventions in place, self-administered questionnaires and key informant interviews targeting religious leaders.

More men than women participated in the self-administered questionnaires and key informant interviews, totalling of 172 men and 72 women. This is a reflection of the gender situation in the religious leadership in this country. However, more women than men who are HIV positive, participated in the focus group discussions, reflecting the fact that there are more women in the various congregations, and there are more women living with HIV. Eighty eight per cent of those that filled the questionnaire had taken a HIV test and over 71% knew the status of their sexual partners, which is all key to the HIV prevention discussion. Over 91% of the participants claimed reasonable knowledge of HIV. Several of the participants had heard of the NPTs, but were not very familiar with the details of how they work or who they were targeted at. Microbicides were the least familiar, with under 25% of the respondents having heard of them. VMMC was the most familiar, with over 72% of the participants having good knowledge of it. There was generally a confusion between PrEP and PEP. Many of the participants were familiar with PEP, as a HIV prevention strategy for people that have been raped or in an accident, and they seemed to think it was the same as PrEP. There was also a similar confusion on HIV vaccines, with some of the participants thinking of it as any vaccine given to avert any of the side effects related to HIV. Details of the findings are given in chapter three.

There was a general feeling of inadequacy as far as knowledge on the NPTs is concerned. Both the religious leaders and the PLHIV said they were ill equipped to discuss the NPTs, and would need to be trained on them if they are to advocate for the same in their various congregations. Due to the lack of knowledge, they were not sure they would advocate for the NPTs. They however were quick to mention that the priority for HIV prevention remained abstinence for the singles and faithfulness in marriage. They were willing to learn about any other method that would save lives, so as to allow them time for evangelism. Key recommendations directly linked to the findings are given in chapter four of this report.
CHAPTER ONE: BACKGROUND AND CONTEXT

1.0 Introduction and Context

HIV and AIDS has impacted negatively on development due to morbidity and mortality, the rise in medical expenses and loss of man hours and employment. Worldwide, an estimated 76 million people have been infected with HIV, with 34 million people having died of AIDS since the beginning of the epidemic. The current estimated number of those living with HIV globally is 36.7 million people. Globally, 1.1 million people died of AIDS related deaths, with 470,000 of them being from Eastern and Southern Africa. There were 2.1 million new infections globally in 2015. Out of these, 960,000 were from Eastern and Southern Africa, accounting for about 45.7% of all the new infections. These statistics are according to the Global AIDS Update Report (2016)\(^1\) and the Political Declaration on HIV (2016)\(^2\), both by the Joint United Nations Programme on HIV and AIDS (UNAIDS).

The Kenya Health Policy 2012-2030 cites AIDS as the leading cause of death in Kenya, accounting for 29.3% of annual deaths\(^3\). The Policy gives direction to ensure significant improvement in overall health status of Kenyans in line with the country’s long term development agenda, Vision 2030, the Constitution of Kenya (2010) and global commitments.

Kenya remains among the countries that account for 89% of new HIV infections in the world, with the fourth largest epidemic in the world.\(^4\) In 2013 Kenya reported 101,560 new HIV infections, which declined to 76,000 in 2015 according to the Kenya HIV Progress report (2016), indicating some progress. Nationally, 44% of new infections in the adult population occurred within heterosexual relationships among people in unions or with regular partners, 20% through casual heterosexual contact, 14% in sex workers and their clients, 15% in prison populations and MSM, together accounting for more than 90% of the new infections. Approximately 29% of all new HIV infections in Kenya are among adolescents and youth.\(^5\)

The national AIDS response in Kenya aims at reducing new HIV infections by 75% by 2019 as expressed in the Kenya AIDS Strategic Framework 2014/15-2018/19.\(^6\) In order to reduce the HIV incidences and achieve this target, different strategies need to be employed to reach different target populations. The religious leaders and their faith communities have an opportunity to contribute to the reduction of new HIV infections in Kenya, as over 97% of Kenyans ascribe to a religious affiliation and are therefore within their reach.

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\(^1\) UNAIDS. Global AIDS Update 2016.
\(^3\) Kenya Health policy, 2012-2030, P. 4.
\(^4\) UNAIDS, World AIDS Day Report. 2014. The fast track p.100
\(^5\) Kenya Modes of Transmission Study 2008, P. 20
1.1 Problem Statement

HIV and AIDS continues to be a problem with unacceptably new infections every year. For every new person on treatment, there are 1.4 people newly infected, highlighting the need for stronger combination prevention strategies. The development of vaccines and other new prevention technologies (NPTs) to prevent HIV infection offers one of the best hopes for slowing down the HIV epidemic.

With over 97% of the Kenyan population ascribing to a religious affiliation, the faith community has a wide reach, cutting across from the national to the county and the grass root level. The place of religious leaders and the unique role they play in the society gives them an opportunity to be agents of change in shaping society’s perspectives towards these new HIV prevention technologies. As trusted and respected leaders of influence, religious leaders can, collectively, arrest HIV related stigma towards new HIV prevention technologies. By building the capacity of religious leaders living with and personally affected by HIV as ‘Heralds of Change’, we would increase their ability to address the above issues.

1.2 The Survey Objectives

The survey was carried out to identify the knowledge, attitudes and practices of religious leaders in different faith communities, in relation to the new HIV prevention technologies. This information will enable INERELA+ Kenya, in partnership with IAVI and the broader faith sector to:

i. Begin a dialogue with religious leaders on the new prevention technologies.

ii. Identify a strategy to harness and leverage on the religious leaders’ strength to reach out to the over 97% of Kenyans through the religious platform, to address the issue of new HIV infections.

iii. Prepare an advocacy agenda that is appropriate and acceptable to the faith community, on the new HIV prevention technologies that will be disseminated and used to empower religious leaders.

