INFLUENCE OF FAITH LEADERS ON REDUCTION OF HIV-RELATED STIGMA: A CASE OF KENERELA+, KOIBATEK DISTRICT, KENYA

BY

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DECLARATION

This research project is the result of my own work and it has never been submitted by any student to any other university for any award.

Signed_____ Date 1st Sept, 2011

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This research project has been submitted for examination with my approval as the supervisor.

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DEDICATION

I dedicate this work to my very supportive husband Peter Lengapiani for being there for me throughout my coursework both financially and as I worked on this research project. To my daughters, Natasha Naisenya and Shirley Sintoya who have had to endure long hours of their mother's busy schedule balancing work, education and family time.

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ABSTRACT

Stigma and discrimination have often been identified as primary barriers to effective HIV prevention, as well as the provision of treatment, care and support. Such viewpoints tend to employ stigma and discrimination as a catch-all for the multiplicity of negative beliefs, attitudes and actions related to the disease. This study is anchored on Theory of Reasoned Action which is based on the assumption that human beings are quite rational and make systematic use of the information available to them, to make choices about whether to enact a behavior or not. The purpose of the study was to examine the influence of KENERELA+ faith leaders on reduction of HIV-related stigma at Koibatek district, Kenya. The study was carried out amongst faith leaders who are members of KENERELA+ at Koibatek district. In accomplishing this the study examined the influence of faith leaders' knowledge on reduction of HIV-related stigma; found out the influence of faith leaders' attitude on reduction of HIV-related stigma; established the influence of socio-demographic factors on reduction of HIV-related stigma; investigated the influence of religious factors on reduction of HIV-related stigma; and established the influence of structural factors and policies on reduction of HIV-related stigma. The study employed a descriptive survey research design. A sample size of 35 was selected using census sampling technique. Data was collected by use of questionnaires containing structured questions. Data collected was analysed for descriptive statistics (frequencies and percentages), Pearson Correlations and Chi square tests. The results were then presented in the form of tables. The study findings were as follows: Faith leaders' knowledge had a significant influence on reduction of HIV-related stigma by the KENERELA+ members of Koibatek District; The positive attitude of KENERELA+ members as faith leaders had a positive influence on reduction of HIV-related stigma; Religious factors as perceived by KENERELA+ members had a positive influence on the reduction of HIV-related stigma; The socio-demographic factors such as gender, education and religion of the KENERELA+ members did not have an influence on reduction of HIV-related stigma; and Structural factors and policies affecting the KENERELA+ members had a significant influence on reduction of HIV-related stigma in Koibatek District. Following these findings the study recommended the following: The Government of Kenya and concerned stakeholders should consider mobilizing resources to scale up awareness campaigns to members of the public to enhance the funding of Faith Based Organizations in promoting and scaling up sensitization activities to people on HIV prevention and management; Faith based Organizations should have policies in place to protect those living with HIV; and Faith leaders in KENERELA+ and other related organizations need to be encouraged to scale up their involvement in activities geared towards stigma reduction. These study findings could be useful to the Ministry of Kenya in guiding the formulation, review and implementation policies and frameworks related to reduction of HIV related stigma.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
APA	American Psychological Association
ARVs	Anti Retro Viral
CADRE	Center for AIDS Development, Research and Evaluation
CDC	Center for Disease Control and Prevention
DTC	Diagnostic Testing and Counseling
FBOs	Faith Based Organizations
FGD	Focused Group Discussion
HCT	HIV Counseling and Testing
HIV	Human Immuno-Deficiency Virus
HSUM	Health Service Utilization Model
KAIS	Kenya AIDS Indicator Survey
KENERELA	Kenya Network of Religious Leaders Living With or Personally Affected by HIV/AIDS
PLWH	People Living With HIV
UNAIDS	United Nations Joint Program on HIV/AIDS
USAID	United States Agency of International Development
WHO	World Health Organization
VCT	Voluntary Counseling and Testing

CHAPTER ONE
INTRODUCTION

This section serves to discuss the background to the study, state and define the problem that the study is addressing, purpose of the study, state the aims and objectives of the research work, justification and significance of the study as well as the research hypothesis, basic assumptions of the study, its scope, limitations and de-limitations. In addition, definition of significant terms and organization of the study has been discussed.

1.1. Background To The Study

Stigma and discrimination have often been identified as primary barriers to HIV prevention, as well as provision of treatment, care and support. Such viewpoints tend to employ stigma and discrimination as a catch-all for multiplicity for negative beliefs and attitudes and actions related to the disease (CADRE, 2005).

HIV-related stigma and discrimination is a pervasive problem worldwide. Since the early days of the AIDS epidemic, stigma and discrimination have been recognized as obstacles for programs providing HIV prevention and care services to people living with and affected by the disease. People living with HIV face stigma and discrimination in a variety of contexts, including the household, community, workplace, and health care setting (Carla, 2008).

In countries throughout the world, fear, ignorance, and misconceptions have resulted in stigmatization of people living with HIV or those associated with them. This negative response has resulted in people being unwilling to reveal their status, or to get tested for HIV. Stigma is of great concern in HIV response interventions because inability to inform others may deprive infected persons of the support and care of their family, and the benefit of available information, support, counseling, and treatment services.

The faith community makes a major contribution to the worldwide response to AIDS, especially in poorer developing countries, where faith-related facilities may (in some areas) be the sole source of health assistance. Religious communities are without question the largest and best organized civil institutions in the world today, claiming the allegiance of billions of believers and

bridging the divides of race, class and nationality. They are uniquely equipped to meet the challenges of our time: resolving conflict, caring for the sick and needy, promoting peaceful co-existence among all people (CADRE, 2005).

The WHO report (2007) found that faith-related organizations were providing 33 to 40 percent of all HIV health care and treatment services in Zambia and Lesotho, and calculated that between 30 and 70 percent of all healthcare infrastructures across the continent is operated by faith-based groups. The faith community makes a major contribution to the worldwide response to AIDS, especially in poorer developing countries, where faith-related facilities may be the sole source of health assistance.

Religious communities, mosques, temples, churches, hospitals and clinics have reached out to provide support to those living with and affected by HIV. Many have been involved in the response since the earliest days of the epidemic. Their leadership has great influence in the lives of many people, and leaders speaking out responsibly about AIDS can make a powerful impact at both community and international level.

However the response of the religious community can also be negative. People living with HIV have been stigmatized by religious leaders and communities of faith. Approaches to HIV prevention methods and attitudes towards people at increased risk of HIV infection such as men who have sex with men, have sometimes hindered the response. Much work remains to be done to eradicate stigma and discrimination.

Castro and Farmer (2005) argue that the study of HIV-related stigma is often decontextualized from larger social processes, ignoring the social, cultural and economic environment in which stigma occurs. An understanding of the role of the community in influencing HIV/AIDS attitudes is essential for the development of community-based efforts to reduce HIV transmission

According to WHO report, (2008), it was noted that in some countries people living with HIV lack knowledge of their rights in society. They need to be educated, so they are able to challenge the discrimination, stigma and denial that they encounter. Institutional and other

monitoring mechanisms can enforce the rights of people with HIV and provide powerful means of mitigating the worst effects of discrimination and stigma.

In a recent article published in the Washington times, Ban Ki-moon, Secretary-General of the United Nations was quoted saying that "We can fight stigma. Enlightened laws and policies are key. But, it begins with openness, the courage to speak out. Schools should teach respect and understanding. Religious leaders should preach tolerance. The media should condemn prejudice and use its influence to advance social change, from securing legal protections to ensuring access to health care" (Washington Times, 2008).

Furthermore, it is clear that faith communities are ideally placed to respond in the broadest way to the epidemic's challenges, not just as providers of services but also (and perhaps most importantly) as networks and movements that reach right to the heart of community and family life. This makes them key players in a holistic, multifaceted, integrated response to AIDS. It is for this reason that this study is deemed necessary to explore what influences faith leaders response to fight against HIV-related stigma and give insight how to effectively engage faith-based organizations in responding to HIV pandemic and promote increased uptake of VCT services, access to care and support for those infected and affected by HIV and AIDS.

1.2 Statement of the Problem

The extent of the HIV pandemic has prompted a call for greater engagement of all groups, including faith-based organizations (FBOs). Religious communities and institutions have been involved in HIV and AIDS response and have reached out to provide support to those living with and affected by HIV. Their leadership has great influence in the lives of many people, and leaders speaking out responsibly about HIV and AIDS can make a powerful impact at both community and international level. In 1987, the late Jonathan Mann, the director of the WHO Global programme on HIV and AIDS identified three phases of HIV/AIDS epidemic; the epidemic of HIV, the epidemic of AIDS and the epidemic of stigma, discrimination and denial. He noted the third phase is " as central to the global AIDS challenge to the disease itself (Mann,1987). Despite international effort to tackle HIV/AIDS since then, stigma and discrimination remain among the most poorly understood aspect of the epidemic. As recently as 2000 Peter Piot, executive director

of UNAIDS, identified stigma as "a continuing challenge" that prevents concerted effort at community, local, national and international level (Piot, 2000).

Stigma still remains one of the most significant challenges in developing countries for all HIV and AIDS programs, which involve the prevention and care continuum. Stigma increases vulnerability to HIV and worsens the impact of infection. Fear of being identified with HIV keeps people from learning about their status, changing behaviour to prevent infecting others, caring for people living with HIV and AIDS, and accessing HIV and AIDS services (UNAIDS/WHO, 2006). Additionally, stigma intensifies the emotional pain and suffering of people living with HIV and AIDS, their families and caregivers (Castro, 1998a; Castro *et al.*, 1998b).

Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world (Ki-moon, 2008).

An understanding of the factors associated with attitudes toward HIV/AIDS is essential for the creation of community-based interventions that aim to dissolve stigmatizing perceptions (Parker and Aggleton, 2003). However the response of the religious community can also be negative. Evidently, people living with HIV have been stigmatized by religious leaders, their approaches and attitudes towards people living with HIV have sometimes hindered positive response to fight against HIV-related stigma and as a result, much work remains to be done to eradicate stigma among faith leaders who are very influential in the communities. This can be achieved by understanding what influences their response to fighting stigma and work towards eradicating the factors that promote stigma as well as enhance the positive responses.

1.3 Purpose of the Study

The purpose of the study was to examine the influence of KENERELA+ faith leaders on reduction of HIV-related stigma in Koibatek District, Kenya in view of the fact that their leadership has great influence in the lives of many people.

1.4 Research Objectives

This study was guided by the following specific objectives:

1. To examine the influence of faith leaders' knowledge on reduction of HIV-related stigma
2. To explore the influence of faith leaders' attitude on reduction of HIV-related stigma
3. To establish the influence of socio-demographic factors on reduction of HIV-related stigma
4. To investigate the influence of religious factors on reduction of HIV-related stigma
5. To establish the influence of structural factors and policies on reduction of HIV-related stigma

1.5 Research Questions

The following research questions guided this study:

1. How does knowledge on HIV and AIDS influence reduction of HIV-related stigma?
2. To what extent does attitude influence reduction of HIV-related stigma?
3. What influence do socio-demographic factors have on reduction of HIV-related stigma?
4. To what extent do religious factors influence reduction of HIV-related stigma?
5. How do structural factors and policies influence reduction of HIV-related stigma?

1.6 Significance of the Study

In this study, it was anticipated that the findings drawn from the survey would be found valuable in widening the knowledge on influence of faith leaders on reduction of HIV-related stigma and the crucial role faith leaders play in addressing stigma in their congregations as well as in the communities they belong to. Therefore this study generates information that gives an insight to faith leaders and FBOS into various key areas to address in the fight against HIV-related stigma and the results of the study could be used to create more knowledge that can guide various stakeholders in making informed decisions when addressing issues related to HIV and AIDS. This is expected to help them come up with workable interventions to address the pandemic in how it's implemented and executed as well as how information is communicated to congregations and individuals.

The users of the knowledge can be at various levels be it at local, provincial, national or international level. The faith based organizations and leaders can benefit by using the findings of the study to address the influencing factors, mind their language when communicating about HIV and AIDS and respond effectively to the pandemic.

