
***PROJECT TITLE:*** **DEVELOPNG A HIV RELATED STIGMA, DENIAL AND DISCRIMINATION REDUCTION INTERVENTION FOR MBITA SUBCOUNTY-HOMA BAY COUNTY**

**Project Implementation Report Submitted to University Of Nairobi HIV Capacity Building Fellowship**

**by,**

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**PROJECT REPORT SUBMITTED AS PARTIAL FULFILMENT FOR THE AWARD OF FELLOWSHIP IN HEALTH PROGRAM MAANGEMENT OF THE UNIVERSITY OF NAIROBI**

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**DECLARATION**

I hereby declare that this project report is my original work and has not been presented for a degree in any university.

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**Signed.....**

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**DEDICATION**

This work is dedicated to my wife Mikelina, my daughter Sharon and my son Kelvin. Albeit for their patience. And to my parents Daniel Maina and Lydia Wangui who endeavored to educate me in my formative years.

**ACKNOWLEDGEMENT**

I would like to acknowledge the following people for their contribution towards completion of this project and without whose help this work would not have been possible. My supervisors Ms. Margaret Mwago and Dr. Anne Nderitu who reviewed and gave direction in compiling this report. Many thanks to UNITID secretariat for project facilitation and Stephen Ondindo for being available to assist whenever required

I further wish to acknowledge Inter Religious Council of Kenya (IRCK) secretariat for the support during the project implementation. Ms Patricia Chamia for the advisory role and Linus Nthigai for the experiential learning insight, Paul Jabiya for the administrative support and Dr. Francis Kuria for the project oversight. Your input is an invaluable gift that i will always feel very much indebted.

My thanks to all those religious leaders, theologians and IRCK staff who contributed to the booklet development and project implantation.

Special thanks to my wife, Mikelina for her encouragement and always nudging me to finish My project

Last but not least, I would like to thank the almighty God, without his grace and providence none of these would have been possible.

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**Abbreviations**

| | |
|---|---|
| AIDS | Acquired immune deficiency syndrome |
| ARV | Anti Retro Viral |
| CASCO | County AIDS and STI Control Officer |
| FBO | Faith Based Organization |
| FGD | Focus Group Discussion |
| GBV | Gender Based Violence |
| HIV | Human immunodeficiency virus |
| IFN | Inter Faith Network |
| IRCK | Inter Religious Council of Kenya |
| MOH | Ministry of Health |
| MSC | Most Significant Change |
| NACC | National AIDS Control Council |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PLHIV | People Living With HIV |
| RCB | Religious Coordinating Bodies |
| SDD | Stigma, Denial and Discrimination |
| SSSDDIM | stigma, shame, silence, denial, discrimination, inaction and mis-action |
| UoN | University of Nairobi |
| UHIV | University of Nairobi HIV Capacity Building Fellowship |
| UNAIDS | Joint United Nations Programme on HIV/AID |

**Definitions of significant terms**

**Congregation**

This term refers to members of a specific religious group who regularly worship at a church or synagogue, mosque or temple.

**Congregational leader**

The term congregational leader refers to a person of faith who is formally recognized as a leader by his congregation denomination as well as a reference point, and often the link for the congregation with other senior religious leaders such as the youth leader, women's leader, men leader and ministry leaders.

**Religious Leader**

The term religious leader refers to a person of faith who is formally recognized by the religious community of which they are a part, as the reference point, and often the decision maker, for matters of doctrine, faith, and practice, and often, governance.

**Faith-based organization**

This term is defined as a formally structured nongovernmental organization founded by a religious congregation or religiously-motivated incorporators and it is explicitly aligned, supportive and accountable to specific faith or interfaith expressions and /or respective religious entities.

**Faith Community**

This term refers to a group of people, regardless of race or creed, joined together by a common faith, focus, goal, or ideas based on the same set of principles, beliefs and values.

**Faith Sector**

This term is used to refer to both faith communities and faith-based organizations

**Stigma**

Stigma refers to the beliefs and attitudes that deeply discredit a person or group because of an association with HIV.

**Discrimination**

Discrimination is treatment or consideration of, or making a distinction in favor of or against, a person or thing based on the group, class, or category to which that person or thing is perceived to belong to rather than on individual merit

## 1.0 Project summary

"DEVELOPNG A HIV RELATED STIGMA, DENIAL AND DISCRIMINATION REDUCTION INTERVENTION FOR MBITA SUBCOUNTY-HOMA BAY COUNTY". The projects goal is to contribute to a reduction of HIV and AIDS prevalence in Mbita sub county, Homabay County. This will be achieved through Stigma, Denial and Discrimination (SDD) reduction. SDD reduction is expected to enhance adherence of HIV and AIDS treatment, Promote HIV Testing and Counseling (HTC) and increase uptake of HIV services in Mbita. Faith communities were mobilized to achieve the project purpose as 97% of Kenyans ascribe to a faith. The project will mobilize Inter Faith Network (IFN) religious leaders to contribute to Stigma, Denial and Discrimination (SDD) reduction in Mbita Sub County where stigma was identified as a barrier to effective HIV response. The intervention used Information based approach where the Fellow and IRCK developed a localized information package. A Faith Based Messages on HIV and AIDS SDD messages booklet was developed and theologians developed religious citations. Skills building interventions was used at the Homabay IFN network where IRCK has an already established presence. Homabay IFN religious leaders were sensitized on SDD reduction within their congregations and action plans for cascading the SDD messages to their congregations developed.

The project budget was Kshs 400,000 and was implemented in 3 months. In concurrence with PEPFAR strategy 3.0, the project will contribute to the 90/90/90 targets and epidemic control that requires delivering right things in the right places, right now and in the right way.