1.3 The New HIV Prevention Technologies

In 2010-2011, new HIV prevention technologies began to show great promise. Several large efficacy trials recently demonstrated proof-of-concept for a HIV vaccine, microbicides, or established efficacy for pre-exposure prophylaxis, treatment-as-prevention (TasP), and Adult Voluntary Medical Male Circumcision (VMMC), and have now been added to the arsenal of prevention options. The need for new tools to strengthen existing strategies for prevention,
facilitate realization of infection reduction targets and ultimately end the pandemic is of paramount importance. These breakthroughs would only influence reduction in HIV infection if there is good will, support and implementation through concerted efforts of all including religious leaders who often are key gate keepers within the communities. These new prevention technologies include:

a) Microbicides — Microbicides are compounds that can be applied inside the vagina or rectum to protect against sexually transmitted infections (STIs) including HIV. They can be formulated as gels, creams, films, or suppositories. Microbicides may or may not have spermicidal activity (contraceptive effect). The availability of microbicides would greatly empower women to protect themselves and their partners. Unlike male or female condoms, microbicides are a potential preventive option that women can easily control and do not require the cooperation, consent or even knowledge of the partner. More information on this can be obtained from http://www.avac.org/microbicides/basics.

b) Pre-exposure Prophylaxis (PrEP) for HIV prevention is a strategy that involves use of antiretroviral medications (ARVs) to reduce the risk of HIV infection in people who are HIV-negative. PrEP is highly protective in both men and women, and targets people with high rates of HIV risk behaviors. PrEP can also be used by sero-discordant couples (where one partner is HIV-positive and the other one is HIV negative individual) as a “bridge” during the period when the HIV-positive individual begins ART, or during the period when he or she chooses not to take ART. PrEP can also be used by sero-discordant couples for safer conception. More information can be obtained from http://www.avac.org/prep/basics.

c) Treatment as Prevention (TasP) is a term that describes the use of antiretroviral drugs (ARVs), for both clinical benefit for people living with HIV and the potential to significantly reduce the risk of onward transmission. In 2011, a landmark clinical trial showed that early initiation of anti-retroviral therapy (ART) for people who are HIV infected cuts the risk of HIV transmission by a stunning 96 percent. The trial provided powerful new momentum to global efforts to expand treatment access — both for the health of individuals living with HIV and for the potential to prevent millions of new infections. There is evidence from trials of sero-discordant couples (in which one person is living with HIV and the other is not) that ART for the HIV-positive partner significantly reduced the chances of onward transmission. There is also evidence that effective ART reduces women’s risk of transmitting HIV via breastfeeding; and there are a range of strategies that use ARVs

10 http://www.avac.org/prevention-option/treatment
(individual antiretroviral drugs and/or combinations) to reduce risk of HIV transmission during pregnancy and labor. More information can be found in http://www.avac.org/resource/treatment-prevention-introductory-factsheet.

d) **Voluntary Medical Male Circumcision (VMMC)** is one of the most powerful and cost-effective HIV prevention tools at hand. Studies from 2006 showed that it reduces a man’s risk of acquiring HIV from a female partner by up to 60 percent, increasing to around 75 percent over time. The primary approach to medical male circumcision is a simple surgery to remove all or part of the foreskin of the penis facilitated by a trained health professional. The term voluntary medical male circumcision differentiates circumcision that is performed by a trained health professional from traditional circumcision, which is performed as part of a religious ritual or cultural rite of passage.

It is however important to note that male circumcision provides only partial protection, and is only one element of a comprehensive HIV prevention package which includes: the provision of HIV testing and counseling services; treatment for sexually transmitted infections; the promotion of safer sex practices; the provision of male and female condoms and promotion of their correct and consistent use. *More information can be found in http://www.avac.org/vmmc/basics.*

e) **HIV Vaccines** - An effective preventive AIDS vaccine would teach the body how to prevent HIV infection. Vaccines are the most powerful public health tools available—and an AIDS vaccine would play a powerful role in ensuring the end to the AIDS epidemic. Scientists have been looking for an HIV vaccine to prevent infection in HIV-negative people for over 30 years. They have made significant discoveries about HIV, the immune system and vaccinology (the science of vaccine development), but no HIV/AIDS vaccine exists today.

Scientists are also developing therapeutic vaccines that could build immune strength in HIV-positive people to reduce their risk of getting sick, and ideally, their reliance on antiretroviral treatment. Therapeutic vaccines are also being evaluated as part of cure strategies (see [www.avac.org/cure](http://www.avac.org/cure)). This factsheet concentrates on preventive vaccines being developed for use by HIV-negative people. *More information can be found in http://www.avac.org/prevention-option/aids-vaccines.*

Evidently, there is need for the new HIV prevention technologies, to facilitate the realization of the infection reduction targets and ultimately end the pandemic. Current updates and information on the new prevention technologies would enable religious leaders better understand and cascade the same to the masses they serve.

1.4 INERELA+ Kenya

The International Network of religious leaders living with or personally affected by HIV (INERELA+) Kenya Chapter is an interfaith platform that supports the involvement of religious leaders in HIV and AIDS initiatives. Through amplification of the prophetic faith voices, the network encourages scaled up and impact oriented responses to both HIV and AIDS, and
poverty eradication at local, national and regional. The network has a membership of over 2,500 religious leaders reaching over 2 million people through congregations and community. Its secretariat is based in Nairobi.

The network, which has presence in 21 counties in Kenya, promotes collaboration of faith and development of leaders, to encourage the development and implementation of multi-sectoral, multi-dimensional and multi-level policies, theologies, programs and strategies for defeating HIV and AIDS. The network also strengthens the capacity of local congregations/faith communities to effectively respond to HIV and AIDS, through addressing its drivers among them stigma engaging adolescents within faith communities on appropriate sexual reproductive health, gender based violence (GBV), poverty, inadequate access to sexual and health rights and discrimination of sexual minorities.

The Vision of INERELA+ Kenya is to see a nation where stigma, shame, denial, discrimination, inaction and mis-action (SSDDIM) are non-existent; and where religious leaders living with or personally affected by HIV and AIDS are witnesses of hope and forces of change in their congregations and communities. INERELA+ Kenya exists to equip, empower and engage Religious Leaders Living with or Personally Affected by HIV and AIDS to live positively and openly as agents of hope and change in their faith communities and countries.