The Ministry of Health may also find the results of this study valuable in forming policies and frameworks that will guide institutions and various partners responding to HIV pandemic in their interventions that are targeting populations of people affected and/or infected by HIV.

1.7 Basic assumptions of the Study

For the purpose of this study the following assumptions were made: that the respondents were willing to participate in the study and freely answer all the questions honestly. Another assumption was that the questionnaire used would capture the relevant data on HIV-related stigma.

1.8 Limitations of the Study

During execution of the study, the following challenges were faced: The illiteracy of some of the interviewees to give correct or full information, therefore the questionnaires were designed in a simple language and the research assistants trained on how to collect data and defined key words. The research assistants were picked from the community and were able to easily interpret the questionnaire to the respondents.

1.9 Delimitation of the Study

The study targeted only faith leaders who are members of KENERELA+, Koibatek District. The study concentrated on KENERELA+ which is a unique faith based organization whose members are either infected or personally affected by HIV and AIDS and held key positions in religious institutions. Therefore bearing great influence on how their congregations respond to reduction of HIV-related stigma.

1.10 Definition of Significant Terms

Faith leaders: refers to all members of KENERELA+ who hold key positions in their denominations.

Faith based organizations: registered group of faith leaders or institution of faith community.

HIV-related Stigma: refers to the 'process of devaluation' of people either living with or associated with HIV and AIDS.

Socio-demographic factors: refers to factors such as age, sex, occupation, level of education, position in church/mosque.

Religious factors: are such factors as beliefs, practices and taboos held by the members of a particular denomination or group.

Influence: impact of a condition on the outcome of a process.

1.11 Organization of the Study

This research report is organized into five chapters. The first chapter discusses the background of the study, states and defines the problem that the project was addressing; the aims and objectives of the study are stated and a description of how the work progressed is given. In the second chapter a wide range of literature that was reviewed is given. This involved systematic identification, location and analysis of documents containing information related to the research problem. It gave the study insight into what had already been done in the selected field, pinpointing its strengths and weaknesses so as to help in the formulation of a theory that aimed at addressing the identified gaps. Chapter three covers the research methodology that was used to collect data and a means of analyzing it for all logical and systematic conclusions. It contains the research design, study population and includes the sample selection criteria, methods of data collection, and methods of data analysis. The next chapter presents the study findings. The data was analyzed using descriptive statistics – frequencies, percentages and mode. The descriptive statistics tools were to help the researcher describe the data and the features of the data that was of interest. The mode (measurement of value) was used more so to analyze the response in the questionnaire. Data analysis tools of SPSS were used and gave a deeper insight into the responses from the respondents into the subject of the research. The generated data was quantitative in nature. The output was presented using tables.

Chapter five summarizes the results of the findings i.e., compared the objectives and the findings, analyzing the results of each sub-variable and recommended improvements to be made on the observed shortcomings.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents reviewed literature related to the study giving an insight into what has already been done by other scholars. The study conferred the literature review, the theoretical and conceptual framework and finally gives a summary of the chapter.

2.2 HIV related-Stigma

The Human Immunodeficiency Virus (HIV) was unknown until the early 1980's but since that time, it has infected millions of persons in a worldwide pandemic. At the end of the 20th century, over 21 million persons worldwide had died from AIDS; another 34 million were living with HIV infection whilst the majority 95% of HIV infected persons were residents of developing nations (UNAIDS, 2006). The HIV/ AIDS pandemic has presented the world with a condition that combines these characteristics - and it has frequently been met with stigma and discrimination, a reaction dubbed "the second epidemic" (Somerville and Orkin, 1989). Here in Kenya, the national prevalence rate of HIV and AIDS is 6.7%. There are about 140,000 deaths due to HIV related illnesses in 2007 which is attributed to low access to care and support by PLWH and high number of people unaware of their status (KAIS, 2008).

Despite the high prevalence of HIV/ AIDS that exists in many Sub-Saharan African countries, very little is known of the prevalence and context of HIV-related stigma in these settings. In nearly 20 Sub-Saharan African countries, an estimated 5% or more of young women 15-24 years are HIV positive, and more than one half of those newly infected with HIV today are between 15 and 24 years old, such that an estimated 11.8 million young people are now living with HIV/ AIDS (USAID, 2008).

'Stigma' is a Greek term denoting a mark that, in ancient times, was burned or cut into the flesh of an unsavoury character - a traitor, criminal, or slave (Harvey, 2001). Goffman (1963) defined stigma as 'an attribute that is deeply discrediting within a particular social interaction', as a

'spoiled social identity' and 'a deviation from the attributes considered normal and acceptable by society' (Harvey *et al.*, 2001).

Some erudite scholars have come up with definitions of Stigma. Firstly, Alonzo and Reynolds (1995) defined stigma as a 'powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as persons'. Secondly, Inside-out Research (2003) describes a large collaborative study on stigma in South Africa and reports that stigma 'can be felt (internal stigma), leading to an unwillingness to seek help and access resources, or enacted (external stigma), leading to discrimination on the basis of HIV status or association with someone who is living with HIV/AIDS'. Thirdly, UNAIDS defines HIV-related stigma and discrimination as: "... a process of devaluation' of people either living with or associated with HIV and AIDS ... Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status " (Nyblade, 2009). Fourthly, According to Alonzo and Reynolds (1995), stigma is 'a construction of deviation from some ideal or expectation'. Stigmatized groups include women; minorities, such as people of colour, homosexuals, and substance abusers, and people who are physically and/or mentally disabled (Harvey *et al.*, 2001).

In addition, other scholars for instance Goffman defined HIV/AIDS stigma as a deeply discrediting attribute that reduces the bearer of HIV/AIDS from a whole and valued individual to a tainted, discounted one. According to Link and Phelan (2001) stigma exists when a person is identified by a label that ostracizes the person and associates them with undesirable stereotypes that result in unfair treatment and discrimination. It is interesting as of today to note that Goffman's concept of stigma is the one most widely acceptable one (Harvey *et al.*, 2001).

Stigma is that part of identity that has to do with prejudice- the setting apart of individuals or groups through the attachment of heightened negative perceptions- and values. Stigma is a process that may occur at individual level but is also influenced by social processes related to assumptions, stereotypes, generalization and labeling of people as falling in to a particular category on the basis of association (CADRE, 2005).

AIDS-related stigma and discrimination is manifested through prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV. They can result in being shunned by family, peers and the wider community; poor treatment in healthcare and education settings; an erosion of rights; psychological damage; and can negatively affect the success of testing and treatment.

AIDS stigma and discrimination exist worldwide, although they manifest themselves differently across countries, communities, religious groups and individuals. They occur alongside other forms of stigma and discrimination, such as racism, homophobia or misogyny and can be directed towards those involved in what are considered socially unacceptable activities such as prostitution or drug use.

Previous studies have shown that even three decades into the global HIV/AIDS epidemic, stigma surrounding HIV/AIDS remains highly prevalent in both developed and developing nations (Busza, 1999; Herek, Capitanio, and Widaman, 2002; Taylor, 2001). UNAIDS report, (2008) estimated that there were more than 33 million people living with the HIV virus by 2007 while a further 2.7 million new infections were recorded in the same year. It recommended that mounting large scale interventions towards reducing stigma would thus optimize investments in HIV prevention, care and treatment. In addition, it also suggests that there is need for a movement across the globe to fight the HIV stigma and discrimination.

The reason for high prevalence rate of HIV-related stigma is because HIV transmission is often closely associated with stigmatized behaviors (injecting drug use or multiple sexual partners) and marginalized sub-groups (men who have sex with men or commercial sex workers) and thus those with HIV are presumed to be associated with these behaviors or groups (Parker and Aggleton, 2003).

People living with HIV may not have any visible] signs of the disease, yet they are more likely to be stigmatized because others maview them 'as contributors to their own problems and unworthy of the care directed to more legitimate victims of illness' (Jillings and Alexus, 1991).

2.2.1 Knowledge on HIV and AIDS, attitude and Practice

Public health campaigns to reduce stigmatization must address individuals on the basis of their socio-demographic characteristics (Mahdi *et al.*, 2006). Factors that contribute to HIV/AIDS-related stigma include perception that HIV/AIDS is a life-threatening disease, and therefore people react to it in strong ways.HIV infection is also associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatized in many societies and the fact that most people become infected with HIV through sex which often carries moral baggage.

High stigma towards HIV and AIDS is also attributed to a lot of inaccurate information about how HIV is transmitted and inadequate information on how HIV is not transmitted, creating irrational behaviour and misperceptions of personal risk.

According to Nnedum (2006) the fact that HIV/AIDS is a relatively new disease also contributes to the stigma attached to it. The fear surrounding the emerging epidemic in the 1980s is still fresh in many people's minds. At that time very little was known about the risk of transmission, which made people scared of those infected due to fear of contagion.

Carla (2008) argues that from early in the AIDS epidemic a series of powerful images were used that reinforced and legitimized stigmatization. This was enacted as follows; HIV/AIDS as a punishment (e.g. for immoral behaviour), HIV/AIDS as a crime (e.g. in relation to innocent and guilty victims), HIV/AIDS as war (e.g. in relation to a virus which must be fought), HIV/AIDS as horror (e.g. in which infected people are demonised and feared) and finally HIV/AIDS as otherness (in which the disease is an affliction of those set apart) and not with the first person me/us.

In 2003, when launching a major campaign to scale-up treatment in the developing world the World Health Organization (WHO) claimed that: "As HIV/AIDS becomes a disease that can be both prevented and treated, attitudes will change, and denial, stigma and discrimination will rapidly be reduced" (WHO, 2003).

There is an emerging consensus among researchers and program implementers that there are at least four "domains," or dimensions, of HIV-related stigma and discrimination: Fear of HIV transmission through casual contact with people living with HIV (i.e., contact that would not lead to transmission), and resulting avoidance of contact with them. Negative judgments/ beliefs about people living with HIV i.e blame, shame, and value judgments are common (Carla, 2008).

2.2.2 Socio-demographic influence

The social stigma of HIV/AIDS insidiously continues to undermine the success of prevention programs (Thorsen, and Martinson, 2008). Few studies have described the determinants of HIV-related stigma in African settings. More specifically, there is an absence of studies that have examined how community environments shape attitudes toward HIV/AIDS. Castro and Farmer (2005) argue that the study of HIV-related stigma is often decontextualized from larger social processes, ignoring the social, cultural and economic environment in which stigma occurs. An understanding of the role of the community in influencing HIV/AIDS attitudes is essential for the development of community-based efforts to reduce HIV transmission, particularly among young people who are currently facing the burden of the HIV epidemic in sub-Saharan Africa.

Societal factors which involve the position held by faith groups or institutions within a society or community as a whole influences their response to reduction of HIV-related stigma these factors include; embeddedness of local religious groups within local community, community setting (rural or urban); relative importance of religion within the community; Moral authority of religious leaders; Historical role of religious groups in providing social services, health care (Nnedum, 2006).

2.2.3 Structural factors influence

Globally, 40 million people were estimated to be living with HIV and AIDS at the end of 2001. Sub-Saharan Africa is clearly the worst affected region. With 28.5 million People Living with HIV and AIDS (PLHA) in 2001, Sub-Saharan Africa accounts for more than 70 percent of all HIV and AIDS cases in the world. Over two million of the three million deaths due to AIDS in 2001 occurred in subSaharan Africa. AIDS is now the leading cause of death in subSaharan Africa and the cause of a 15- year drop in life expectancy in the region, from 62 to 47 years. New

HIV infections are highest among young people, and young women have consistently been found to have higher (in some cases as much as six times as high) prevalence rates of HIV than men of the same age (Joint United Nations Programme on HIV/ AIDS; 2004).

Most countries and societies have recognized that forms of stigma and discrimination are antagonistic to concepts of human rights and equality. Constitutions, bill of rights and various pieces of legislation have been enacted with a view to addressing and limiting such practices South Africa in general and in relation to HIV and AIDS has a wide range of constitutional and legal provisions that set out to address inequalities and which provide protection from discrimination on various grounds (CADRE, 2005).