## 2.0 Introduction and background

Homa Bay County is one of the 47 Counties of Kenya. It's made up of eight constituencies; sub Counties namely Kasipul, Kabondo, Kasipul, Karachuonyo, Rangwe, Homa Bay Township, Mbita, Mbita and Suba. Its total population was estimated to be 1,053,465 in 2012 (County Government of Homabay, 2013)

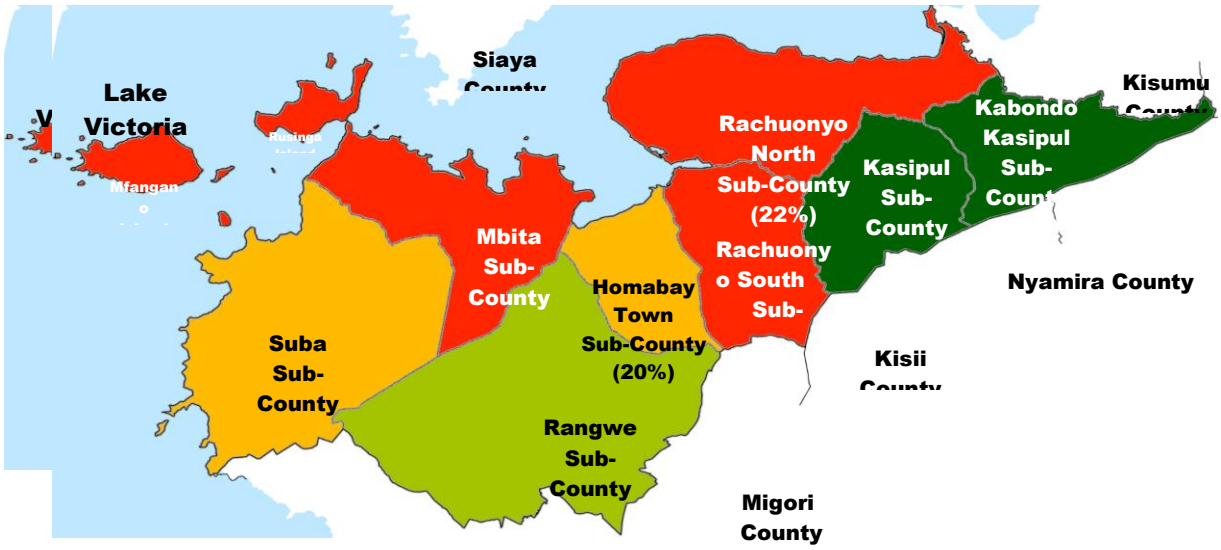
The project sought to address HIV prevalence in Mbita sub county, Homabay County through Stigma, Denial and Discrimination (SDD) reduction. This was done through mobilizing Inter Faith Network (IFN) religious leaders where they were sensitized on SDD and the SDD

messaging cascaded to their congregations. IRCK in consultation with theologians developed an SDD booklet that was used to train the IFN religious leaders. SDD reduction is expected to enhance adherence of HIV and AIDS treatment, Promote HIV Testing and Counseling (HTC) and increase uptake of HIV services in Mbita. The project will contribute to the PEPFAR 3.0 90/90/90 targets of having 90% PLHIV know their status (tested), 90% who are tested linked to ARV's and 90% on ARV's are retained with undetectable viral suppression. SDD will scale up the core interventions which are —ART, PMTCT, VMMC for maximum impact on the epidemic with substantial declines in HIV incidence. PEPFAR 3.0 posits the right things as targeting children, adolescent girls and key populations to increase their access to these core interventions, strengthen children's resilience, and decrease gender-based violence, discrimination and other barriers to HIV prevention, treatment and care.

This project sought to address the HIV prevalence in Mbita Sub County through Stigma, Denial and Discrimination (SDD) reduction. It's confirmed from studies that 23 percent of the population of Mbita sub-county is HIV-positive. PEPFAR 3.0 posits visualizes right places to mean we will focus our efforts on pinpointing the geographic areas at sub-national levels with the highest disease burden in every country .This will maximize resources and reach epidemic control focusing on geographic areas with the greatest need for treatment and prevention A desk review on Mbita confirmed that Stigma, Denial and Discrimination (SDD) is impeding uptake of HIV services in Mbita Sub County. SDD was further identified as a gap through a focus group discussion with religious leaders and that it was a big challenge to uptake of HIV services in Mbita. Key informant interviews with health officials informed SDD as a leading cause of treatment failure, morbidity and mortality in Homabay County hospital.

Desk review of Literature on HIV and AIDS showed that despite significant steps being made in the battle against HIV in the past decade by the various players in the sector, Stigma and discrimination remains a key obstacle to the uptake of HIV services. The HIV stigma index 2014 report shows that HIV stigma and discrimination in Kenya is high at 45 with marked regional variations. Homabay had a stigma index of 37 which was considered high and that it undermines the community's ability to control HIV transmission and care for those living with HIV. The HIV prevalence in Homabay County is shown in figure 1 below

**Figure 1: The average HIV prevalence in the Homa Bay County by sub counties.**




***Retracted from First Homabay County Multi Sectoral AIDS Strategic Plan 2014-2019***

Further it is envisaged that IFN religious leaders will cascade the messaging to their congregants. Stigma, Denial and Discrimination (SDD) reduction is expected to enhance the adherence of HIV/AIDS treatment, increase uptake of HIV services and promote HIV testing and counseling in Mbita Sub County.

IRCK has partnered with UHIV after an Organizational Capacity Assessment (OCA) found that there was no existing HIV program at IRCK and this has necessitated the need for this project. This was facilitated by UHIV. Further, IRCK has tried initiating HIV programs before but has been constrained by lack of finances and low program management capacity

The Inter-Religious Council of Kenya (IRCK) in partnership with University of Nairobi (UoN) is implementing a project on Developing a HIV Related Stigma, Denial and Discrimination Reduction Intervention for Mbita sub County-Homabay County.