INERELA+ Kenya will use the findings of this report to begin a dialogue with religious leaders on the new prevention technologies. Together with a selected team of religious leaders, INERELA+ Kenya will prepare an appropriate advocacy agenda on new HIV prevention technologies that will be disseminated and used to empower religious leaders. The information will then be cascaded down to the grassroots.
CHAPTER TWO: APPROACH AND METHODOLOGY

This survey was undertaken by INERELA+ Kenya in collaboration with IAVI. A consultant was assigned the task of data collection, report writing and providing feedback. The approach and methodology applied in this survey was developed by the consultant with guidance from the INERELA+ Kenya management.

2.0 The Survey Scope

This survey was undertaken in 11 counties of the 47 counties in Kenya. The counties were selected from among the counties where INERELA+ Kenya members are, so as to facilitate data collection. The counties were spread out in different regions of the country, and were all among the medium and high HIV incidence counties, as detailed in Annex 1. They included, Nairobi, Machakos, Nyeri, Eldoret, Muranga, Makueni, Mombasa, Nakuru, Kajiado, Kiambu and Migori.

2.1. Data Collection Methodology and Tools

To meet the objectives of the survey, a combination of data collection methodologies and analysis were used. The survey applied both qualitative and quantitative methodologies of data collection and information gathering. It also made use of both primary and secondary data. The data collection methods included:

- **A desk review of secondary data** – A desk review was carried out to get background information on the HIV situation and the new HIV prevention technologies.

- **Key informant interviews** – Structured open-ended questionnaires were designed and used on a sample of national and congregation religious leaders from different faith communities. Fourteen key interviews were carried out.

- **Focus group discussion** – This was carried out with 42 people living with HIV (PLHIV) from different faiths. The FGDs sought to get their views on the programmes in the various faith communities targeting them, as well as their feelings about attending these programmes. Two focus group discussions with 2 groups of religious leaders – one from the Muslim faith and the other from a Christian faith were held, to get a broad view on their knowledge and attitudes of the new prevention technologies.

- **Self-administered questionnaires** – Assessing knowledge, attitudes and practice was developed and administered in the selected counties. It was administered to 230 participants. It mainly contained closed-ended questions with choices of possible answers to select from.

This survey had a total of 286 participants. It was anonymous and so the views will be presented generally in this report. The different views given will not be linked to any specific faith, agency or person.
2.3 Survey Team

The exercise was led by a consultant hired by INERELA+ Kenya through a competitive bidding process. She worked closely with the INERELA+ Kenya secretariat and the members, from the various regions.

2.4 Process

The different questionnaires mentioned above were prepared and validated. The validation sought to assess the ease of comprehension and relevance of the questions, to ensure that the correct information was collected. The questions were tested on two different groups: a group of nine (9) Christians and eleven (11) Muslims both in Nairobi, on May 5, 2016. The results from the two groups were analyzed. The questions were largely understood, but the few that were not, were adjusted to make them more comprehensible and easier to fill. Some of the questions had explanations added to them for clarity.

One question was added to the self-administered questionnaire, to check the comfort level of the respondents in disclosing their HIV status. Two questions that required a lot of writing were removed and instead added to the key informant interviews where the interviewer could probe for further explanations and get the information required. The layout of the questionnaires was also modified to make them easier to use. Once the analysis was done and the questions modified, the questionnaires were sent out to the selected regions and administered. The key informant interviews went through a similar process and were eventually administered to the selected senior religious leaders.

2.5 Strengths of the Survey

- INERELA+ Kenya has a good working relationship with many religious leaders from various faith communities. They were therefore willing and ready to participate in the survey.
- The survey was able to reach more senior religious leaders as key informants than originally targeted, from diverse religious communities.
- Most of the major religions have their head offices in Nairobi, making the key informant interviews easier to carry out.
- The survey was able to get the views of religious leaders from 11 of the 47 counties through the self-administered questionnaire.
- The survey got views from religious leaders from diverse religious communities, with the Christian and Muslim leaders forming the larger number.
- The focus group discussions reached 42 PLHIV as opposed to the original target of 15. They were from diverse faiths and so were able to give a recipients view of the knowledge, attitudes and practice in their faith communities.

2.6 Limitations of the Survey

- Due to distance and finances, it was not possible to carry out the survey in all the 42 counties in Kenya. However, 26% of the counties participated.
• KAP surveys sometimes present difficulty in ensuring an accurate interpretation of data, despite the caution taken by the researchers. The reliability of the data can be frequently impacted by underlying contextual and cultural factors, particularly when dealing with a sensitive issue such as HIV and AIDS which has moral connotations. Some of the participants opted to leave some questions blank.

• In KAP surveys, social norms and pressures may bias reporting. Most respondents for example, claimed they would reach out in love to PLHIV and sex workers. On the other hand, most of the PLHIV cited incidences of stigmatization and discrimination within their places of worship, creating divergent views.

• There was some variation of information from similar congregations, particularly between the self-administered questionnaires and the key informant interviews representing the same faith. This was probably because the researcher was able to probe for deeper insights in the key informant interviews, and therefore get a better sense of the real situation on the ground.
CHAPTER THREE: KEY FINDINGS

This section summarizes the findings elicited from the data collected using the different methods and expressed by the various survey participants. This is presented under four broad thematic headings. The socio-demographic information of the respondents, knowledge, attitudes and practice.

3.1 Social and Demographic Data of the Respondents

This information was collected for the sake of finding out the calibre of respondents that participated in the survey. Using the three different survey methods, the survey reach was as follows:

3.1.1 Gender

More men than women participated in the self-administered questionnaires and key informant interviews. This included a total of 172 men and 72 women. This could be attributed to the fact that there are more men in leadership positions than there are women.

More women however, were involved in the PLHIV FGDs. This could be attributed to various factors. There are said to be more women in the churches than men. A gender audit carried out by INERELA Kenya in 2015 revealed that over 70% of the attendees in churches are women.11 There are also more women infected by HIV. It could also be due to the fact that they happen on week days when most men are at work. Women are also said to have better health-seeking behaviour than men and so they attend support group meeting more than their male counterparts. Out of the 42 people that attended the FGDs, only three were men.