Political or structural factors are those which relate to the frameworks, partnerships and other relations in which religious groups are embedded, and their capacity to affect change. The National aids response framework, degree of collaboration between major religions, government and other actors in national aids response including cultural belief systems. Response towards fight against stigma is also influenced by donor framework and priorities in relation to FBOs as well as ability to mobilize resources in kind, human, financial.

Until recently, many African governments were hesitant to recognize the magnitude of the continent's HIV epidemic, dismissing critics as racist or misguided (Boone and Batsell, 2001). The pervasive silence surrounding the HIV/AIDS epidemic in sub-Saharan Africa has led to limited public discussion and continued stigmatization of those who are infected (Goliber, 2006).

In the Washington Times (2008, 6th August), *Ban Ki-moon, Secretary-General of the United Nations was quoted saying* "We can fight stigma. Enlightened laws and policies are key. But it begins with openness, the courage to speak out. Schools should teach respect and understanding. Religious leaders should preach tolerance. The media should condemn prejudice and use its influence to advance social change, from securing legal protections to ensuring access to health care."

2.2.4 Religious factors influence

Stigma and discrimination have often been identified as primary barriers to HIV prevention, as well as provision of treatment, care and support. Such viewpoints tend to employ

stigma and discrimination as a catch-all for multiplicity for negative beliefs and attitudes and actions related to the disease (CADRE, 2005).

In some contexts, HIV and AIDS related stigma and discrimination has been reinforced by religious leaders and organizations, which have used their power to maintain a status quo rather than to challenge negative attitudes towards marginalized groups and PLWA. For example at the international symposium, religious health organizations break the silence on HIV/AIDS, organized by the African regional forum of religious health organizations during the 13th international AIDS conference in July 2000 (Singh, 2001), it was noted that religious doctrines, moral and ethical positions regarding sexual behavior, sexism and homophobia, and denial of the realities of HIV and aids have helped create the perceptions that those infected have sinned and deserve their "punishment" increasing the stigma associated with HIV/ AIDS.

Religion and religious beliefs are foundations of community life in a majority of societies. Religion prescribes ethical guidelines for many aspects of daily life and also navigates belief systems and norms surrounding sexuality. HIV vulnerability caused by religious beliefs and practices is as a result of religious institutions' denounciation of HIV infection as sinful. Such religious judgments play a significant role in generating HIV and AIDS related stigma which increases vulnerability (Cadre, 2005).

Some of the factors that influence religious leaders' response include perception that HIV infection is the result of personal irresponsibility. Doctrinal positions of dominant religions in relation to disease causality, sexuality and gender also influences as well as degree of conformity with various doctrines. Chesney and Smith (1999), explains that religious taboos have inhibited open discussion about an epidemic that spreads primarily through sexual contact. Some faith groups in Africa believe that AIDS is a divine punishment for those who have been sexually promiscuous. These factors explain, in part, the reluctance of many adults to openly admit to carrying the virus.

Faith leaders are ideally placed to deal with realities of HIV and AIDS and the intersections between faith, care and hope (Health Development Networks, 2001). FBOs promote values of hope, compassion, tolerance and care for the needy; they are embedded within communities and understand local needs and conditions and have long histories of delivering health care and other social services in poor and under-developed countries. Yet some FBOs have

been involved in denouncing or rejecting PLWH- including their own clergy. Negative sanctions have included forcing HIV positive clergy and members out of parishes and compelling them to confess the "sins" that led to their infection and leading congregations in special prayers for HIV-positive followers who may be punished for their status (Paterson, 2008).

Studies of HIV related stigma within FBOs point to interlinked factors that are related to such occurrences, including reduction of HIV infection to issues of individual morality and sin (Dube, 2001). The failure of many FBOs to engage openly in topics fundamental to HIV and AIDS prevention including human sexuality and women's empowerment (Paterson, n.d), and denial that HIV is a problem in one's faith.

The diverse and contradictory roles of FBOs in relation to HIV and AIDS needs to be understood as a contingent upon a range of factors which include: Attitudinal and conceptual factors, Knowledge attitude and behaviors of local religious figures, in relation to HIV and AIDS, openness of various religions in discussing or confronting HIV, their attitudes towards positive religious leaders and finally relationship between major religions and other belief systems such as traditional beliefs.

2.3 Theoretical framework

This study was guided by the theory of Reasoned Action which is based on the assumption that human beings are quite rational and make systematic use of the information available to them, to make choices about whether to enact a behavior or not. The Theory of Reasoned Action, advanced in the mid-1960s by Fishbein and Ajzen, is based on the assumptions that human beings are usually quite rational and make systematic use of the information available to them and that people consider the implications of their actions in a given context at a given time before they decide to engage or not engage in a given behavior.

This theory is conceptually similar to the Health Belief Model but adds the construct of behavioral intention as a determinant of health behavior. Both theories focus on perceived susceptibility, perceived benefits, and constraints to changing behavior. It focuses on the role of personal intention in determining whether a behavior will occur. It states that a person's intention is a function of two basic determinants:

1. Attitude (toward the behavior), and

2. 'Subjective norms', i.e., social influence.

Normative beliefs play a central role in the theory, which generally focus on what an individual believes other people, especially influential people such as religious leaders, would expect him/her to do. For example, for a person to start caring for PLWH, his/her attitude might be "having casual contact with a PLWH does not put me at any risk of HIV infection" and subjective norms (or the normative belief) could be "our religious leaders preach that we should be good Samaritans and love one another as we love ourselves, they would expect me to do so as well." Interventions using this theory to guide activities focus on attitudes about risk-reduction, response to social norms, and intentions to change risky as well stigmatizimg behaviors.

Over time it became clear that it was important to consider whether a behavior is under a person's control or not, and the construct of perceived control was added to the theory.

2.4 Conceptual Framework

The conceptual framework of the study is as diagrammatically represented below showing the relationships between the independent and dependent variables as identified in the statement of the problem, objectives and research questions.

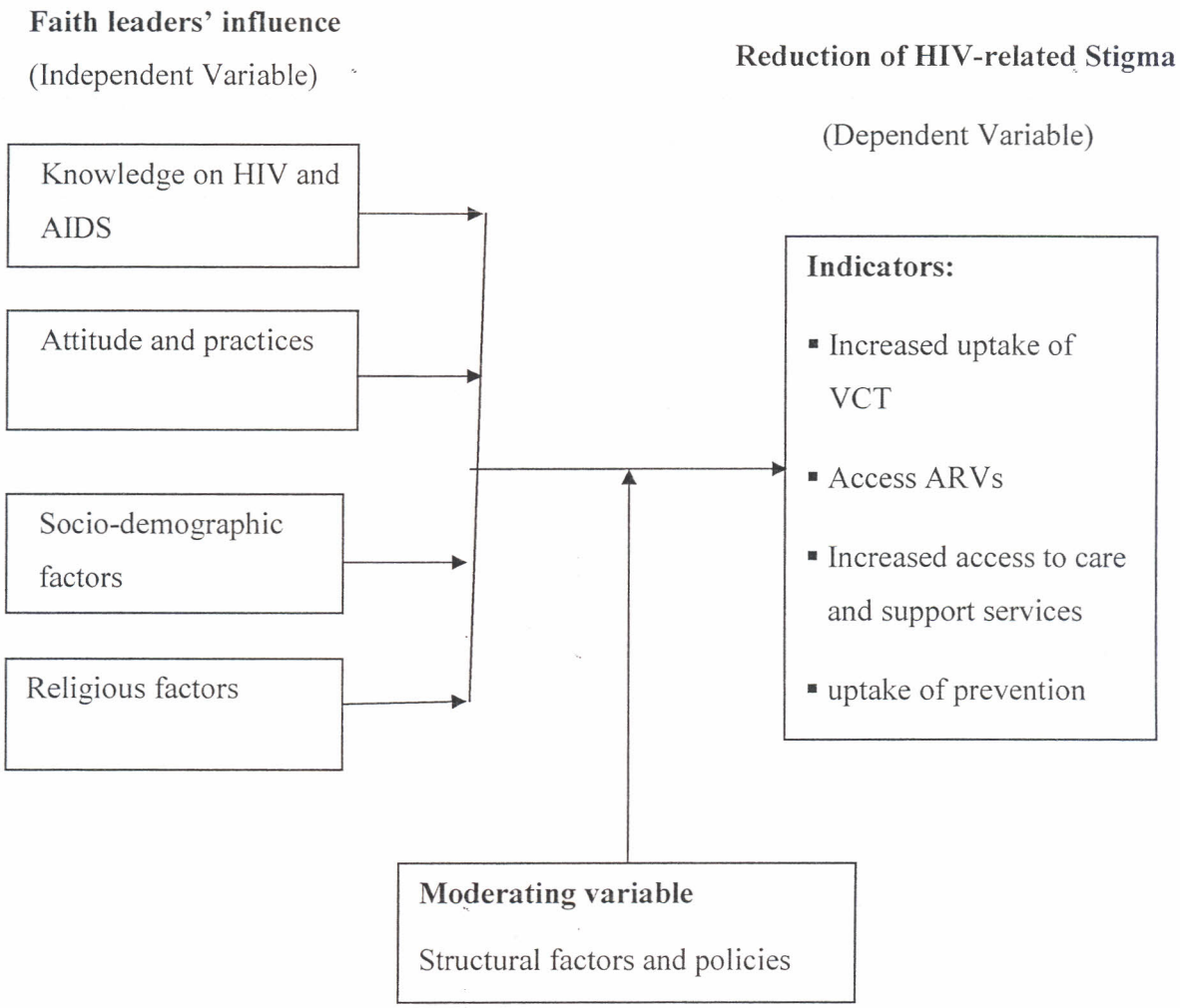

Figure 1: Conceptual Framework

2.5 Knowledge gaps

In 1987, the late Jonathan Mann, the director of the WHO Global programme on HIV and AIDS identified three phases of HIV/AIDS epidemic; the epidemic of HIV, the epidemic of AIDS and the epidemic of stigma, discrimination and denial. He noted the third phase is " as central to the global AIDS challenge to the disease itself (Mann,1987). Despite international effort to tackle HIV/AIDS since then, stigma and discrimination remain among the most poorly understood aspect of the epidemic. Piot (2000) identified stigma as "a continuing challenge" that prevents concerted effort at community, local, national and international level.

Stigma still remains one of the most significant challenges in developing countries for all HIV and AIDS programs, which involve the prevention and care continuum. Stigma increases vulnerability to HIV and worsens the impact of infection. Fear of being identified with HIV keeps people from learning about their status, changing behaviour to prevent infecting others, caring for people living with HIV and AIDS, and accessing HIV and AIDS services (UNAIDS/WHO, 2006). Additionally, stigma intensifies the emotional pain and suffering of people living with HIV and AIDS, their families and caregivers (Castro, 1998a; Castro *et al.*, 1998b).

"Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world (Ki-moon, 2008).

An understanding of the factors associated with attitudes toward HIV/AIDS is essential for the creation of community-based interventions that aim to dissolve stigmatizing perceptions (Parker and Aggleton, 2003).

In some countries people living with HIV lack knowledge of their rights in society. They need to be educated, so they are able to challenge the discrimination, stigma and denial that they encounter. Institutional and other monitoring mechanisms can enforce the rights of people with HIV and provide powerful means of mitigating the worst effects of discrimination and stigma.

Stigmatized individuals may suffer discrimination that can lead to loss of employment and housing, estrangement from family and society, and even increased risk of violence. HIV/AIDS-related stigma also fuels new HIV infections because it can deter people from getting tested for

the disease, make them less likely to acknowledge their risk of infection, and discourage those who are HIV-positive from discussing their HIV status with their sexual and needle-sharing partners.

Here in Kenya, our places of worship, that is churches, mosques and temples have not done enough to counteract this trend. We are still hearing sermons reinforcing the condemnation of Persons Living with AIDS (PLWAs), marginalizing them and reducing their status in the eyes of fellow-believers. This is very unfortunate for the opinions of religious leaders generally count for much in their congregations and even outside them and their opinion on morals tend to be respected (Wajibu, 2005).