The Inter-Religious Council of Kenya (IRCK) is a multi-religious coalition that mobilizes the moral and social resources of religious people to address shared concerns. The IRCK has created

a multi-religious partnership in Kenya that mobilizes the moral and social resources of religious people to address shared concerns.

IRCK is constituted as coalition of all major faith communities in Kenya namely through their Religious Coordinating Bodies (RCB's); Kenya Catholic Conference of Bishops (KCCB), National Council of Churches of Kenya (NCCK), Evangelical Alliance of Kenya (EAK), Organization of African Instituted Churches (OAIC), Seventh Day Adventist Church (SDA), Supreme Council of Kenyan Muslims (SPKEM), National Muslim Leaders Forum (NAMLEF), Shia Ithnasharia Muslim Association (SHIA) and Hindu Council of Kenya (HCK). Each of these religious coordinating bodies has a national coverage with structures that ensure reach at the grassroots level and are the affiliates with which IRCK works. Additionally, the organization has formed Local Interfaith Networks to act as platforms for local advocacy and action. These Networks were formally formed as District Interfaith Networks and are currently being restructured to be County Interfaith Networks in line with the new Constitutional Dispensation.

## 3.0 Project Objectives

### 3.1 Goal

Contribute to a reduction of HIV and AIDS prevalence in Mbita sub county-Homabay County, Kenya by addressing Stigma, Denial and discrimination (SDD).

### 3.2 Project Purpose

The project aims to reduce Stigma, Denial and Discrimination in Mbita sub county, Homabay County. Reduction of SDD is expected enhance adherence to HIV/AIDS treatment, Increase uptake of HIV services and promote HIV testing and counseling (HTC).

### 3.3 Specific objectives

i. Establish a qualitative baseline of Stigma, Denial and Discrimination (SDD) in Mbita sub county, Homabay County

ii. Develop Faith based SDD message booklet

iii. Sensitize 25 religious leaders on SDD reduction to cascade SDD reduction messages to their congregations.

### 3.4 Deliverables /Outputs

1. Baseline of Stigma, Denial and Discrimination (SDD) in Mbita sub county, Homabay County- **Output;** Baseline Report

2. A booklet with messages on Stigma, Denial and Discrimination (SDD) developed- **Output;** Faith SDD booklet

3. Stigma, Denial and Discrimination (SDD) booklets produced and disseminated- **Output;** Dissemination report

4. 16 Homabay Inter Faith Network (IFN) religious leaders sensitized on SDD reduction - **Output;** Dissemination report

## 4.0 Project Implementation Methodology

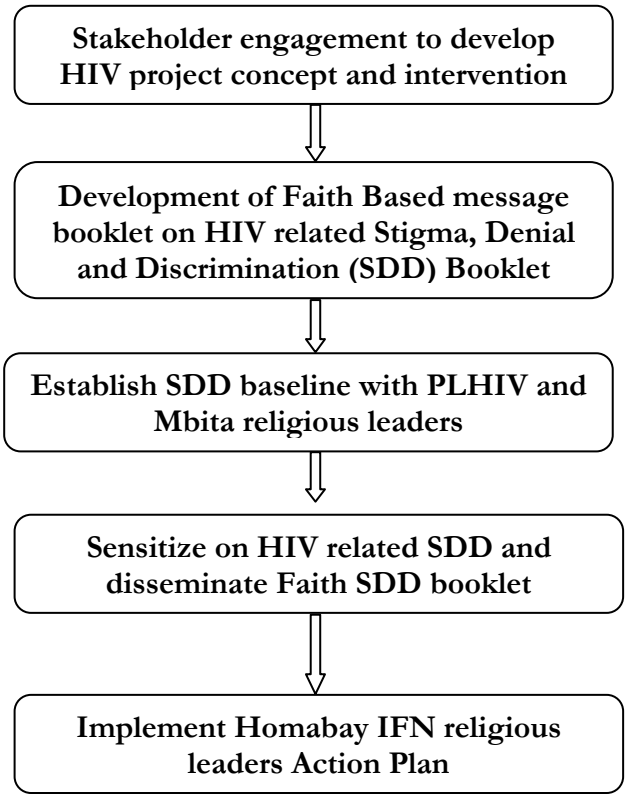
IRCK uses the congregational model in all its projects and this has proven important in ensuring that beneficiaries keep receiving the benefits long after the project come to the end. In this strategy, Religious Leaders are capacitated to deliver the intervention through the existing faith structures. The empowered religious leaders cascade messages to their congregations through worship services and other faith forums. This ensures IRCK does not create any new structure but work within the existing ones. Because Religious Leaders are spread all over the communities, there is a guarantee that once they are capacitated, the knowledge remains within the society.

This Stigma, Denial and Discrimination (SDD) project adopted IRCK congregational model and involved consensus with religious leaders in all its phases. IRCK secretariat works with Standing Commissioners who are technical experts nominated by the nine religious coordinating bodies which constitute IRCK. In project implementation the fellow worked closely with the secretariat and the Health and Wellbeing Standing Commissioners to review the project proposal, work plan and plan for activities. This was done through the monthly Health and Wellbeing Standing Commissioners meeting where consensus was sought on project activities and methodology.

The project mobilized Inter Faith Network (IFN) religious leaders to contribute to Stigma, Denial and Discrimination (SDD) reduction in Mbita Sub County where stigma was identified as a barrier to effective HIV response. The intervention used Information based approach where a Faith Based Messages on HIV and AIDS SDD Booklet was developed and disseminated. The SDD booklet was developed with the help of IRCK Health and Wellbeing Standing Commissioners and religious theologians as experts in theology. Skills building interventions was used in the IFN network where IRCK has an already established presence. IFN religious leaders were sensitized on SDD reduction and the importance of cascading SDD reduction messages to their congregations. The developed SDD booklet will be used as a reference point by IRCK and its partners for SDD advocacy even after even after project closure.