3.1.2 Leadership Positions

All the 14 participants in the Key informant interviews were in key national leadership positions. They therefore were familiar with the knowledge, attitudes and behaviours of their faith communities. They presented their views which were a reflection of the views of their faith congregations. In the self-administered questionnaires, we had the different levels of leadership represented, including the congregation-level and departmental leadership positions. They all had valuable insights from the different perspectives.

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3.1.3 Age

All the participants of the key informant interviews as well as the majority of participants for the self-administered questionnaires were over 35 years of age. Those that were under were mainly the youth leaders, Sunday school teachers and church workers. This could be attributed to the fact that people ascend into leadership positions with time and experience. About 69% of the FGD participants however, were under the age of 46.

3.1.4 Marital Status

Twelve of the 14 participants in the key informant interviews were married, and in a monogamous relationship, whereas two were in a polygamous marriage. Most of those that filled the questionnaires were married, and in a monogamous relationship, although there were some in a polygamous relationship, as some religions allow for that. They pointed out that they are expected to be faithful to their marital partners as a religious practice, and this would also help in HIV prevention. The majority of those in a marriage relationship had been married for over 10 years.
The majority (57%) of the PLHIV interviewed in the FGDs were not in a formal marital union as shown in Fig 8 below. Of those in a marital union, 14 had been married for between 1-10 years, 4 for between 11 – 20 years, and none above 21 years. This could point to the effect of HIV on marital unions, broken either as a result of issues arising or as a result of death. Seven of the 42 had been divorced with 11 widowed.

3.1.5 Education Levels

All the participants had some form of formal education. The majority of the religious leaders had secondary and post-secondary education. This means that they are literate and could read and comprehend, if information is made available to them.
The majority of the FGD participants had primary level education, which was quite the opposite of the religious leaders.

### 3.1.6 Religions & Faith Communities

Over 90% of the survey participants were from different Christian communities. There were 8.4% participants from the Muslim community, and 1.4% from other religious communities namely The Jehovah’s Witness and a Rastafarian.

#### 3.1.7 Knowledge of Individual HIV Status and that of the Sexual Partner

Eighty-eight per cent of those that filled the questionnaire had taken a HIV test. This pointed to a good practice in regards to HIV prevention among the faith leaders. All the people who participated in the FGDs knew their HIV status. Majority of those that participated in the survey had no problem disclosing their HIV status. This pointed to major milestones in overcoming stigma in the faith communities. Nonetheless, there was a 5.4% of the religious leaders that did not know their HIV status, which was a point of concern, as this is the entry point to HIV prevention and treatment.

Over 71% of the participants knew the status of their marital partner. This points to empowerment among the religious leaders. The concern however, was with the 11% who did not know the status of their spouses, posing a risk for HIV infection.
3.2 Knowledge on HIV and the New HIV Prevention Technologies (NPTs)

3.2.1 General Knowledge on HIV

This section of the study sought to find out what the respondents know about HIV prevention and related topics. Over 91% of the participants claimed reasonable knowledge of HIV, with only 9% claiming not to know much. The PLHIV in the FGDs seemed to have more general knowledge on HIV, which could be as a result of interest as they were living with the virus. What came out strongly from the self-administered questionnaires and the FGDs was the desire for more information, regularly given. Many said that HIV sensitization efforts in the country had gone down, citing the risk of Kenya’s HIV epidemic relapsing to what it used to be in the 1990s. They requested to be kept updated on the new HIV prevention methods as many of them were still only familiar with the abstinence, be faithful and condom (ABCs) strategies. A few were familiar with the ‘SAVE’ methodologies.

Most of the respondents did not have information readily available to them, but over 38% of the participants said that there was a leader or counselor in the faith community who had a little more knowledge on HIV than the rest. When this person is away, there may be little or no help available for the person seeking assistance.
3.2.2 Knowledge of a Person Living with HIV in their Congregations

Over 60% of the religious leaders said they knew someone in their congregation that was HIV positive. All the people acknowledged the need to support the PLHIV in one form or another. The suggested support included material support such as food and clothing when in need and psych-social support. They felt that the PLHIV needed to be shown love and acceptance. There was a lot of discussion on the need for stigma reduction.

3.2.3 Knowledge of the New HIV Prevention Technologies (NPTs)

Many of the survey participants said they had heard about most of these new HIV prevention technologies as shown in fig. 18 below. This was mainly through trainings and media. Many however said that they were not very familiar with the details of how most of them worked or who they were targeted at.

a. Microbicides: These seemed to be the least familiar of all the NPTs. Under 25% of the religious leaders had heard of microbicides, with 24 saying they knew of places they could refer for them. None of the FGD participants had heard of microbicides.

b. Pre-exposure Prophylaxis (PrEP): This was the most misunderstood method. Many who claimed to know about PrEP confused it for post-exposure prophylaxis (PEP), which most people were familiar with. They talked about it in relation to rape and accidents, saying...
they had recommended it to people who had gone through a rape ordeal or an accident. The 101 people that said they had HIV knowledge about PrEP may therefore not be a true picture of those that actually know about it. There were three people however who seemed to understand it as a good method for the negative partner in a discordant relationship. One person raised the issue of it being a license for people to plan to misbehave which is contrary to what the faith community advocates for. Forty nine participants said they knew of places where they could refer people for PrEP. About 14% of the FGD participants had heard of PrEP.

c. **Treatment as Prevention (TasP):** Many understood TasP basically as ARVs that are given to those that are HIV positive as a form of treatment. They however did not quite understand how that is considered a prevention method. A few understood the prevention aspect in relation to re-infection in a positive concordant relationship. Four of the religious leaders mentioned that it could protect the negative partner in a discordant relationship as the viral load would be low. Seventy-nine of them said they knew of places near their place of worship that they could refer people for the service. Forty percent of the FGD participants were aware of the TasP, and they all seemed to understand it as protection of PLHIV from re-infection.