2.6 Operationalization of Sudy Variables

Influence of faith leaders is the independent variable and was studied to find out how it impacts on reduction of HIV-related stigma. Factors that will be studied to measure influence of faith leaders' response include; knowledge on HIV and AIDS, attitude and practices, socio-demograhic factors, structural factors and policies in place.

Socio-demographic factors in this study they refer to variables such as age, education, religion, place of residence.

Knowledge on HIV and AIDS herein refers to the amount of correct information one has on HIV and AIDS and trainings on the same.

Attitude and practices: this refers to the manner those infected or affected by HIV are viewed or treated. The approaches faith leaders take when relating to those living with HIV.

Structural factors and policies; this refers to the laws and frameworks that are in place in a country that guide and regulate the way activities are done or implemented.

Religious factors: refer to factors that are dictated by our faith or conviction also stipulated in the doctrines that provide guidance to faith institutions or communities.

Reduction of HIV-related stigma; This is the dependent variable in this study and refers to acceptance of people both infected and affected by HIV as well as people infected coming out freely to talk about their status, seek care and support and advocate for their rights.

2.7 Summary of the Chapter

In this chapter, the researcher reviewed literature related to the study with an aim of giving an insight into what has already been done in the field of HIV and AIDS fight against stigma. under the following themes: HIV- related stigma, influence of socio demographic factors, influence of religious factors as well as structural influence on faith leaders response to reduction of HIV-related stigma. In addition, theoretical and conceptual framework have also been covered

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the materials methods that were used to achieve the study's objectives. The study design, details of how the data was obtained, processed, analyzed and interpreted to fulfill the research objectives is discussed. The methodology elements herein included the research design that was applied; target population; sampling design and procedures; the types of data; research instruments; as well as data processing and analysis techniques.

3.2 Research Design

The researcher employed the descriptive survey design. A descriptive research attempts to describe such things as possible behavior, attitudes, values and characteristics while a survey involves asking a large group of respondent's questions about a particular issue (Mugenda and Mugenda, 2003). The researcher then used statistical techniques to make conclusion about the population based on a representative sample. A descriptive survey research presents facts concerning the current status of a situation citing relationships of variables under study and therefore found appropriate for the study

3.3 Target Population

The target population was 35 that comprised of the total active members of KENERELA+ Koibatek District. The population composed of faith leaders- lay or ordained and those who held key positions in their churches or mosques.

3.4 Sample size and Sampling procedure

A sample is a finite part of a statistical population whose properties are studied to gain information about the whole (Webster, 1985). According to Patton (1990), sampling is the act, process, or technique of selecting a suitable sample, or a representative part of a population for the purpose of determining parameters or characteristics of the whole population.

3.4.1 Sampling procedure

The researcher employed census because the total population of Koibatek District was small. The strategy used was to select only respondents who are active members of KENERELA+, Koibatek District.

3.4.2 Sample size Selection

The sample consisted of 35 respondents who were identified through census sampling. All members were eligible for the study though the study was only able to reach 32 persons.

3.5 Data Collection Instruments

This study employed descriptive survey method and thus administered structured questionnaires and conducted interviews to collect information. The study used structured or closed ended questionnaires as the main tool for collecting data. Questionnaires were used since it was effective for obtaining information from the given population within a short time. This was quite ideal given the short period of time available for data collection. Each item in the questionnaire addressed a specific objective

A standardized questionnaire was developed with closed ended questions comprising a list of all possible alternatives from which respondents selected answers that best suited them. The questionnaire was developed for the faith leaders and was intended to capture various themes namely; attitudes, knowledge on HIV and AIDS and behavior towards PLWH as well as the religious, structural factors and policies influencing reduction of HIV related stigma. Any other devices such as a pencil, a paper test, a questionnaire the study used to collect data were also classified as research instruments.

3.5.1 Pilot testing of Instruments

Pretesting was conducted by the researcher in Mogotio District. Tisiik FBO was issued with 10 questionnaires which were completed by its active members who were faith leaders in order to assess its validity, reliability and to make the instrument clearer for actual data collection in KENERELA+, Koibatek District. The filled questionnaires were then collected, received feedback and reviewed. The necessary corrections and adjustments were made on the instrument before the actual data collection.

3.5.2 Validity of the instruments

Validity of instruments is the accuracy of and meaningfulness of the inferences, based on the research results. Mugenda and Mugenda (2003) refer to validity as the accuracy and meaningfulness of inferences which are based on research results. It is the degree to which results obtained from the analysis of data actually represent the phenomenon under study. To ensure validity, the study worked closely with the supervisor who provided guidance on the correct inferences to be made.

3.5.3 Reliability of the instruments

M'Mugambi (2008) says that reliability is concerned with estimates of the degree to which a research instrument yields consistent results data after repeated trials. This study used a standard questionnaire administered to faith leaders in a guided interview. These questionnaires were pre-tested first during the pilot study conducted in Mogotio District.

3.6 Data Collection Procedure

The study used structured or closed ended questionnaires for data collection. This was quite ideal given the short period of time available for data collection. Each item in the questionnaire addressed a specific objective.

The researcher obtained permission from the relevant authorities before embarking on the study. The study identified research assistants and had sessions with them to ensure that they clearly understood the information that was being sought as well as observe the ethical issues. Consent from the respondents was sought before administering the research instrument.

Before administering the questionnaires, clear instructions were provided to the respondents and clarifications made. Later the completed questionnaires were collected and analyzed.

3.7 Data analysis techniques

Data collected was analyzed for descriptive statistics (frequencies and percentages), Pearson Correlations and Chi square tests. The results were then presented in form of tables. It was also found to be the most appropriate statistical procedure due to its ability to show the influence of multiple variables on one designated dependent variable. The independent variables were influence of faith leaders' knowledge, attitude, practices, their socio-demographic factors such as gender and level of education, socio- structural factors and policies. The dependent variable was reduction of HIV-related stigma

3.8 Ethical Consideration

For participation in this study, all the participants were assured of total confidentiality and the information they gave was used for research purposes only. There was no direct benefit to the participants, but the results would be of value to them. Permission was sought from the organization before conducting the study. Confidentiality was maintained in each case by assigning each respondent a random number.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents findings of the study. The study examined the influence of faith leaders' knowledge on reduction of HIV-related stigma; found out the influence of faith leaders' attitude on reduction of HIV-related stigma; established the influence of socio-demographic factors on reduction of HIV-related stigma; investigated the influence of religious factors on reduction of HIV-related stigma; and established the influence of structural factors and policies on reduction of HIV-related stigma. To accomplish this data was collected from total active members of KENERELA+ Koibatek District.

4.2 Response Return Rate

A total of 35 questionnaires were distributed targeting the active members of KENERELA+ Koibatek District. The study was able to get a response from 32 respondents out of the 35 questionnaires distributed; that is a response rate of 91%. The reason cited in the cases of non response was unavailability of the respondents for contact. A series of meetings were arranged by the researcher but still these respondents did not turn up and could not be easily traced.

This following section presents the findings arising indicating the general characteristics of the respondents and the influence of faith leaders on reduction of HIV-related stigma through KENERELA+ Koibatek District.

4.3 General Characteristics of the respondents

4.3.1 Gender of the respondents

The gender of the respondents was sought where the results are given in Table 4.1 below

Table 4.1: Gender of the respondents

Response	Frequency	Percentage
Male	14	44
Female	18	56
Total	32	100

The study used a sample size made up of 56% female and 44% male. This implied that, there was a slightly higher percentage of females compared to males involved in reduction of HIV-related stigma through KENERELA+ Koibatek District. Men are very secretive and they do not open up; in other words their health seeking behavior is unfavourable and their response in sensitive issues such as HIV is rated as poor.

4.3.2 Age of Respondents

The study sought to establish the respondents' age and the result are as given in Table 4.2.

Table 4.2: Age of Respondents

Response	Frequency	Percentage
Less than 30 years	12	38
31 – 40 years	14	44
41 – 50 years	6	19
Total	32	100

According to the findings, most of the respondents (44%), were aged between 31-40 years, 38% were aged less than 30 years, while 19% were aged between 41-50 years. This implied that KENERELA+ Koibatek District group members were mainly youthful, hence, could still reach out to their age mates and were more vulnerable to stigma, therefore could reap benefits from this group.

The findings in respect to highest academic qualification attained by the respondents is presented in Table 4.3

Table 4. 3: Highest academic qualification

Response	Frequency	Percentage
Primary	6	19
Secondary	8	25
College	12	38
University	6	19
Total	32	100

The findings revealed that most of the respondents (38%) interviewed had attained college level, 25% had attained Secondary level, 19% had attained University level while 19% had attained Primary level. This implied that that a sizable percentage of 57% had attained college level and above and therefore were in a position to comprehend what the program was geared to and understand the value and process of HIV stigma reduction.

4.3.3 Respondents' religion

According to the findings, majority of the respondents (69%), were Christian, while 31% were Muslim. The interpretation is that there were more Christian members than there were Muslim members in KENERELA+ Koibatek District group. The contributing factor is that there are more Christians than Muslims in the study area.

For those who were Christians the study established their denomination as shown in Table 4.4.

Table 4.4: Christian denomination

Response	Frequency	Percentage
Catholic	11	34
Anglican	2	6
Protestant	9	28
Not Applicable	10	31
Total	32	100

The findings showed that most of the respondents (34%) indicated that they were of Catholic denomination, 31% were Muslims, 28% were Protestants, while 6% were Anglicans.

The respondents were asked to describe their involvement in their local congregation and the response is given in Table 4.5

Table 4.5: Involvement in their local congregation

Response	Frequency	Percentage
Pastor	10	31
Priest	2	6
Imam/Sheikh	2	6
Choir member	2	6
Congregant	10	31
Elder	6	19
Total	32	100

The findings showed that 31% described their involvement in their local congregation as congregants / members, 31% were Pastors, 19% said that they were elders, 6% were priests, 6% were Imam/Sheikhs, while 6% were choir members. This implied that most of the respondents were actively involved in church activities.

4.4 Influence of faith leaders' knowledge on reduction of HIV-related stigma

This section presents findings related to the influence of faith leaders' knowledge on reduction of HIV-related stigma.

4.4.1 Respondent's knowledge of the acronym HIV and AIDS

The respondents were asked to state what the acronym HIV and AIDS stood for and the responses are given in Table 4.6.

Table 4.6: Respondent's knowledge of the acronym HIV and AIDS

	Correct		Incorrect		Total	
	Frequencies	Percentages	Frequencies	Percentages	Frequencies	Percentages
HIV	28	88	4	13	**32**	**100%**
AIDS	26	81	6	19	**32**	**100%**

The findings indicated that majority of the respondents 28 and 26 correctly defined the acronym HIV and AIDS respectively. These constituted 88 % for HIV and 81% for AIDS. Only 4 respondents incorrectly defined HIV while 6 incorrectly stated the acronym AIDS which represented 13% and 19% respectively. A correct answer was an indication of basic awareness of HIV and AIDS.

4.4.2 Respondent's attendance to any workshop or training on HIV and AIDS

The respondents were asked if they had attended any workshop or training on HIV and AIDS and the findings showed that majority of the respondents (69%) indicated that they had attended some workshop or training on HIV and AIDS, while 31% indicated that they had not. The interpretation was that at least most of the respondents had basic facts about HIV and AIDS.

4.4.3 Details of HIV and AIDS workshop attended

The respondents were asked to give details of training undertaken and the results are as shown in Table 4.7.

Table 4.7: Details of HIV and AIDS workshop attended

Response	Frequency	Percentage
Not Applicable	8	25
Training on VCT	8	25
HIV prevention	4	13
Stigma Reduction	6	19
HIV management	6	19
Total	32	100

The findings showed that the workshop attended included Training on VCT (25%), Stigma Reduction (19%), HIV management (19%) and HIV prevention (13%). 25% did not give a response, implying that they had not attended any training. In respect to knowledge, attitude and practices that influence reduction of HIV-related stigma, the respondents were asked to respond to various statements. Chi Square tests were computed and the findings are as given in the tables below.