Desk review of literature, focused group discussion (FGD) and key informant interviews with health workers posited the following as sources of high SDD in Homabay County; Customs and myths, discriminatory practices towards OVC and PLHIV and inadequate HIV related information. The conceptual framework for the project is shown in figure 2 below

**Figure 2: Conceptual Framework of SDD in Mbita Sub County**



### 4.1 Project planning

The following project documents were developed between July- December 2016 during the project planning phase in consultation with IRCK advisor and UoN supervisor; SDD work plan, SDD logical framework, SDD Detailed Implementation Plan (DIP), SDD Gantt chart, SDD Monitoring and Evaluation Framework, SDD Quality tool and SDD risk plans. IRCK-UoN project document was also developed and this outlined the grant details, MOU and the OCA report gaps. The risk plan, Detailed Implementation Plan (DIP) and the work plan were regularly updated mainly due to delay in funds disbursement.

Regular SDD project review meetings were held with IRCK Advisor, UoN supervisor, IRCK secretariat and the Health and Wellbeing Standing Commissioners (SC) to guide project planning phase and align the SDD project to the OCA gaps. Further, the following planning and review meetings were held; 9th August 2016 UoN-IRCK project review meeting, 5th December 2016 review of SDD work plan and activities with IRCK standing commissioners, 8th- 9th December 2016 aligning UoN-IRCK SDD project to IRCK 2013-2018 strategic plan and 27th January 2017 review of SDD work plan and aligning it with OCA report.

The SDD project was developed alongside the identified Organizational Capacity Assessment (OCA) gaps where it was identified IRCK has no existing HIV project. Other gaps filled by the project included program initiation, program planning, service delivery standards, program evaluation and program closure and sustainability plans. A logical framework matrix was developed to logically connect activities, output, outcome and desired goal as shown in table 1 below.

**Table 1: LOGICAL FRAMWORK**

| Logic of intervention | Objectively | Means of verification | Assumptions |
|---|---|---|---|

| | **Identifiable Indicators** | | |
|---|---|---|---|
| **Goal:** Contribute to a reduction of HIV and AIDS prevalence in Mbita sub county-Homabay County, Kenya by addressing Stigma, Denial and discrimination (SDD). | | | |
| **Project Outcomes**<br>1.Increased awareness of HIV related Stigma, Denial and Discrimination (SDD) among faith communities in Mbita | 1. No of IFN leaders cascading SDD messages | 1.No of SDD activities organized within faith congregations | 1.SDD message cascading to congregants will be effective |
| Project Outputs<br>1.Baseline on SDD<br>2.HIV related SDD booklet developed<br>3. 25 IFN leaders sensitized on HIV related SDD | 1.Key informant/FGD<br>2. One (1) Faith Based Messages on HIV and AIDs related SDD Booklet Developed<br>3. IFN leaders trained as TOT's<br>4. M&E visits | 1.Baseline report<br>2. One (1) Faith Based Messages on HIV and AIDs related SDD Booklet Developed and disseminated<br>3. No of IFN leaders sensitized on HIV related SDD<br>4. No of IFN leaders supported to cascade SDD messages<br>5.No of M&E visits done | 1.Field resources will be available<br>2.Content developers will be available<br>3.No of desired IFN leaders will be achieved<br>4.Field facilitation will be available |
| **Activities**<br>1. Key Informant interview/FGD/ Rapid SDD Baseline<br>2.1 Develop SDD booklet<br>2.2 Production and dissemination of 30 SDD booklets.<br>3. Sensitizing Homabay IFN leaders on SDD reduction<br>4. Support of TOT's in cascading SDD messages<br>5. Monitoring field visit | Inputs<br>1.Human resources Fellows, Theologians, Standing commissioners and IFN leaders.<br>2. Office Supplies Laptops, Camera, Flip charts, Internet and note books.<br>3.Field resources Transport reimbursements, Conference packages and IFN support facilitation | | UHIV will provide required project finances and facilitation. |

### 4.2 Project Implementation

The project goal was to contribute to the reduction of HIV and AIDS prevalence in Mbita Sub County through Stigma, Denial and Discrimination (SDD) reduction among the faith communities. SDD reduction was expected to enhance adherence of HIV and AIDS treatment, Promote HIV Testing and Counseling (HTC) and increase uptake of HIV services in Mbita. This was done through mobilizing Inter Faith Network (IFN) religious leaders to be champions of SDD reduction within their congregations. IFN religious leaders were sensitized on importance of SDD reduction and cascading SDD reduction messages to their congregations. Action plans were developed in conjunction with the IFN religious leaders.

Five activities formed the implementation milestones. This included;

1. Stakeholder engagement (FGD) with Homabay religious leaders to inform on preferred HIV response intervention project
2. A Qualitative baseline with People Living with HIV (PLHIV) in Mbita sub county to establish challenges and experiences faced by the group. This informed the projects dissemination report with Homabay Inter Faith Network (IFN) religious leaders
3. Development of a Faith Messages on HIV related Sigma, Denial and Discrimination (SDD) booklet to be used for sensitization and capacity building for the SDD project.
4. A Qualitative Baseline with Mbita religious leaders to establish existing HIV services within the faith communities in Mbita. This gave insight on opportunities for introducing and enhancing HIV related SDD activities. This was an input during the subsequent dissemination with Homabay IFN religious leaders
5. Dissemination workshop for Homabay IFN religious leaders on HIV related SDD. The SDD booklet and baseline reports were used. Action plans for stigma reduction and cascading SDD messages were made at this workshop

### 4.3 Stakeholder engagement

A focused group discussion (FGD) was first conducted on 25th February 2016 at the ACK Christ the Healer Cathedral Hall with Homabay Interfaith Network (IFN) religious leaders on the high prevalence of HIV in Homabay County. A total number of 15 religious leaders drawn from EAK, ACK, KCCB, SDA, OAIC and CIPK attended the meeting. The Executive Director IRCK and UHIV fellow were in attendance. The discussion was centered on the UoN-IRCK partnership towards capacity building and enhancing national response towards HIV/AIDs response. Homabay County led in national HIV statistics and a partnership and congruence with religious leaders towards a shared response with the national government was articulated by the UHIV fellow.