d. **Voluntary Medical Male Circumcision (VMMC) –** VMMC seemed to be the most widely known of the new prevention technologies. Many participants said they had heard that male circumcision reduces HIV infection risk by 60%. The VMMC campaigns seem to have been well understood and widely accepted. Many of the cultures in Kenya, and one of the key religions advocate for male circumcision, and so VMMC is not a foreign concept. One of the religious groups interviewed said that they advocate for all men to be circumcised upon conversion, if they were not already circumcised. This is part of their religion. Over 72% of the survey participants had heard of VMMC, with Ninety-eight people said they knew places near their place of worship where they could refer people for the service as shown in fig. 19 below.

e. **HIV Vaccines –** This was another misunderstood NPT. Reading through the filled questionnaires, some of the participants thought that these were any vaccines given to avert any of the side effects related to HIV and not specifically a vaccine for HIV. This was despite clarifying it in the questionnaire after the pilot phase. Those that demonstrated the understanding for the same said they had heard about the research, but were not sure if it was now ready for use. Eight of the FGD participants said they had heard of the research. Those that understood it raised some pertinent questions. One asked what would happen to the HIV negative person that was exposed to the vaccine, should it fail to work. The issue of exposing people that were not infected to the virus was challenged by some as a moral issue. Some said it may prepare the minds of the recipients to engage in
behaviour that is not morally right, as the people using it would feel protected from the risk of infection.

It was clear from the responses that these new HIV prevention technologies had been disseminated somewhere, and that many of these religious leaders had heard of them, but they had not really understood them. One of the key informants stated that it was good to give information to the congregants on all the HIV prevention technologies, so that they would be able to make informed choices. It was also good to allow them to make their own choices based on their understanding of the information, so that they could take responsibility for their choices and actions and own the results/consequences.

3.2.4 Knowledge of where to seek services from

We asked the participants if they knew where to get the HIV prevention methods and technologies near their places of worship. We also asked them if they knew of a voluntary counselling and testing (VCT) place near their places of worship. The numbers were as follow in fig. 19 below.

![Fig. 19. Number of survey participants who knew where to get the NPTs near their places of worship](image_url)

It is worth noting that the PreP and HIV vaccines may not give a true representation due to the confusion explained in the earlier section.

3.2.5 Knowledge of Key Populations

Literature on HIV reveals that there are populations that are at higher risk of HIV infection because of their behaviour. These are the populations referred to as key populations. These include the sex workers and the men who have sex with men among others. We sought to find out if the religious leaders knew of any in their congregations. Most of the participants do not know a sex worker in their faith community, and even less knew of MSM in their faith communities as shown in fig. 20 and 21 below.
3.3 Attitudes of HIV Prevention and the New HIV Prevention Methods

This bit of the study sought to find out what the respondents felt about certain issues related to HIV prevention. In this section, the views of the PLHIV as collected in the focus-group discussion will be compared to the views of the religious leaders as given in the self-administered questionnaires and in the key informant interviews.

3.3.1 Attitudes towards HIV

HIV was acknowledged by all the respondents, as an issue that needed to be tackled. The respondents felt that they were affected. Some religious leaders stated that they were tired of burying people as a result of HIV related complications, and that it was important to keep people alive on earth to allow them time to evangelise and turn their hearts to God.

3.3.2 Attitudes towards PLHIV

The respondents were both sympathetic and empathetic towards PLHIV. They said, “They are God’s creation and they need to be helped.” “I sympathise. I acknowledge that sex is not the only mode of transmission.” “They are part of the society like everyone else. They should be appreciated and involved in activities just like everyone else.” “We embrace them. We acknowledge they are part of us and our families. We are all affected.”

Some of the PLHIV confirmed some of the sentiments. One is quoted as saying, “My pastors know my status and they counsel me. When I miss church, they send someone to check on me at home.” “The leadership of the church have slowly accepted me. They call upon me now to support other congregants that disclose their positive HIV status.” “I am able to get counselling and material help when I am down.” These that felt the support of their faith communities however were fewer than those that felt they would not disclose.

Some of the religious leaders were not so empathetic. One said, “If people lived according to the laws of God, then HIV would not be so rampant.” Comments such as these brought out
the judgemental attitudes that some of the leaders still held towards PLHIV, that could explain some of the views given by the PLHIV during the FGDs.

One of the PLHIV said, “I was “cleansed” and chased away in two different congregations when I disclosed, so I cannot dare disclose again in my new congregation.” Other comments included, “The people who know my status avoid me when I get in church, and they will not sit near me or shake my hand.” “I cannot say my status because even my children will not be allowed to play with the other children.” “I cannot serve in the place of worship if they know I am positive because I am seen to be sinful.” “Because I cannot fast due to my medication, people look down on me.” “I am not allowed to participate in Holy Communion because of my status.” Generally from the PLHIV’s views, stigma was deemed to still be high within the faith groupings.

There seems to be a general acceptance of PLHIV by the religious leaders from the self-administered questionnaires as well as the key informant interviews. Many of the religious leaders said they had no problem having the PLHIV serve in leadership in the congregations, as shown in fig. 22 below.

![Fig. 22. Acceptance of PLHIV in Leadership roles](image)

Most of the PLHIV however seemed to feel differently, and did not feel accepted in the faith communities. The majority (71%) of the PLHIV were however not very comfortable disclosing their status in their congregations for fear of stigma and discrimination. Most feared the reactions of both the congregants and the leaders, and they felt there was need for further awareness before they could be accepted. Some of their comments are captured in annex 2 of this report.
3.3.3 Attitudes towards Key Populations

The discussion on key populations evoked different strong emotions. The sex workers were generally more accepted within the faith communities, with several respondents viewing them as victims of poverty. Many respondents said that sex workers should be empowered to help them change to businesses that were more acceptable. They suggested that the faith communities should help sex workers find alternative livelihoods. The majority of the participants on the other hand condemned MSM. Some called it an abomination to God and said that the Holy Book is clear about this. They said they should be made to understand that their practice is sinful and anti-social. Most who agreed that the faith communities should engage with MSM suggested that they seek counselling and guidance from the faith communities.