4.4.4 HIV and AIDS spread due to immoral behaviour

The response to the statement that HIV and AIDS spread due to immoral behaviour is given in Table 4.8.

Table 4.8: HIV and AIDS spread due to immoral behaviour

	Observed N	Expected N	Residual
Agree	16	16.0	.0
Disagree	16	16.0	.0
Total	32		

The results indicated a neutral stand; in that 16 out of 32 agreed that HIV and AIDS spread due to immoral behaviour, and 16 out of 32 disagreed with the statement. This implied that there was lack of proper knowledge on this aspect. The state shows that the observed number for both choices was equal to the expected number.

4.4.5 Congregants and HIV

The response to the statement that Congregants who get HIV get what they deserve is given in Table 4.9.

Table 4.9: Congregants who get HIV get what they deserve

	Observed N	Expected N	Residual
Agree	4	16.0	-12.0
Disagree	28	16.0	12.0
Total	32		

The findings revealed that majority of the respondents (28 out of 32) disagreed with the fact that Congregants who got HIV got what they deserved. This aspect of response was influenced by the knowledge acquired by the KENERELA+ members. This response shows positive trends towards reduced HIV stigma.

4.4.6 Rights of People living with HIV and AIDS

The response to the statement that 'People living with HIV and AIDS have a right to decide who should know about it' is given in Table 4.10

Table 4.10: The right of the People living with HIV and AIDS

	Observed N	Expected N	Residual
Agree	22	16.0	6.0
Disagree	10	16.0	-6.0
Total	32		

The results showed that most of the respondents (22 out of 32) agreed that People living with HIV and AIDS had a right to decide who should know about it. Only 10 disagreed. The implication is an aspect lack of proper knowledge on their rights as persons.

4.4.7 Sex workers were the only women who had to worry about getting HIV

The response to the statement that 'Sex workers were the only women who had to worry about getting HIV' is given in Table 4.11.

Table 4.11: Sex workers were the only women who had to worry about getting HIV

	Observed N	Expected N	Residual
Agree	6	16.0	-10.0
Disagree	26	16.0	10.0
Total	32		

Majority of the respondents (26 out of 32) disagreed to the statement that 'Sex workers are the only women who have to worry about getting HIV.' This showed an aspect of awareness and was a proof of their understanding of the risk of HIV.

4.4.8 Issues of Marriage in People with HIV and AIDS

The response to the statement that 'People with HIV and AIDS should still be allowed to get married, as long as both partners know about it' is given in Table 4.12

Table 4.12: People with HIV and AIDS should still be allowed to get married, as long as both partners know about it

	Observed N	Expected N	Residual
Agree	24	16.0	8.0
Disagree	8	16.0	-8.0
Total	32		

Majority of the respondents (24 out 32) demonstrated they had relevant knowledge as to whether People with HIV and AIDS should still be allowed to get married, as long as both partners know about it. The observed number 24 was above the expected number 16.0 and therefore the study concluded that there was lack of proper knowledge.

4.4.9 Faith leaders have a right to know if any of their members is HIV positive

The response to the statement that 'Faith leaders have a right to know if any of their members is HIV positive.' is given in Table 4.13.

Table 4.13: Faith leaders have a right to know if any of their members was HIV positive

	Observed N	Expected N	Residual
Agree	6	16.0	-10.0
Disagree	26	16.0	10.0
Total	32		

The findings revealed that most of the respondents (24 out 32) disagreed to the statement that Faith leaders had a right to know if any of their members was HIV positive.

4.4.10 Men who go to sex workers or use drugs are the only men who have to worry about getting HIV

The response to the statement that 'Men who go to sex workers or use drugs are the only men who have to worry about getting HIV' is given in Table 4.14.

Table 4.14: Men who go to sex workers or use drugs are the only men who have to worry about getting HIV

	Observed N	Expected N	Residual
Agree	4	16,0	-12.0
Disagree	28	16.0	12.0
Total	32		

The findings revealed that most respondents (28 out 32) disagreed to the statement 'Men who go to sex workers or use drugs are the only men who have to worry about getting HIV'. This response showed that most of the respondents had a good understanding of this aspect.

4.4.11 HIV positive women should not get pregnant

Regarding whether HIV positive women should not get pregnant, the response is given in Table 4.15.

Table 4.15: HIV positive women and pregnancy

	Observed N	Expected N	Residual
Agree	8	16.0	-8.0
Disagree	24	16.0	8.0
Total	32		

The findings revealed that most respondents (24 out 32) disagreed to the statement 'HIV positive women should not get pregnant'. This response showed that most of the respondents had a proper knowledge on this aspect, which touched on the right to relationships and HIV transmission.

4.4.12 Congregants who test positive have the right to decide whether or not their religious leaders should be informed

The analysis of responses to the statement that 'Congregants who test positive have the right to decide whether or not their religious leaders should be informed' is given in Table 4.16.

Table 4.16: Congregants who test positive have the right to decide whether or not their religious leaders should be informed

	Observed N	Expected N	Residual
Agree	24	16.0	8.0
Disagree	8	16.0	-8.0
Total	32		

The findings revealed that most respondents (24 out of 32) disagreed to the statement 'congregants who test positive have the right to decide whether or not their religious leaders should be informed'. This response showed that most of the respondents had a good understanding of this aspect.

The respondents were asked whether they agreed to the statement that 'Congregants with HIV should be kept at a distance from others', to which all of them disagreed. This implied that the knowledge they had acquired had reduced the HIV related stigma. All the respondents also disagreed to the statement that People with HIV and AIDS should not continue living with their family.

4.5 Influence of faith leaders' attitude on reduction of HIV-related stigma

This section presents the findings related to the Influence of faith leaders' attitude on reduction of HIV-related stigma. The study sought to find out whether the 32 respondents agreed or not in respect to various factors and the result showed that all the respondents agreed that HIV was a punishment for bad behavior; they all agreed that People with HIV and AIDS should be ashamed of themselves. This attitude was not favourable towards reduction of HIV-related stigma, since they would then say that people should bear their punishment.

4.5.1 Being ashamed if someone in my family had HIV

The respondents were asked if they would be ashamed if someone in my family had HIV and the result is given in Table 4.17

Table 4.17: Being ashamed if someone in my family had HIV

	Observed N	Expected N	Residual
Agree	4	16.0	-12.0
Disagree	28	16.0	12.0
Total	32		

The findings showed that the test had an observed number of 28 for Disagree against an expected number of 16.0. This was the only response with an observed number higher than the expected number. The interpretation was that 28 out 32 respondents disagreed to the fact that they would be ashamed if someone in their family had HIV. The interpretation was that they had a positive attitude, favourable to HIV related stigma reduction.

4.5.2 HIV linked to promiscuous behaviour

The respondents were asked if they agreed that People with HIV and AIDS are promiscuous and the findings revealed that all the respondents disagreed. This was an attitude that was favourable towards stigma reduction.

4.5.3 HIV is a punishment from God/Allah

The respondents were asked if they agreed that HIV is a punishment from God/Allah and the results are given in Table 4.18.

Table 4.18: HIV is a punishment from God or Allah

	Observed N	Expected N	Residual
Agree	2	16.0	-14.0
Disagree	30	16.0	14.0
Total	32		

The findings showed that the test had an observed number of 30 for those who disagreed against an expected number of 32. This was the only response with an observed number higher than the expected number. The interpretation was that 30 out 32 respondents disagreed that to the statement that HIV is a punishment from God or Allah. The interpretation was that they had a positive attitude, favourable to HIV related stigma reduction.

4.5.4 Feeling ashamed if infected by HIV

The respondents were asked if they agreed would feel ashamed if I was infected with HIV and the findings show that all the respondents agreed. The respondents felt that they would be ashamed if infected by HIV. This was an attitude that was not favourable towards stigma reduction. This was a show of self stigma which needed to be addressed.

4.5.5 People with HIV and AIDS should bear the consequences of their bad behavior

The respondents were asked if they agreed that People with HIV and AIDS should bear the consequences of their bad behavior and the result is given in Table 4.19.

Table 4.19: People with HIV and AIDS should bear the consequences of their bad behavior

	Observed N	Expected N	Residual
Agree	2	16.0	-14.0
Disagree	30	16.0	14.0
Total	32		

The findings showed that the test had an observed number of 30 for Disagree against an expected number of 32. This was the only response with an observed number higher than the expected number. The interpretation was that 30 out 32 respondents disagreed to the statement that People with HIV and AIDS should bear the consequences of their bad behavior. The interpretation was that they had a positive attitude, favourable to HIV stigma reduction.

4.6 Influence of religious factors on reduction of HIV-related stigma

The study examined a number of statements related to the Influence of religious factors on reduction of HIV-related stigma and the finding is given in Table 4.20.

Table 4.20: Influence of religious factors on reduction of HIV-related stigma

	Response	Frequency	Percentage
People who test HIV positive should abstain from sexual activity	Disagree	16	50
	Agree	16	50
Faith leaders should provide correct information about condoms?	Don't know	2	6
	Disagree	4	13
	Agree	26	81
HIV and AIDS is a punishment from God	Disagree	26	81
	Agree	6	19
Issues of Sexuality and HIV and AIDS must be included in sermons	Disagree	4	12
	Agree	28	88
Even Christians/ Muslims are allowed to use condoms for HIV prevention	Don't know	2	6
	Disagree	4	13
	Agree	26	81
Congregants should freely talk about HIV and AIDS	Agree	32	100
Mosques/ Churches should set aside funds to care and support those infected with HIV.	Disagree	4	12
	Agree	28	88

The study findings revealed that 50% disagreed to the statement that people who test HIV positive should abstain from sexual activity, while 50% agreed. This implied that there was a mixed feeling and this aspect needed to be clarified, since as religious leaders, they were likely to give conflicting information. It was also established that majority of the respondents (81%) agreed to the statement that Faith leaders should provide correct information about condoms, 13% disagreed, while 6% indicated that they did not know. This implied that the respondents appreciated the magnitude of HIV and AIDS and were determined to have it tackled.

The findings also showed that majority of the respondents (81%) disagreed that, HIV and AIDS is a punishment from God, while 19% agreed. The interpretation was that they now believed it had causes that it could be managed with proper measures. It was also established that majority of the respondents (88%) agreed that issues of Sexuality and HIV and AIDS must be included in sermons, while 12% disagreed. This pointed towards open willingness to contribute towards HIV stigma reduction.

The findings also showed that majority of the respondents (81%) agreed that even Christians/ Muslims were allowed to use condoms for HIV prevention, 13% disagreed, while 6% did not know. This implied that the use of condoms in curbing the spread of HIV was no longer a great concern. The findings also showed that all the respondents (100%) agreed congregants should freely talk about HIV and AIDS. The interpretation was that religious leaders had learnt to be accommodative to HIV and AIDS and that there was nothing to hide thus a move towards HIV stigma reduction.

It was also established that majority of the respondents (88%) agreed that Mosques / Churches should set aside funds to care and support those infected with HIV, 12% disagreed. This aspect would enhance HIV management and associated reduction of associated stigma.

4.7 Influence of socio-demographic factors on reduction of HIV-related stigma

So as to determine whether the socio-demographic factors on reduction of HIV-related stigma Pearson Correlations were computed relating specific socio-demographic factors and these are presented in the section below.