The religious leaders identified Stigma, Denial and Discrimination (SDD), poverty and culture as major barriers in tackling HIV in Homabay County. Of concern the religious leaders highlighted that stigma and disclosure was a major barrier towards combating HIV in Homabay County. This was manifested in PLHIV throwing ARVs at dump sites, high treatment failures on clients on HAART and non disclosure of sero status when marrying or inheriting a spouse. This information was corroborated with the desk review done by the fellow indicating Homabay County had a stigma index of 37 against a national reference of 45. Further, majority of cases resulting to morbidity and mortality in Homabay County referral Hospital were attributed to HIV/AIDS.

The religious leaders further sought to be capacitated with skills to tackle stigma as a way of enhancing their efforts towards the national HIV response. This later informed the project proposal development and opened further engagements with Homabay religious leaders which culminated to the development of the proposal dubbed "DEVELOPNG A HIV RELATED STIGMA, DENIAL AND DISCRIMINATION REDUCTION INTERVENTION FOR MBITA SUBCOUNTY-HOMA BAY COUNTY". The project proposal was presented to UoN and CDC in March 2016 and approved in July 2016.

### 4.4 Development of a Faith Messages on HIV related Sigma, Denial and Discrimination (SDD) booklet

The Faith Based message on HIV related SDD booklet was developed in conjunction with theologians and IRCK Health and Well-Being standing commissioners (SC). The objective of the booklet was to; The booklet will be used as a reference and information package for religious leaders in HIV related SDD reduction, create awareness on HIV related SDD and challenge stigmatizing attitudes and beliefs among faith communities. It was developed in three stages namely; UoN Fellow produced a working SDD zero draft, a draft working workshop with stakeholders to develop the SDD booklet and a review and validation workshop to adopt the booklet.

It's imperative to note that the SDD booklet was contextualized to fit Homabay County by engaging Homabay IFN religious leaders through the drafting and validation stages of the booklet. The Key scripture messages to support stigma reduction developed by religious theologians on this project are only unique to this booklet (Chapter 6). The booklet was based previous works by Inter Religious Council of Kenya (IRCK) and Religions for Peace (2008) Combating HIV and AIDS Related Stigma, Denial and Discrimination, *A Training Guide for Religious Leaders*.

By engaging the IRCK Health and Wellbeing Standing Commissioners as technical experts in message development ensured the booklet was in line with the tenets of the nine religious coordinating bodies (RCB's). Engagement of theologians from the major faiths provided scripture references to the booklet and buy in by the faith community.

First, a message development working workshop was held at Convent International Guest House on 14$^{th}$ February where the IRCK standing commissioners, Theologians and IRCK secretariat reviewed a draft booklet developed by the UHIV Fellow. Representation was six (6) standing commissioners representing; SDA, SUPKEM, EAK, KCCB, KWFN and NAMLEF. Three

theologians were in attendance representing; SUPKEM, OAIC and EAK. The Director, National AIDS Control Council (NACC) was invited as a technical expert and a partner of IRCK in the workshop. The panel reviewed the draft and contributed content which the Fellow wrote down minutes for further editing.

A second review and validation meeting was held on 28th February 2017 at IRCK board room and in attendance were IRCK Executive Director, Health and Wellbeing Standing Commissioners (EAK and OAIC), two theologians (KCCB and NCCK) and two Homabay Inter Faith Network (IFN) religious leaders as stakeholders of the project. The Fellow gave a recap of the draft booklet meeting held on 14th February 2017 at Convent Guest Hotel and presented the reviewed SDD draft document in a chronological order chapter by chapter. The output of the validation meeting was an agreed booklet with HIV messages supported by spiritual references. The Fellow would occasionally engage theologians Dr. Hassan Kinyua (SUPKEM) and Rev. Elias Agola (NCCK) personally or through emails on aligning the faith messages. A further review by Mr. Wilfred Amaleba a Health and Wellbeing Standing Commissioner polished the final document.

The final "*Faith Messages on HIV related Stigma, Denial and Discrimination (SDD)*"had this chapters

1. Chapter 1: *About HIV and AIDS*. This chapter was contextualized to give an overview of HIV and AIDS, HIV prevention and management through adoption of the SAVE method. The SAVE method (Safe practices, Access to treatment, Voluntary Counseling and Testing (VCT) and Empowerment) was adopted as a generic model for the booklet

2. Chapter 2: *Myths and misconceptions of HIV*. This chapter was contextualized to the local setting by highlighting common myths on HIV and providing subsequent true facts on HIV to demystify beliefs held by faith communities. Among them faith healing, belief in HIV as a curse and HIV as a punishment from God

3. Chapter 3: *Stigma, Denial and Discrimination*. Introduced stigma as a concept, causes HIV related stigma and is manifestation within the faith communities. More so, the topic highlights types of HIV related in the individual, congregational and public stigma.

4. Chapter 4: *Stigma reduction approaches.* This chapter was contextualized to provide approaches for religious leaders in order to tackle SDD within the various levels in our community. The approaches highlighted in this booklet were; *Empowerment with knowledge* by providing congregations with right information about HIV, *Skills building among PLHIV* in order to enhance their coping skills, *Formation of support groups* to provide for social support to PLHIV, *Protection of orphans and vulnerable groups* in order to guarantee human rights, *participative interaction of PLHIV* and the non infected to change attitude on PLHIV, *Making appropriate referrals* for medical care and administrative action for PLHIV and lastly, *pastoral and spiritual counseling* to meet psychological needs for PLHIV.