The acceptability of the faith communities engaging in some way with the key populations was important to the survey, as these were among the populations that are deemed as key drivers of new HIV infections and they would benefit from the NPTs.

3.3.4 Attitude towards New HIV Prevention Technologies (NPTs)

Much as the NPTs were not very familiar, many of the religious leaders were open to learning about anything that would help save lives. The survey sought to find out if they would be willing to recommend them to their congregants. Those who said yes said so because they
felt it was worth trying anything that would work. Those who said no had thought through some of the moral issues attached to some of the NPTs. Others simply said no because they were not familiar with the NPTs, and would not use their congregations to try them out before they fully understood them. Some said they were not sure, because they were not familiar, and so had the potential to be swayed either way after some sensitisation or training. The figure below shows how they felt about these prevention technologies and methods.

![Fig. 26. Would you recommend the NTPs to your congregation?](image)

The religious leaders emphasised that abstinence for the singles and faithfulness for the married remained the HIV prevention priority for the faith communities. However, it would be good to learn about anything else that could be of benefit to their congregations. The PLHIV said they would be happy to learn about the NPTs and would be willing to try out anything that would improve their quality of life and that of their loved ones.

### 3.4 Practice of HIV Prevention and Particularly the New HIV Prevention Methods

The practice part of the study sought to find out what the respondents actually do, or how they behave towards issues related to HIV prevention. Again the views of the PLHIV, regarding the various practices, as collected in the focus-group discussion, will be compared to the views of the religious leaders, as given in the self-administered questionnaires and in the key informant interviews.

#### 3.4.1 HIV Awareness Creation in Faith Communities

Almost 50% of the participants claimed to have a time set aside for HIV awareness. Nonetheless, those that had, were not very structured. HIV was discussed alongside other topics as a subsidiary. One congregation mentioned that they had a health month every year, and they would pick out a theme for it. This year, for example, the theme was drug abuse, and so HIV would be discussed as a related issue. Some congregations had formed a CBO or NGO to deal with social issues. All the HIV related issues would be channelled to this group, alongside other social issues. It is worth noting that most of the people that discussed HIV awareness targeted the youth and not the whole congregation. Many talked of having these HIV discussions in youth seminars.
The other half of the participants said they did not have a set time for discussing HIV, but it would sometimes come up in sermons if it related to the sermon topic. There were some congregations that did not discuss HIV at all and claimed that HIV would not be an issue if people only lived according to the Holy Book. Some said they did not discuss it, as they lacked the capacity and knowledge to do so.

### 3.4.2 Practice towards PLHIV

#### 3.4.2.1 Material and Spiritual Support

Material support such as food and clothes is given by many of the congregations during a set time in the year, usually around the festive season. Support for OVCs is generally offered, including to children orphaned by HIV. The PLHIV confirmed this as the practice in most congregations. They said they receive dry foods such as maize flour and sugar, as well as clothes. The support was however not exclusive to PLHIV, but to all the needy in the congregation as part of the benevolence ministry.

Visitation of the sick in their homes is done for those in the congregation that are ailing, and it is not exclusive to PLHIV. Most of the faiths have a designated person or group that does this on behalf of the congregation. The PLHIV that had this as a practice in their congregations said they appreciated it a lot as it would encourage them and they would get help for food when they were not in a position to work. Some of the religious leaders said they would integrate HIV information in the sermons.

#### 3.4.2.2 Counselling and Psychosocial Support

Counselling and psychosocial support is offered to those that disclose, on a case by case basis in most congregations. Some of the congregations cited that they have a leader or a counsellor who has the skills to offer this kind of support. Some of the faith communities have support groups for PLHIV. A few of the congregations have set up health facilities and NGOs as the social arm of the faith community, and so have professionals to handle PLHIV. One congregation involved in the survey said they have set up a special unit within their hospital for HIV. They encourage members of their congregation to take a HIV test as HIV prevention and treatment help is readily available.

The PLHIV confirmed that some congregations have support groups for them. It was interesting to note that many of them have more people from other congregations. We asked them why they preferred to go for support groups in other congregations, and they said it was because of the stigma. They opted to go for support group meetings in places where they were not known by the community, as they worshipped in places where they were pretty well known. They also said that some of the congregations make use of community health workers and social workers to support them during the meeting and to follow them up as need arose.
Some of the PLHIV did not appreciate the support groups in some of the places of worship. Some said they were a waste of time because they are not structured and do not have a plan. They felt that they were there to make the church look like they were reaching out, whereas in the real sense, they did not benefit from them. Many said they would appreciate them more if there were teachings that they could gain from.

The majority of the congregations we interviewed did not have support groups. Some said they had tried, by they failed because of stigma in the community. Others said that the PLHIV wanted some material gains from those groups, which they could not offer consistently. The PLHIV opted for support groups run by NGOs as they receive monetary and other material support more regularly. Some religious leaders said they simply lacked the know-how of running support groups, and opted to refer.

### 3.4.3 Practice towards Key Populations

Only one of the congregations we interviewed had an intervention targeted at the key populations. This congregation deliberately went out to the streets, spoke to sex workers and invited them to their place of worship. They gave them odd jobs to do during the day to earn some money for upkeep. Although this had become an intervention embraced by the congregation, it was an initiative of the senior religious leader. The aim of the programme was to get them off the streets and engage them in alternative livelihoods. They cited challenges of the programme, but they said they were glad to keep trying. Other respondents said they would engage with sex workers who would seek help on a one on one basis, and others still, had no idea what to do. There was no faith group that we interviewed that had any intervention for MSM.

### 3.4.4 Practice towards New Prevention Technologies

The survey sought to check the familiarity of the new prevention technologies by asking the participants if they had ever used any of these methods/technologies. Again the researcher added condoms to the list, to gauge the acceptability.

![Fig. 27. Percentage of survey participants that have used the various NPTs](image)

Over 53% of the religious leaders said they had used a condom, mainly as a method of family planning. All the participants in the FGD had used condoms for HIV prevention, bringing the
overall use to 60%. The confusion of PrEP versus PEP continued, and so the 8% may not be a true picture of those that had actually used PrEP. This was the same case with the HIV vaccines. It was also not clear if all who claimed to have done VMMC had actually gone through circumcision as adults, or whether there were those that ticked that point, simply because they had gone through circumcision earlier, as a rite of passage. These are some of the limitations of a self-administered questionnaire, as there is no room to probe further.