4.7.1 A Pearson correlation showing the relationship between gender and attitude towards PLWHA

Table 4.21: A Pearson correlation showing the relationship between gender and factors for HIV stigma reduction

		Gender	People with HIV and AIDS should bear the consequences of their bad behavior	Issues of Sexuality and HIV and AIDS must be included in sermons	Have you attended any workshop on training of HIV and AIDS
Gender	Pearson Correlation	1	-.228	.048	.051
	Sig. (2-tailed)	.	.210	.796	.782
	N	32	32	32	32
People with HIV and AIDS should bear the consequences of their bad behavior	Pearson Correlation	-.228	1	-.098	-.383(*)
	Sig. (2-tailed)	.210	.	.595	.031
	N	32	32	32	32
ssues of Sexuality and HIV and AIDS must be included in sermons	Pearson Correlation	.048	-.098	1	-.153
	Sig. (2-tailed)	.796	.595	.	.403
	N	32	32	32	32
Have you attended any workshop on training of HIV and AIDS	Pearson Correlation	.051	-.383(*)	-.153	1
	Sig. (2-tailed)	.782	.031	.403	.
	N	32	32	32	32

* Correlation is significant at the 0.05 level (2-tailed).

The findings showed that there was a negative Pearson correlation at (-228) between Gender and their response to the statement that, People with HIV and AIDS should bear the consequences of their bad behavior (attitude towards PLWHA). The interpretation was that the respondents had a positive attitude irrespective of gender. That is gender did not influence attitude towards stigma reduction.

The findings also revealed a positive Pearson correlation at 0.048 between Gender and their response to the statement that 'Issues of Sexuality and HIV and AIDS must be included in sermons'. The level of 0.048 is however, below the significant level at 0.05, therefore insignificant in this relationship. This finding is further explained in the cross-tabulation below.

Table 4.22: Issues of Sexuality and HIV and AIDS must be included in sermons (gender response)

	Response	Male	Female	Total Frequency	Percentage
Issues of Sexuality and HIV and AIDS must be included in sermons	Disagree	2	2	4	13
	Agree	12	16	28	88
	Total	14	18	32	100

The responses reflect a similar pattern of response implying that gender was not a basis. All respondents (members of KENERELA+) irrespective of gender had a positive attitude, and thus aligned towards HIV stigma reduction.

The findings also revealed a positive Pearson correlation at 0.051 between Gender and attendance to HIV and AIDS training workshop. The level of 0.051 is slightly above the significant level at 0.05, therefore significant in this relationship. The involvement of females in HIV and AIDS training workshop was slightly higher than that of males. This finding is further explained in the cross-tabulation (see Table 4.23).

Table 4.23: Attendance to HIV and AIDS training workshop (gender response)

	Response	Male	Female	Total Frequency	Percentage
Have you attended any workshop on training of HIV and AIDS	Yes	10	12	22	69%
	No	4	6	10	31%
		14	18	32	100%

The responses reflect a similar pattern of response implying that gender was not a basis. All respondents (members of KENERELA+) irrespective of gender had a positive attitude, and thus aligned towards HIV stigma reduction.

The findings established the gender perspective in respect to structural factors influencing HIV related stigma reduction as presented in table 4.24.

Table 4.24: Gender perspective in respect to structural factors influencing HIV related stigma reduction

		Gender		Religion	
		Male	Female	Christian	Muslim
Do you think that people who test HIV-positive should be tattooed in a small area near their groin to warn new sexual partners of their HIV status to avoid malicious infections	Disagree	14	12	16	10
	Agree	0	6	6	0
	Total	14	18	22	10

The findings revealed that majority of the respondents (12 out of 18 females) disagreed with the statement that HIV-positive should be tattooed in a small area near their groin to warn new sexual partners of their HIV status to avoid malicious infections, while all males disagreed, all the respondednts who agreed were female. The interpretation was that women did not have a say when it came to making decisions on sex, thus they were more vulnerable. All respondents who agreed to the approach of having HIV-positive persons tattooed in a small area near their groin were Christian females. The interpretation was that Muslims had realised the fact that they were at risk of getting infected with HIV compared to Christians. If people were marked this would increase HIV related stigma as well as increas irresponsible behaviour.

4.7.2 Attendance to HIV and AIDS training workshop in accordance to respondents' age

The study assessed the respondents Attendance to HIV and AIDS training workshop in accordance to respondents' age and this is given in table 4.25.

Table 4. 25: Attendance to HIV and AIDS training workshop (basis on respondents' age)

	Response	Respondent Age (Years)			Percentage
		Less than 30 years	31 - 40 years	41 – 50 years	
Have you attended any workshop on training of HIV and AIDS	Yes	13	38	19	69
	No	25	6	0	31
	Total	38	44	19	100

The findings showed that there was most of the respondents (38%) who had attended workshop on training of HIV and AIDS were aged between 31 and 40 years, most people who had not attended workshop on training of HIV and AIDS, while all the persons aged between 41 and 50 years (represented by 19%) had attended workshop on training of HIV and AIDS. The implication was that more elderly persons were keen on the aspect of attending training and therefore, more elderly persons had the potential of being less stigmatized than the younger persons.

4.7.3 Religion and view on discrimiation of the Congregants with HIV

The study examined the relationship between Religion and view on discrimiation of the congregants with HIV and the findings are as given in the Table 4.26.

Table 4.26: Religion and view on discrimiation of the Congregants with HIV

	Response	Religion	
		Christian	Muslim
Congregants with HIV should be kept at a distance from others	Disagree	22	10

According to the findings, all the respondents irrespective of the their religion disagreed to the statement that the congregants with HIV should be kept at a distance from others. Therefore

religion did not determine the level of HIV related stigma, implying an equal potential of all persons to reduce HIV stigma irrespective of religion.

4.8 Influence of structural factors and policies on reduction of HIV-related stigma

This section presents the findings related to the influence of structural factors and policies on reduction of HIV-related stigma.

4.8.1 If HIV-positive should be tattooed in a small area near their groin to warn new sexual partners of their HIV status

The study sought to find out from the respondents if they agreed that people who test HIV-positive should be tattooed in a small area near their groin to warn new sexual partners of their HIV status to avoid malicious infections.

Table 4.27: HIV-positive should be tattooed in a small area near their groin

	Observed N	Expected N	Residual
Disagree	26	16.0	10.0
Agree	6	16.0	-10.0
Total	32		

According to the Chi- square results, majority of the respondents (26 out of 32) disagreed to the statement that people who test HIV-positive should be tattooed in a small area near their groin to warn new sexual partners of their HIV status to avoid malicious infections. The observed number of 26 is higher than the expected value at 16.0. Therefore, the study concludes that majority of the respondents, do not support this view.

4.8.2 Testing all members in the congregation so as to give us accurate statistics

The study sought to find out from the respondents if they agreed that everyone in the congregation should be tested to give us accurate statistics and allow us to know who HIV+ is and who is not; and the result and is given in Table 4.28.

Table 4.28: Everyone in the congregation should be tested to give us accurate statistics

	Observed N	Expected N	Residual
Don't know	2	10.7	-8.7
Disagree	20	10.7	9.3
Agree	10	10.7	-.7
Total	32		

Majority of the respondents (20 out of 32) disagreed to the statement that everyone in the congregation should be tested to give us accurate statistics and allow us to know who HIV+ is and who is not The observed number of 26 is higher than the expected value at 10.7, therefore, the study concludes that majority of the respondents, do not support this view.

4.8.3 Forcing HIV positive persons to tell new sexual partners about their HIV status

The response on the respondent's view as to whether a person who is HIV positive should not be forced to tell new sexual partners about their HIV status is given in Table 4.29.

Table 4.29: A person who is HIV positive should not be forced to tell new sexual partners about their HIV status

	Observed N	Expected N	Residual
Don't know	2	10.7	-8.7
Disagree	14	10.7	3.3
Agree	16	10.7	5.3
Total	32		

The findings showed that most of the respondents (16 out of 32) agreed that a person who is HIV positive should not be forced to tell new sexual partners about their HIV status, 14 out of 10.7 respondents disagreed. The two observed numbers 16 and 14 are above the expected number of

10.7, thus reflecting mixed feelings. This therefore meant that there was lack of awareness on how to treat this aspect.

4.8.4 Government Funding to Faith Based Organizations for sensitization of people on HIV prevention and management

The response to whether the respondents agreed or not that Faith Based Organizations should be funded by the government to sensitize people on HIV prevention and management is shown in Table 4.30.

Table 4.30: Government Funding to Faith Based Organizations for sensitization of people on HIV prevention and management

	Observed N	Expected N	Residual
Don't know	2	10.7	-8.7
Disagree	2	10.7	-8.7
Agree	28	10.7	17.3
Total	32		

The findings showed that the test had an observed number of 28 for Agree an expected number of 10.7. This was the only response with an observed number higher than the expected number. The interpretation was that 28 out 32 respondents agreed that Faith Based Organizations should be funded by the government to sensitize people on HIV prevention and management.

4.8.5 All religious organizations should have policies in place to protect those living with HIV

The response to whether the respondents agreed or not that all religious organizations should have policies in place to protect those living with HIV is given in Table 4.31.

Table 4.31: Religious organizations should have policies in place to protect those living with HIV

	Observed N	Expected N	Residual
Don't know	2	16.0	-14.0
Agree	30	16.0	14.0
Total	32		

The findings showed that the test had an observed number of 28 for Agree an expected number of 16.0. This was the only response with an observed number higher than the expected number. The interpretation was that 28 out 32 respondents agreed that all religious organizations should have policies in place to protect those living with HIV. This also meant that if they acknowledged their participation role in put in place protection policies.

4.9 Discussion

4.9.1 General Characteristics of the respondents

On the aspect of the general characteristics of the respondents, the study used a sample made up 56% female and 44% male Men are very secretive and they do not open up; in other words their health seeking behavior is unfavourable and male involvement in all interventions aimed at reduction of HIV related stigma should be emphasized so that both men and women equally participate in addressing their health issues. According to the findings, most of the respondents (44%), were aged between 31-40 years, 38% were aged less than 30 years, while 19% were aged between 41-50 years. This implied that KENERELA+ Koibatek District group members were mainly youthful, hence, could still reach out to their age mates and were more vulnerable to stigma as well as they are the at risk group when it comes to HIV infection and prevalence rate. Therefore, the members could reap benefits from this group addressing their peers. It was also found that most of the respondents (38%) interviewed had attained College level, 25% had attained Secondary level, 19% had attained University level. This is an advantage since passing information on HIV related issues will easily be learnt and correct information passed to the next group of beneficiaries who could be congregants in their respective churches/ mosques.The study also found that majority of the respondents (69%), were Christian, while 31% were Muslim. This shows that majority of people can easily be reached by KeNERELA+ members whether in churches or mosques since they are represented in the organization. Regarding their denomination most of the respondents (34%) indicated that they were of Catholic denomination, 31% were Muslims, 28% were Protestants, while 6% were Anglicans. Also established was that 31% described their involvement in their local congregation as congregants / members, 31% were Pastors, 19% said that they were elders. These are key people in the FBO are very influential in passing information on HIV and AIDS and contribute greatly to the reduction of HIV related stigma.

4.9.2 Influence of faith leaders' knowledge on reduction of HIV-related stigma

The study examined the influence of faith leaders' knowledge on reduction of HIV-related stigma. From the findings it was found that majority of the respondents knew what the abbreviation HIV and AIDS stood for. On average 90% answered correctly, while 10% answered incorrectly. The

findings showed that majority of the respondents (69%) indicated that they had attended some workshop on training of HIV and AIDS. The findings showed that the courses performed included Training on VCT (25%), Stigma Reduction (19%), HIV management (19%) and HIV management (13%). This was a positive step in reducing HIV stigma. This approach is supported by various researchers for instance, Mahdi, et al., 2006) posits that public health campaigns to reduce stigmatization must address individuals on the basis of their socio-demographic characteristics (Majority of the respondents (28 out of 32) disagreed with the fact that Congregants who got HIV got what they deserved. The findings revealed that majority of the respondents (26 out of 32) disagreed to the statement that 'Sex workers are the only women who have to worry about getting HIV. Majority of the respondents (24 out 32) demonstrated lack of knowledge as to whether People with HIV and AIDS should still be allowed to get married, as long as both partners know about it. This fears are also presented in Carla (2008) who argues that from early in the AIDS epidemic a series of powerful images were used that reinforced and legitimized stigmatization. Carla (2008) further posits that as HIV AIDS becomes a disease that can be both prevented and treated, attitudes will change, and denial, stigma and discrimination will rapidly be reduced.