5. Chapter 5: *The Role of Religious leaders in tackling SDD* highlighted the activities religious leaders can be engaged in within the faith communities in order to challenge HIV related SDD.

6. Chapter 6: *Key messages with scripture references*. Action messages to emphasize on care and love for PLHIV among faith communities were developed and under pinned with religious citations for spiritual guidance

**4.5 Focus Group Discussion (FGD) Baseline report with PLHIV in Mbita Sub County**

This SDD project was an implementation project and took on a qualitative approach for the rapid baseline to inform on the Stigma, Denial and Discrimination (SDD) reduction intervention. In order to be able set benchmarks and action points for the dissemination of SDD project, IRCK conducted a rapid baseline survey on the current levels of HIV related SDD among the faith communities in Homa Bay County and specifically Mbita Sub County. This also filled in the OCA gap where it was indicated IRCK needs to conduct baseline studies on all its projects.

Two (2) focus group discussions (FGD) with women and youth (PLHIV) support groups were held on 13$^{th}$ March 2017 to understand their perspectives on how faith community handles SDD within their congregations and how best this can be handled. A FGD guide (annex 1) was developed for elicit responses around HIV related SDD. Further, action points for religious leaders were identified in the FGD which were used to sensitize Homabay IFN religious leaders

on the support PLHIV within congregations want. The women support group FGD (12 members) was held from 9.00 am-12pm while the Youth support group FGD (12 members) was held at 12pm-3pm both at Mbita ACK church.

The objectives of the Focused Discussion (FGD) with PLHIV in Mbita Sub County was

1. To establish levels and forms of stigma within the faith communities of stigma in Mbita Sub County
2. To evaluate the causes of HIV related SDD in Mbita Sub County
3. To establish coping mechanisms for PLHIV on HIV related SDD in Mbita Sub County.

### 4.4.1 Stigma levels

Qualitative stigma manifestations of HIV related SDD were established and were based on the Focused Group Discussions (FGD) held with People Living with HIV and AIDS (PLHIV) in Mbita Sub County .The stigma analysis formed is similar to the national stigma index formed and the peculiar differences can be explained more on the homogenous settlement and the cultural beliefs of people in Mbita. This implied that people knew each other from the villages, worship areas, towns and health facilities visited. More so, the local population being homogenous people had common shared norms and practices across the sub county.

HIV related stigma, Denial and Discrimination (SDD) was alive in Mbita and was manifested in the following forms.

1. People living with HIV preferred to visit HIV clinics farther away from their localities to reduce the chance of meeting someone who knows them while picking ARV's. This includes local villagers and health care workers known to the PLHIV. One member expressed "I am registered in three (3) HIV clinics away from my village to facilitate review and ARV drug picks with utmost confidentiality. In case I meet someone I know in a certain clinic, I would definitely go to the next one".
2. Resisting faiths and faith healing was identified as another barrier to effective HIV response in that community. It was observed that Mbita Sub County had a mix of contemporary faiths mixed with Instituted African churches or faiths. This coupled with shared beliefs and norms led to PLHIV seeking faith healing for HIV at the expense of Anti Retroviral Treatment (ART) compromising ARV adherence and subsequent

treatment failure outcomes. Myths and misconceptions that HIV was a result of "witchcraft" resulted in PLHIV seeking resisting divine interventions and witchdoctors' antidotes.

3. Physical HIV and AIDS symptomatic events were used to gauge people's perception on when to seek HIV treatment and care or disclose their HIV status. People waited until when they were bedridden for them to seek care as the burden of early HIV testing would "cut short a person's comfort zone of being HIV free". Further, attributing of HIV symptoms to unrelated events such as witchcraft or common ailments resulted in people seeking care when they were late in the HIV clinical stages.
4. Cultural beliefs and practices were identified as barriers to effective HIV response and among the identified ones in Mbita Sub County included;
    i. Wife inheritance
    ii. Tran's generational marriages "older married men marrying younger spouses"
    iii. Death rite rituals "Disco matanga night vigilance".
    iv. Fish for sex culture which also promoted exchange of services such as food and bodaboda rides for sex
5. Gender perspective in HIV and AIDS transmission was identified as a stigma manifestation in the community. Women bore the brunt of outcasts when a spouse died after HIV diagnosis with labels such as "they are the one who brought upon the disease to their son". This explicitly contributed to HIV related SDD subsequent response to the stigmatized such depression and adherence to HIV treatment and care.
6. HIV services center setting influenced how PLHIV utilized the HIV services on offer. Existence of standalone HIV clinics and pharmacies within health centers resulted in PLHIV shunning these services as this resulted with them being stigmatized by community members. It was noted "that some villagers would peep on health center fences to see queuing to stock their ARV drugs".
7. It was established the funding withdraw for Community Health Extension Workers (CHEW's) by the National and County Governments eroded gains made in HIV education extension services. Mbita is a county with many far flung islands and the presence of government and International NGO's was not effectively felt. However, it

was noted that PLHIV were the majority CHEW volunteers and after withdraw of funding they ended up demoralized.

8. It was established PLHIV had formed support groups to meet their psychological and financial needs. It was however noted the support groups were established as means of meeting common challenges such providing for Income Generating Activities (IGA) to provide for daily subsistence, Nutrition needs and social support for as a counter measure towards manifested HIV related SDD. However, these challenges have a national outlook and unique to Mbita sub county alone.

Table 2 below shows representations for the women and youth groups in Mbita and services offered. Notably, psychosocial and spiritual counseling for meeting emotional needs of the members was lacking among services offered.