Some of the religious leaders had previously recommended some of these methods to their congregations. Most of the recommendations were done during sensitization and training sessions, and not on a one on one basis. Some said they recommended the condom to discordant couples, HIV positive concordant couples, as well as youth that looked like were engaging in risky sexual behaviour. Again in this question, we see most of the people recommending PrEP for rape and accident victims, which points to the mix up between PrEP and PEP.

None of the PLHIV in the FGD discussion had ever used microbicides, PrEP or the HIV vaccines. All of them had used condoms, and some had also used TasP. One of the men had gone through VMMC, as shown in figure 27 below.
CHAPTER FOUR: RECOMMENDATIONS

The religious leaders acknowledged the urgent need to address the issue of new HIV infections. They agreed that it would be prudent to know about the new HIV prevention technologies, so that they could play their part in guiding their congregations. The religious leaders noted that contradictions could exist, and clarified that the views in their Holy Books would take precedence, even above their personal views, cultures and traditions. This chapter makes some recommendations on the way forward, based on the survey findings, for the religious leaders to consider in the formation of an advocacy agenda.

4.1 Knowledge

4.1.1. Knowledge of HIV
Many of the religious leaders said they were willing to be involved in HIV prevention, but they were not confident of having adequate knowledge. HIV is dynamic and information changes very frequently.

4.1.2. Knowledge of HIV Status
Knowledge of one’s HIV status is an important step to HIV prevention. Most of the survey respondents knew their HIV status, but there was a 5.4% that did not. There was another 11% that did not know the status of their sexual partners. This means that they cannot have an effective conversation on HIV prevention with their congregations.

Recommendation 1: Constant sensitisation and training on HIV be carried out, targeting the religious leaders so that they can reach the 97% population that ascribe to a faith in Kenya.

Recommendation 2: Develop simple, theologically sound HIV sensitisation material to be used by all the different congregations, hedging on the common threads and principles of the faiths. This can be used by the different religious leaders to enlighten their congregations.

Recommendation 3: Develop key HIV prevention messages and messages related to the NPTs that the religious leaders can pass on to their congregations.

Recommendation 4: Train trainers of trainers (TOTs) from among the faith communities that commit to quarterly trainings, and can cascade the information to their faith communities, and clusters within their congregations.

Recommendation 5: Encourage all the religious leaders to take a HIV test as an entry point to HIV prevention. They in turn should encourage their congregations to take a test, with the couples testing together.
4.1.3. Knowledge of New Prevention Technologies

The knowledge of the NPTs was evidently very limited among the religious leaders and the PLHIV. There is need for a training session to enlighten them on these NPTs if they are to advocate for them to the congregations.

Recommendation 6: Organise for training sessions on NPTs. The trainings should target the religious leaders and the selected TOTs. They in turn should organise training sessions in the support groups targeting the PLHIV and sensitisation sessions to their congregations. This should be done alongside all other HIV prevention methods so as to avoid any mix up such as what we saw with the PEP and PrEP.

Recommendation 7: Where possible, involve the religious leaders as early as possible in the development stages of the NPTs such as the HIV vaccines, so as to allow them a chance to ask any critical moral questions and to get their buy-in.

4.1.4. Knowledge of Where to get the NPTs

When the different NPTs are available, it is important that the religious leaders are aware of where to get them so that they can refer their congregants.

Recommendation 8: Create a referral directory that contains information on where one can get the different NPTs in the different counties. This should be accessible to all the religious leaders, for effective referral.

4.1.5. Knowledge on Key populations

Despite the discussion of the key populations being a very sensitive issue in the faith communities due to the moral connotations, it is evident that it is a conversation that needs to happen if new HIV infections are to be reduced.

Recommendation 9: The religious leaders need to familiarise themselves with the issues that lead to the risky sexual behaviour that the key populations engage in, and begin to address them within their congregations, using a non-judgemental approach. This is an opportunity to draw them out in love, and offer them guidance and counsel in line with the Holy Books to avert new HIV infections.

Recommendation 10: Make information on HIV prevention and NPTs available in the places of worship, in libraries and resource centres. This would make it easy for the congregations to access the relevant information and be empowered.
4.2 Attitudes

4.2.1 Attitudes towards HIV

The attitude that some of the religious leaders had of HIV being a result of sexual sin needs to be addressed if HIV prevention efforts are to be effective. As one of the respondents said, “Not all HIV infection is as a result of sexual sin”. Another one asked, “Where is the forgiveness that the religions preach?”

**Recommendation 11:** HIV sensitisation should be continuously carried out in the faith congregations, with proper information given and aligned to principles of faith such as love, forgiveness, helping those in need etc.

4.2.1 Attitudes towards PLHIV

Stigma in many faith communities is still very real. This keeps PLHIV quiet, and reduces the effectiveness of HIV prevention strategies.

**Recommendation 12:** All religious leaders need to be empowered on Stigma, Shame, Denial, Discrimination, Inaction and Mis-action (SSDDIM) using the ‘SAVE’ toolkit.

4.2.2 Attitudes towards Key Populations

It is evident that key populations form part of the 97% of Kenyans that ascribe to a faith, and form the congregation, and that they play a major role in the new HIV infections.

**Recommendation 13:** Religious leaders can reach out to the key populations in their congregations. They can do this using the already existing structures and strategies, within their congregations, or by making use of congregation members who have different skills sets to help them start up effective initiatives.

4.2.3 Attitude towards New HIV Prevention Technologies

The religious leaders emphasised that abstinence for the singles and faithfulness for the married remained the HIV prevention priority for the faith communities. However, they felt it would be good to learn about anything else that could save lives and benefit to their congregations. **Recommendation 6** will help to address the attitudes expressed, as well.