4.9.3 Influence of faith leaders' attitude on reduction of HIV-related stigma

Regarding the Influence of faith leaders' attitude on reduction of HIV-related stigma, the findings revealed that all the respondents disagreed that HIV was a punishment for bad behavior; they all disagreed that People with HIV and AIDS should be ashamed of themselves; 28 out 32 respondents disagreed to the fact that they would be ashamed if someone in my family had HIV; all the respondents disagreed to the statement that HIV is a punishment from God or Allah; 30 out 32 respondents disagreed that they would feel ashamed if they were infected with HIV. The findings also showed that 30 out 32 respondents disagreed to the statement that People with HIV and AIDS should bear the consequences of their bad behavior. Negative attitude by religious leaders can adversely affect efforts towards reduction of HIV-related stigma. Studies of HIV related stigma within FBOs point to interlinked factors that are related to such occurrences, including reduction of HIV infection to issues of individual morality and sin (Dube, 2001). The failure of many FBOs to engage openly in topics fundamental to HIV and AIDS prevention including human sexuality and women's empowerment.

4.9.4 Influence of religious factors on reduction of HIV-related stigma

The study investigated the influence of religious factors on reduction of HIV-related stigma. The study findings revealed that 50% disagreed to the statement that people who test HIV positive should abstain from sexual activity, while 50% agreed; and majority of the respondents (81%) agreed to the statement that Faith leaders should provide correct information about condoms. It was also established that majority of the respondents (88%) agreed that Mosques / Churches should set aside funds to care and support those infected with HIV, 12% disagreed; majority of the respondents (88%) agreed that issues of Sexuality and HIV and AIDS must be included in sermons. It was also established that majority of the respondents (81%) agreed that even Christians/ Muslims were allowed to use condoms for HIV prevention. The findings also revealed that all the respondents (100%) agreed congregants should freely talk about HIV and AIDS; and that majority of the respondents (81%) disagreed that, HIV and AIDS is a punishment from God. A study by Cadre (2005) revealed that HIV vulnerability caused by religious beliefs and practices is as a result of religious institutions' denounciation of HIV infection as sinful. Such religious judgments play a significant role in generating HIV and AIDS related stigma which increases vulnerability.

4.9.5 Influence of socio-demographic factors on reduction of HIV-related stigma

The study also examined the influence of socio-demographic factors on reduction of HIV-related stigma. The findings revealed that there was a negative Pearson correlation at (-228) between Gender and their response to the statement that, People with HIV and AIDS should bear the consequences of their bad behavior (attitude towards PLWHA); and a positive Pearson correlation at 0.048 between Gender and their response to the statement that 'Issues of Sexuality and HIV and AIDS must be included in sermons'. All respondents (members of KENERELA+) irrespective of gender had a positive attitude, and thus aligned towards HIV stigma reduction. The findings also revealed that most of the respondents (38%) who had attended workshop on training of HIV and AIDS were aged between 31 and 40 years, most people who had not attended workshop on training of HIV and AIDS, while all the persons aged between 41 and 50 years (represented by 19%) had attended workshop on training of HIV and AIDS. The implication was that more elderly persons were keen on the aspect of attending training and therefore, more elderly persons

had the potential of being less stigmatized than the younger persons. Castro and Farmer (2005) argue that the study of HIV-related stigma is often decontextualized from larger social processes, ignoring the social, cultural and economic environment in which stigma occurs. An understanding of the role of the community in influencing HIV/AIDS attitudes is essential for the development of community-based efforts to reduce HIV transmission, particularly among young people who are currently facing the burden of the HIV epidemic in sub-Saharan Africa.

4.9.6 Influence of structural factors and policies on reduction of HIV-related stigma

The study also examined the Influence of structural factors and policies on reduction of HIV-related stigma. It was established that majority of the respondents (26 out of 32) disagreed to the statement that people who test HIV-positive should be tattooed in a small area near their groin to warn new sexual partners of their HIV status to avoid malicious infections. Majority of the respondents (20 out of 32) disagreed to the statement that everyone in the congregation should be tested to give us accurate statistics and allow us to know who HIV+ is and who is not . The findings showed that most of the respondents (16 out of 32) agreed that a person who is HIV positive should not be forced to tell new sexual partners about their HIV status, 14 out of 32 respondents disagreed. It was established that 28 out 32 respondents agreed that Faith Based Organizations should be funded by the government to sensitize people on HIV prevention and management; and that 28 out 32 respondents agreed that all religious organizations should have policies in place to protect those living with HIV. This is in agreement with the finding by Goliber (2006) which revealed that the pervasive silence surrounding the HIV/AIDS epidemic in sub-Saharan Africa has led to limited public discussion and continued stigmatization of those who are infected.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter summarizes and concludes the research findings as carried out. At the end of the chapter, some recommendations are proposed to the organization under study in order to solve the problem under study, based on the research findings. The purpose of this study was to examine the influence of KENERELA+ faith leaders on reduction of HIV-related stigma at Koibatek district, Kenya. In accomplishing this, the study examined the influence of faith leaders' knowledge on reduction of HIV-related stigma; found out the influence of faith leaders' attitude on reduction of HIV-related stigma; established the influence of socio-demographic factors on reduction of HIV-related stigma; investigated the influence of religious factors on reduction of HIV-related stigma; and established the influence of structural factors and policies on reduction of HIV-related stigma.

5.2 Summary of the findings

Data was collected from active members of KENERELA+ Koibatek District. The study was able to interview 32 respondents out of the target sample of 34 respondents. On the aspect of the general characteristics of the respondents, the study used a sample made up 56% female and 44% male. According to the findings, most of the respondents (44%), were aged between 31-40 years, 38% were aged less than 30 years, while 19% were aged between 41-50 years. It was also found that most of the respondents (38%) interviewed had attained College level, 25% had attained Secondary level, 19% had attained University level. The study also found that majority of the respondents (69%), were Christian, while 31% were Muslim. Regarding their denomination most of the respondents (34%) indicated that they were of Catholic denomination, 31% were Muslims, 28% were Protestants, while 6% were Anglicans. Also established was that 31% described their involvement in their local congregation as congregants / members, 31% were Pastors, 19% said that they were elders.

The study examined the influence of faith leaders' knowledge on reduction of HIV-related stigma. From the findings it was found that majority of the respondents knew what the abbreviation HIV

and AIDS stood for. On average 90% answered correctly, while 10% answered incorrectly. The findings showed that majority of the respondents (69%) indicated that they had attended some workshop on training of HIV and AIDS. The findings showed that the courses performed included Training on VCT (25%), Stigma Reduction (19%), HIV management (19%) and HIV management (13%). Majority of the respondents (28 out of 32) disagreed with the fact that Congregants who got HIV got what they deserved. The findings revealed that majority of the respondents (26 out of 32) disagreed to the statement that 'Sex workers are the only women who have to worry about getting HIV. Majority of the respondents (24 out 32) demonstrated lack of knowledge as to whether People with HIV and AIDS should still be allowed to get married, as long as both partners know about it.

The findings revealed that most of the respondents (24 out 32) disagreed to the statement that Faith leaders had a right to know if any of their members was HIV positive; most respondents (24 out 32) disagreed to the statement 'Men who go to sex workers or use drugs are the only men who have to worry about getting HIV'. Most respondents (24 out 32) disagreed to the statement 'HIV positive women should not get pregnant'; while most respondents (24 out 32) disagreed to the statement 'congregants who test positive have the right to decide whether or not their religious leaders should be informed'. On the same aspect of knowledge, most of the respondents agreed to the statement that 'Congregants with HIV should be kept at a distance from others', to which all of them disagreed.

Regarding the influence of faith leaders' attitude on reduction of HIV-related stigma, the findings revealed that all the respondents disagreed that HIV was a punishment for bad behavior; they all disagreed that People with HIV and AIDS should be ashamed of themselves; 28 out 32 respondents disagreed to the fact that they would be ashamed if someone in my family had HIV; all the respondents disagreed to the statement that HIV is a punishment from God or Allah; 30 out 32 respondents disagreed that they would feel ashamed if they were infected with HIV. The findings also showed that 30 out 32 respondents disagreed to the statement that People with HIV and AIDS should bear the consequences of their bad behavior.

The study investigated the influence of religious factors on reduction of HIV-related stigma. The study findings revealed that 50% disagreed to the statement that people who test HIV positive

should abstain from sexual activity, while 50% agreed; and majority of the respondents (81%) agreed to the statement that Faith leaders should provide correct information about condoms. It was also established that majority of the respondents (88%) agreed that Mosques / Churches should set aside funds to care and support those infected with HIV, 12% disagreed; majority of the respondents (88%) agreed that issues of Sexuality and HIV and AIDS must be included in sermons. It was also established that majority of the respondents (81%) agreed that even Christians/ Muslims were allowed to use condoms for HIV prevention. The findings also revealed that all the respondents (100%) agreed congregants should freely talk about HIV and AIDS; and that majority of the respondents (81%) disagreed that, HIV and AIDS is a punishment from God.

The study also examined the influence of socio-demographic factors on reduction of HIV-related stigma. The findings revealed that there was a negative Pearson correlation at (-228) between Gender and their response to the statement that, People with HIV and AIDS should bear the consequences of their bad behavior (attitude towards PLWHA); and a positive Pearson correlation at 0.048 between Gender and their response to the statement that 'Issues of Sexuality and HIV and AIDS must be included in sermons'. All respondents (members of KENERELA+) irrespective of gender had a positive attitude, and thus aligned towards HIV stigma reduction. The findings revealed that majority of the respondents (12 out of 18 females) disagreed with the statement that HIV-positive should be tattooed in a small area near their groin to warn new sexual partners of their HIV status to avoid malicious infections. It was also revealed that all respondents who agreed to the approach of having HIV-positive persons tattooed in a small area near their groin were Christian females.

It was also established that there was a positive Pearson correlation at 0.051 between Gender and attendance to HIV and AIDS training workshop. All respondents (members of KENERELA+) irrespective of gender had a positive attitude, and thus aligned towards HIV stigma reduction. Most of the respondents (38%) who had attended workshop on training of HIV and AIDS were aged between 31 and 40 years, most people who had not attended workshop on training of HIV and AIDS.

According to the findings, all the respondents irrespective of the their religion disagreed to the statement that the congregants with HIV should be kept at a distance from others. Therefore

religion did not determine the level of HIV stigma, implying an equal potential of all persons to reduce HIV stigma irrespective of religion.

The study also examined the Influence of structural factors and policies on reduction of HIV-related stigma. It was established that majority of the respondents (26 out of 32) disagreed to the statement that people who test HIV-positive should be tattooed in a small area near their groin to warn new sexual partners of their HIV status to avoid malicious infections. Majority of the respondents (20 out of 32) disagreed to the statement that everyone in the congregation should be tested to give us accurate statistics and allow us to know who HIV+ is and who is not . The findings showed that most of the respondents (16 out of 32) agreed that a person who is HIV positive should not be forced to tell new sexual partners about their HIV status, 14 out of 32 respondents disagreed. It was established that 28 out 32 respondents agreed that Faith Based Organizations should be funded by the government to sensitize people on HIV prevention and management; and that 28 out 32 respondents agreed that all religious organizations should have policies in place to protect those living with HIV.