**Table 2: Existing PLHIV support groups around Mbita town**

| No. | Name | Meeting schedules | Supports offered |
|---|---|---|---|
| 1. | Smart ladies Rusinga women group | Every Sunday | Table banking, merry go round, hire purchase, |
| 2. | Safina women group | Every Wednesday | Social support |
| 3. | Mugoria Self Help Group | Every Saturday | Social support and table banking |
| 4. | Kanyarode women group | Every Saturday | Table banking |
| 5. | Magoria women group | Thursday | Merry go round |
| 6 | Nyakare women group | Every Wednesday | Merry go round and social support |
| 7. | Victory self-help group | 1st Sunday of every month | Counseling and social support |
| 8. | Gembe self help womens group | 1st Sunday of every month | Farming, table banking and paying school fees |
| 9. | Unique youth support group | Every Sunday | Social support and ARV follow up |
| 10. | Mudomari youth group | Once a month on Friday | Empowering youth and social support |
| 11. | Waregi youth group | Every Saturday | Social support and table banking |
| 12. | Nyangina youth support group | 1st Sunday of every month | Farming, table banking and paying school fees |

**4.5 Focus Group Discussion (FGD) Baseline Report with Mbita religious leaders**

Further, two (2) focus group discussions (FGD) were held on 14th March 2017 with Christian and another one with Muslim religious leaders (men/women and youth) on how the faith sector understand and handles HIV related SDD within their congregations and how best this can be handled. The Muslim religious leaders FGD was held at Mbita Jamia Mosque from 9am-12pm and in attendance were seven (7) religious leaders. The Christian religious leaders FGD was held at Mbita ACK church from 12.15 pm-3pm where eight (8) Christian religious attended (ACK, PEFA, NCCK, KCCB and Bahai). A total of 39 participants: 12 members of women support groups, 12 members of youth support groups: 7 Muslim religious leaders and 8 Christian religious leaders were involved in the baseline.

The Objective Focused Group Discussions (FGD) with Mbita religious leaders was to:

1. Evaluate the level of knowledge on HIV related SDD among Mbita religious leaders.
2. To identify existing HIV related SDD activities within the faith community in Mbita
3. To identify challenges and support required by Mbita religious in providing HIV related SDD support and provide for the dissemination workshop action points
4. To provide input for the SDD project dissemination workshop with Homabay Inter Faith (IFN) religious leaders who were the key champions in tackling SDD in Mbita

**4.5.1 Mbita religious leaders Baseline report**

The focus group discussion with Mbita religious leaders was guided by responses cascaded from PLHIV FGD. The observations are discussed below;

1. Mbita religious leaders were knowledgeable on HIV and HIV related SDD but there existed no programs within their calendar of worship for sharing HIV related information and capacity building on HIV related SDD. Calendar events which empower communities such as World AIDS day or HIV caravans were non-existent within worship calendar.
2. Organized participative interaction of PLHIV and the affected at the congregational level was lacking. Some expressed not the lack of will but the know how to empower congregants and integrate HIV education within worship services as a major barrier for effective HIV response. This would entail actively engaging PLHIV as champions at the congregation level for HIV related SDD reduction.

3. Some religious leaders expressed they didn't know how to introduce HIV and AIDS education and dissemination and were willing to do so once they were guided by the higher echelons of the senior religious leaders.
4. Social support groups for PLHIV supported or sponsored under the umbrella of religious faiths were lacking. The religious leaders expressed the need of being empowered with skills in establishing and running social support groups. It was however observed Mbita Jamia Mosque ran a social support program which empowered PLHIV in the community with material and financial assistance irrespective of their religion. More so, the group established proper booking and also maintained the confidentiality of their members. The Seventh Day Adventist (SDA) ran a Health development assistance program and HIV was one of the components in that program.
5. It was also established there was high resentment and stigma around Most at Risk Populations (MARP's) such as sex workers and Men having sex with men (MSM). Sex and sexuality was equally a sensitive topic around the local religious leaders. Discretion on what to say was carefully exercised and the religious cited direction from senior religious leaders was required.
6. It was observed that religious leaders were willing to offer pastoral care and counseling for PLHIV among faith communities as soon as guidelines and directions was offered from the county religious leaders.

### 4.6 Sensitization and Dissemination

The SDD booklet was used to create awareness on HIV related SDD and challenge stigmatizing attitudes and beliefs among faith communities. The SDD booklet had Six (6) chapters and the dissemination was conducted on two days (2) which was on the 15th and 16th March, 2017. Topics covered from the booklet included; About HIV and AIDs, Myths and Misconceptions of HIV, Stigma, Denial and Discrimination (SDD), Stigma reduction approaches, the role of religious leaders in tackling SDD and Key messages with scripture references.

The target audience was the Homabay Inter Faith Network (IFN) religious leaders where they were sensitized on stigma reduction in the faith communities. A total number of 16 IFN religious leaders were in attendance and their representation was as follows Evangelical Alliance of Kenya (EAK), Seventh Day Adventist (SDA), Kenya Conference of Catholic Bishops (KCCB), SUPKEM, Council of Imam Preachers of Kenya (CIPK), Anglican Church of Kenya (ACK) and Organization of African Instituted Churches (OAIC)

#### 4.6.1 Workshop training Objectives

1. To evaluate current knowledge on HIV related Stigma, Denial and Discrimination (SDD) among the Homabay Inter Faith Religious Leaders.
2. To build capacity on HIV related Stigma, Denial and Discrimination (SDD)
3. To develop action points on the way forward towards SDD reduction in Faith communities

This was the core project implementation activity where the project sought to sensitize 25 religious leaders on Stigma, Denial and Discrimination reduction. The objective was cascading SDD reduction messages to their congregations through the congregational model. The sensitization involved a pre test on SDD to gauge the level of knowledge and awareness on HIV and SDD. Specifically the areas covered by the pre test tools covered on knowledge on HIV, AIDS, HIV transmission, myths around HIV, stigma and discrimination, causes of HIV SDD, examples of SDD in faith communities and interventions on reducing HIV related SDD. Table 3 below highlights the religious leader's knowledge on the HIV and HIV related SDD