4.3 Practice

4.3.1 HIV Prevention

Most of the survey respondents said they were aware of HIV prevention, but some said they lacked the capacity and knowledge to effectively discuss it with their congregations and so
avoided the issue. Taking into consideration recommendations 1-10 may help them start up beneficial programmes within their congregations.

4.3.2 Support for PLHIV

Several congregations have an initiative that reaches PLHIV as part of the vulnerable populations within their congregations. Whereas the PLHIV appreciate the effort, suggestions were made on how these initiatives could be more beneficial.

Recommendation 14: Speak of HIV with hope – not negatively as it is addressed in some congregations, understanding that HIV can be acquired through other ways other than sex. PLHIV therefore need love and not judgement.

Most of the time, PLHIV are able to work and earn a living, but due to stigma, people avoid employing them. This pushes them to rely on handouts and it affects their self-esteem.

Recommendation 15: Empower congregations to overcome stigma and give work to PLHIV. Where possible, the churches, mosques and temples can give part-time jobs to PLHIV or help them start up income generating activities, to earn a living.

Recommendation 16: Help in the education of children of PLHIV, especially for the single parents. PLHIV are often unable to find meaningful employment, and so their children miss school due to lack of school fees beginning the cycle of poverty.

Recommendation 17: Involve PLHIV in the formation of support groups and other programmes in the congregations. They have the experience of having lived with HIV and so have a lot to share.

Recommendation 18: Give guidance and counsel to PLHIV, but do not force them to your beliefs e.g. to stop medication because you have prayed for them and believe they are healed, or pushing them to stop conventional medicines to talk alternative medication. PLHIV should be allow to make their own decisions and own their results.

Recommendation 19: Encourage congregation involvement in the prevention and support efforts of HIV, and not just the leaders.

4.3.3 Practice towards New Prevention Technologies

The NPTs are still very unfamiliar to many of the religious leaders and their faith communities. Knowledge on them, as made in recommendations 6-8 is critical.

Recommendation 20: The VMMC campaigns were very effective from the results exhibited in chapter three. Lessons from those campaigns should be studied and employed in the scale up of the other NPTs.
REFERENCES

- UNAIDS. Ending the AIDS epidemic by 2030: Reducing sexual transmission report, April 11, 2014

Websites:

- http://www.avac.org/resource/treatment-prevention-introductory-factsheet
- http://www.avac.org/vmmc/basics
- http://www.avac.org/cure
ANNEXES

ANNEX ONE: HIV INCIDENCE PER COUNTY IN KENYA

ANNEX TWO: HOW COMFORTABLE ARE PLHIV IN THE PLACES OF WORSHIP (EXTRACTS FROM THE FGDS)

**Question:** Are you comfortable disclosing your HIV status in your congregation?

**Yes (12)**
- I have sensed love in the congregation
- I have sensed understanding from the leaders
- I want to reach others who may be in the congregation and are afraid of disclosing and seeking help.
- I want spiritual support

**No (29)**
- I was “cleansed” and chased away in two different congregations when I disclosed, so I cannot dare disclose.
- I fear I will be chased away.
- We are discriminated against.
- Stigma in my congregation is still very high.
- The people who know my status avoid me when I get in church, and they will not sit near me or shake my hand.
- I cannot say my status because even my children will not be allowed to play with the rest.
- I cannot serve in the church if they know I am positive because I am deemed to be sinful.
- I cannot participate in Ramadhan. I do not fast and so people look down on me for that.
- I am not allowed to participate in Holy Communion in my church.
- In my church, discussion around STIs and HIV is forbidden. We cannot take a HIV test because it entails removal of blood. We are not even allowed to get a blood transfusion if we need it. I therefore cannot disclose that I have taken a HIV test or that I am on medication. Whenever I am unwell, I hide from my church members. I attend this support group because no one is from my faith.
ANNEX THREE: SURVEY PARTICIPANTS

<table>
<thead>
<tr>
<th>GROUPS AND CONGREGATIONS PARTICIPATING IN KEY INFORMANT INTERVIEW GROUPS</th>
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<tbody>
<tr>
<td>1. Kenya Council of Imams and Ulama (KCIU)</td>
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<tr>
<td>2. Organization of African Instituted Churches (OAIC)</td>
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<tr>
<td>4. Supreme Council of Kenya Muslims (SUPKEM)</td>
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<td>5. The Anglican Church of Kenya (ACK)</td>
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<td>6. The Seventh-day Adventist Church</td>
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<td>7. Gospel Evangelical Churches of Kenya (GECK)</td>
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<td>8. Deliverance Church, Kenya</td>
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<tr>
<th>FAITH GROUPS REPRESENTED BY PARTICIPANTS OF THE SELF-ADMINISTERED QUESTIONNAIRES &amp; FOCUS GROUP DISUSSION</th>
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<tbody>
<tr>
<td>Faith Group</td>
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<tr>
<td>Muslims</td>
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<tr>
<td>Seventh-day Adventist Church</td>
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<td>Catholics</td>
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<tr>
<td>Mainstream Protestant churches including AIC, PCEA, ACK, Salvation Army.</td>
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<tr>
<td>Charismatic/ Pentecostal Churches including Redeemed Gospel Church, NPC, Full Gospel, Gospel Evangelical Churches of Kenya (GECK), Deliverance Church, PAG, NPC.</td>
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<td>African Instituted churches including The Coptic Orthodox, God Past Appeal, National Independent Church of Africa, Holy Spirit Church of East Africa.</td>
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<td>Jehovah’s Witness</td>
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<td>Rastafarian</td>
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<td>AIPC</td>
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<td>Participant’s Roles</td>
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<td>National leaders including National Coordinators, Secretary Generals. Bishops, Deacons, Imams, National Treasurer</td>
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<td>Local Pastors, Priests, Imams</td>
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<td>Youth leaders</td>
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<td>Women representatives</td>
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<td>Teachers including Sunday School Teachers</td>
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<td>Congregation- ordinary members</td>
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<td>Congregations - HIV+ women</td>
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<td>Congregations - HIV+ men</td>
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<td>Congregations- ordinary church Leaders</td>
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