5.3 Conclusions

Following the study findings, the following conclusions are made:

i. Faith leaders' knowledge had a significant influence on reduction of HIV-related stigma by the KENERELA+ members of Koibatek District. Majority of the respondents interviewed demonstrated knowledge of the abbreviation HIV and AIDS stood for. They indicated having attended some workshop on training of HIV and AIDS. This had an influence on how they perceived HIV stigma reduction. The workshops attended covered aspects related to Training on VCT (25%), Stigma Reduction (19%), HIV management (19%) and HIV management (13%).

ii. The positive attitude of KENERELA+ members as faith leaders had a positive influence on reduction of HIV-related stigma. For instance all the members disagreed that HIV was a punishment for bad behavior; they all disagreed that People with HIV and AIDS should be ashamed of themselves. The members disagreed that People with HIV and AIDS should bear the consequences of their bad behavior. This positive attitude was created a favorable environment for HIV stigma reduction.

iii. Religious factors as perceived by KENERELA+ members had a positive influence on the reduction of HIV-related stigma. For instance the members felt that Mosques / Churches should set aside funds to care and support those infected. They disagreed to the statement that people who test HIV positive should abstain from sexual activity. KENERELA+ members feel that Faith leaders should provide correct information about condoms.

iv. The socio-demographic factors such as gender, education and religion of the KENERELA+ members did not have an influence on reduction of HIV-related stigma. All respondents (members of KENERELA+) irrespective of gender had a positive attitude, and thus aligned towards HIV stigma reduction. The involvement of females in HIV and AIDS training workshop was slightly higher than that of males. More elderly persons were keen on the aspect of attending training and therefore, more elderly persons had the potential of being less stigmatized than the younger persons. Religion did not determine

the levle of HIV stigma, implying an equal potential of all persons to reduce HIV stigma irrespective of religion.

v. Structural factors and policies affecting the KENERELA+ members had a significant influence on reduction of HIV-related stigma in Koibatek District. The members upheld the fact that Faith Based Organizations should be funded by the government to sensitize people on HIV prevention and management. Regarding other aspects on practice the members felt that all religious organizations should have policies in place to protect those living with HIV and that HIV positive should not be forced to tell new sexual partners about their HIV status.

5.4 Recommendations

Following the findings, the study recommends as follows:

i. The Government of Kenya and concerned stakeholders should consider mobilizing resources to scale up awareness campaigns to members of the public to enhance the funding of Faith Based Organizations in promoting and scaling up sensitization activities to people on HIV prevention and management.

ii. Faith based organizations should have policies in place to protect those living with HIV. Such policies would touch on their rights. For instance the right to confidentiality and free participation for access to livelihood.

iii. Faith leaders in KENERELA+ and other related organizations need to be encouraged to scale up their involvement in activities geared towards stigma reduction. This can actualized through concerted efforts by the Government of Kenya.

5.4.1 Suggestions for further studies

1. A study to be undertaken to assess whether the PLWHAs are aware of their rights in Koibatek District.
2. A study to be undertaken to assess the extent of policy formulation and implementation for the protection of PLWHAs by Faith based Organizations in Koibatek District.

5.5 Contribution to the body of knowledge

This section presents the study's contribution to existing knowledge as shown in Table 5.1.

Table 5.1: Contribution to knowledge

No.	Objectives	Contribution to knowledge
1	To examine the influence of faith leaders' knowledge on reduction of HIV-related stigma	Faith leaders' knowledge had a significant influence on reduction of HIV-related stigma by the KENERELA+ members of Koibatek District.
2	To find out the influence of faith leaders' attitude on reduction of HIV-related stigma	The positive attitude of KENERELA+ members as faith leaders had a significant influence on reduction of HIV-related stigma.
3	To investigate the influence of religious factors on reduction of HIV-related stigma	Religious factors as perceived by KENERELA+ members had a positive influence on the reduction of HIV-related stigma.
4	To establish the influence of socio-demographic factors on reduction of HIV-related stigma	The socio-demographic factors such as gender, education and religion of the KENERELA+ members did not have an influence on reduction of HIV-related stigma.
5	To establish the influence of structural factors and policies on reduction of HIV-related stigma	Structural factors and policies affecting the KENERELA+ members had a significant influence on reduction of HIV-related stigma in Koibatek District.

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APPENDICES

Appendix I: Transmittal letter

Emily Chepng'eno
P.O. BOX 255 -20105
Mogotio.
7TH May, 2011.

THE National coordinator,
KENERELA+,
Nairobi.
kenerela@google.com

Dear Madam,

RE: PERMISSION TO CONDUCT AN ACADEMIC RESEARCH IN YOUR FBO

I am a student of the University of Nairobi in the Department of Extra Mural studies, Nakuru campus pursuing a Master of Arts degree in project planning and management. My admission number is L50/78770/2009.

I am conducting a study on **faith leaders' influence on the reduction of HIV-related stigma** and have identified your FBO as a source of the data required. This is to introduce myself and request your endorsement during data collection process. Your participation is very important; therefore, your honest responses as you answer the questions completely and clearly as possible will be required.

Be assured that the information that you will provide will be handled with utmost confidentiality and you will not be required to give your name. The data collected will be used for study purposes only.

Thank you for your cooperation,

Yours faithfully,
Emily Chepng'eno

Appendix IV

QUESTIONNAIRE

Dear Respondent,

My name is Emily Chepng'eno, holder of ID card number 22811226; I am currently a second-year Master of Arts in Project Planning and Management (MA - PPM) student at University of Nairobi School of Continuing and Distance Education. I am a resident of Nakuru town for more than 3 years and a staff in World Vision Mogotio IPA. After discussing my area of research with my supervisor Dr. John Mironga, he recommended that I collect and collate views from you to be used purely for academic purposes. I am particularly interested with the influence of faith leaders on the reduction of stigma and discrimination in relation to HIV and AIDS. In this process the study will focus only on faith leaders who are members of KENERELA+, Koibatek District. I would very much appreciate the opportunity to talk with you about your involvement in; knowledge, attitude and practices that influence reduction of HIV-related stigma, establishing the socio-demographic factors that influence your response to reduction of HIV-related stigma, investigating religious factors that influence your response to reduction of HIV-related stigma. The information you will give in this questionnaire will highly assist in creating more knowledge that will guide various stakeholders in making informed decisions when addressing issues related to HIV and AIDS. I assure you that the information you give will be confidential and used for academic purposes only.

This questionnaire has 4 sections as follows: Section 1, Section 2, Section 3 and Section 4. The filling of the questionnaire is expected to take about 15 minutes. The contents of the sections are as follows:

- Section 1 will seek socio-demographic factors that influence your response to reduction of HIV-related stigma
- Section 2 will gather data on Knowledge, attitude and practice that influence reduction of HIV-related stigma.

- Section 3 will gather data on religious factors that influence religious leaders' response to reduction of HIV-related stigma
- Section 4 will find out the structural factors and policies that influence religious leaders' response to reduction of HIV-related stigma

Thank you for your consideration

INSTRUCTIONS

Kindly answer all the questions provided. The information will be used for academic purposes only.

Do not write your name on the questionnaire

Please be as honest as possible

Don't spend too much time thinking about the answers.Your first reaction is probably the right one

For each question put a tick in the block next to the answer you choose.

If you don't understand a question, please don't hesitate to ask for clarification

Once you have finished filling in the questionnaire, please put it on the table in front of the venue

Thank you very much for your co-operation!

SECTION ONE

Socio-Demographic factors that influence your response to reduction of HIV-related stigma

1. Respondent Code (Official use) .....
2. Your gender: Male [ ] Female [ ]

3. Respondent Age (Years)

   Less than 30 [ ] 31 – 40 [ ] 41 – 50 [ ] More than 50 [ ]

4. Your highest level of education

   Primary [ ] Secondary [ ] College [ ] University [ ]

5. Your Religion:

Christian [ ] Muslim [ ] African traditionalist [ ] Others [ ] (Specify).....

6. If Christian what is your denomination?

Catholic [ ] Anglican [ ] Protestant [ ] Others [ ] (Specify).....

7. Describe your involvement in your local congregation

Pastor [ ] Priest [ ] Imam/Sheikh [ ] Others [ ] (Specify).....

SECTION TWO:

Knowledge, attitude and practices that influence reduction of HIV-related stigma

1. What does the acronym HIV and AIDS stands for;

   H ..... **A** .....

   I ..... **I** .....

   V ..... **D** .....

   S .....

2. ave you attended any workshop on training of HIV and AIDS

   Yes [ ] No [ ]

   If Yes, Give details .....

   .....

3. I am going to read out some statements to you. Please give me your answer in Agree, Disagree, or Don't Know (DK).

Code as: Agree-**01** Disagree-**02** DK-**99**

1	HIV and AIDS spreads due to immoral behaviour	☐☐
2	Congregants who get HIV get what they deserve.	☐☐
3	People living with HIV and AIDS have a right to decide who should know about it.	☐☐
4	Sex workers are the **only** women who have to worry about getting HIV	☐☐
5	People with HIV and AIDS should still be allowed to get married, as long as both partners know about it.	☐☐
6	Faith leaders have a right to know if any of their members is HIV positive.	☐☐
7	Men who go to sex workers or use drugs are the **only** men who have to worry about getting HIV	☐☐
8	HIV positive women should not get pregnant.	☐☐
9	Congregants who test positive have the right to decide whether or not their religious leaders should be informed.	☐☐
10	Congregants with HIV should be kept at a distance from others.	☐☐
11	People with HIV and AIDS should not continue living with their family?	☐☐

4. I am now going to read a series of statements.

Please tell me if you agree or disagree with these statements or are indifferent

No.	Questions	Coding categories	
1	HIV is a punishment for bad behavior	Agree	1
		Indifferent	2
		Disagree	3
2	People with HIV and AIDS should be ashamed of themselves	Agree	1
		Indifferent	2
		Disagree	3
3	I would be ashamed if someone in my family had HIV	Agree	1
		Indifferent	2
		Disagree	3
4	People with HIV and AIDS are promiscuous	Agree	1
		Indifferent	2
		Disagree	3
5	HIV is a punishment from God/Allah	Agree	1
		Indifferent	2
		Disagree	3

No.	Questions	Coding categories	
6	I would feel ashamed if I was infected with HIV	Agree	1
		Indifferent	2
		Disagree	3
7	People with HIV and AIDS should bear the consequences of their bad behavior	Agree	1
		Indifferent	2
		Disagree	3
8	People with HIV and AIDS are to blame for bringing the disease to the community	Agree	1
		Indifferent	2
		Disagree	3
9	I would feel ashamed to be seen in public with a friend who is known to have HIV	Agree	1
		Indifferent	2
		Disagree	3
10	People with HIV and AIDS got what they deserved	Agree	1
		Indifferent	2
		Disagree	3
11	How would most people in your congregation respond to the following statement: Men are not able to control their sexual desires, therefore they are not to blame if they become HIV positive through promiscuous behavior	Agree	1
		Indifferent	2
		Disagree	3

SECTION THREE:

Religious factors that influence religious leaders' response to reduction of HIV-related stigma

For each of the following questions please choose and tick one of the following answers:

Agree or Disagree (Tick the box next to your answer)

1. People who test HIV positive should abstain from sexual activity

   Agree [ ] Disagree [ ]

2. Faith leaders should provide correct information about condoms?

   Agree [ ] Disagree [ ]

3. HIV and AIDS is a punishment from God

   Agree [ ] Disagree [ ]

4. Issues of Sexuality and HIV and AIDS must be included in sermons

   Agree [ ] Disagree [ ]

5. Even Christians/ Muslims are allowed to use condoms for HIV prevention

   Agree [ ] Disagree [ ]

6. Congregants should freely talk about HIV and AIDS

   Agree [ ] Disagree [ ]

7. Mosques/ Churches should set aside funds to care and support those infected with HIV.

   Agree [ ] Disagree [ ]

SECTION FOUR:

Structural factors and policies that influence religious leaders' response to reduction of HIV-related stigma

For each of the following questions please choose and tick one of the following answers: Agree, Disagree. Tick the box next to your answer.

1. Do you think that people who test HIV-positive should be tattooed in a small area near their groin to warn new sexual partners of their HIV status to avoid malicious infections

   Agree [ ] Disagree [ ]

2. Everyone in the congregation should be tested to give us accurate statistics and allow us to know who is HIV+ and who is not

   Agree [ ] Disagree [ ]

3. A person who is HIV positive should not be forced to tell new sexual partners about their HIV status

   Agree [ ] Disagree [ ]

4. Faith Based Organizations should be funded by the government to sensitize people on HIV prevention and management.

   Agree [ ] Disagree [ ]

5. All religious organizations should have policies in place to protect those living with HIV

   Agree [ ] Disagree [ ]

THE END