**Table 3: Religious leaders Knowledge on HIV**

| No. | Questions | Response |
|---|---|---|
| 1. | What is HIV? | 70% were able to define HIV as human immuno-deficiency virus while 30 gave answer closer to the meaning |
| 2. | What is AIDS? | 75% define AIDs as acquired immune deficiency syndrome while 25% were not able to define |
| 3. | Mention ways of HIV Transmission? | -Mother to child transmission<br>-Through sexual intercourse<br>-Through sharp objects<br>-Through wound contact by infected person<br>-Cultural practices<br>-Use of unsterilized needles |
| 4. | Myths associated with HIV Transmission | Majority of the respondents disagreed with myths associated with HIV transmission |

### 4.6.2 Training activities

The sensitization workshop began with a brief background of the SDD project and the partnership between IRCK and University of Nairobi. The IRCK secretariat was led by the Mr. Linus Nthigai- IRCK Monitoring and Evaluation manager, Mr. Gabriel Maina- UoN Fellow and Ms Abdiwahed Maliyun – IRCK Program Assistant. The Homabay IFN religious leaders were led by their secretary Cannon Hezekiah Oduor of ACK.

The UoN Fellow reviewed the projects inception journey from the first meeting held at ACK - Christ the King Hall on 26th February 2016 where it was identified that Stigma was a barrier to effective HIV response in Homabay County. In attendance in that Focused Group Discussion (FGD) meeting was IRCK Executive Director, UoN Fellow and 15 Homabay IFN religious leaders at the Christ the King ACK hall on 26th February 2016. The booklet was unveiled to the IFN members where it was indicated that the booklet was drafted with input from IRCK secretariat, Theologians and IRCK standing commissioners. Cannon Hezekiah (ACK) and Rose Oyoo (SDA) informed the members of their participation in the SDD validation meeting held on 28th February 2017.

The presentation was done on power point and flip charts and centered on the Faith SDD booklet and the baseline reports from PLHIV and Mbita religious leaders. The Faith Based Message on HIV & AIDS Stigma, Denial and Discrimination. SDD booklet was presented to the IFN members. The booklet was supplemented with the Faith Sector FBO Action Plan and Combating HIV and AIDS related stigma, Denial and Discrimination handout (Religions for Peace 2008). On 15th march 2017 three chapters of the SDD booklet were covered. This included; Facts about HIV and AIDS, Myths and Misconceptions of HIV and Stigma, Denial and Discrimination in faith communities. On 16th March 2017, three (3) last chapters were presented and discussed upon by the IRCK secretariat and Homabay IFN members in a plenary session.

### 4.6.3 Discussions on plenary

Key deliberations on stigma reduction approaches were done and this focused on;

1. Empowerment with knowledge where religious leaders empower themselves with accurate information and empower their congregations with the same so as to dispel myths and misconceptions. Religious leaders have to look out for HIV reference materials to expand their knowledge on HIV and AIDS
2. Equipping PLHIV with coping Skills through pastoral counseling and psychosocial support. So that PLHIV would lead a spiritual, emotional and psychological balanced life
3. Supporting the formation of HIV support groups within worship places as this would enhance capabilities of PLHIV
4. The support and protection of orphans and vulnerable groups in order to promote human rights of people affected or infected
5. The active participation of PLHIV in worship related activities where they would act as champions of HIV related SDD
6. Making appropriate referrals of PLHIV to appropriate HIV services or appropriate administrative agencies

### 4.6.4 Recommendations based on the evaluation of training workshop

1. IRCK should conduct capacity building of senior religious leaders on HIV and related SDD so as to bring them on board in this intervention
2. IRCK should mobilize financial and technical resources for the faith community in order to undertake HIV related SDD interventions and have an effective faith based response towards SDD.
3. Stigma, Denial and Discrimination (SDD) intervention programs have not been established within worship facilities and the Homabay IFN religious leaders were willing to incorporate SDD interventions within their worship programs.
4. There was need to involve senior religious leaders in providing SDD intervention so that they can provide strategic leadership, facilitate incorporation of HIV activities in worship programs and calendars and mobilize resources required in undertaking HIV related SDD activities.
5. Stand alone HIV services such as should be integrated within the core health facilities to reduce the stigma associated with this seclusion. It was noted this compromised adherence to HIV treatment and care.
6. Funding for Stigma, Denial and Discrimination should be included as a component in all HIV activities which include treatment and care.
7. Religious leaders should be in the forefront in challenging retrogressive cultural practices which enhance the spread of HIV and HIV related SDD. Wife inheritance was identified

as one cultural practice which would be appropriately handled through key messages such as " HIV testing is important for those couples wishing to marry or re-marry"

### 4.7 Action plans based on the Faith Messages on HIV Related SDD dissemination

At the end of the seminar the religious leaders in collaboration with the fellow and IRCK M&E manager were able to develop action work plans with activities, strategy (How), timelines (When) and responsibilities (Who). The rapid baseline informed the gap on what PLHIV within the faith communities wanted their religious leaders to do for them and the seminar sensitized religious leaders on SDD and the needs of PLHIV within their congregations. The action work plans developed with religious leaders will be used to monitor and evaluate the project. The participatory process of developing the work plans between IRCK and the Homabay IFN religious leaders will enhance ownership and enhance a participatory monitoring and Evaluation. The action plans are shown in table 4 below

**Table 4: Action work plans developed by religious leaders**

| ACTIVITY | HOW | WHEN | WHO |
|---|---|---|---|
| Formation of support groups | -Mobilization<br>-Networking | 3 months | All |
| Discuss life skills after service | -Announcements<br>-Training | continuous | All |
| HIV testing | -Create awareness and linkage | continuous | All |
| Reduce stigmatization | -create awareness on importance of knowing our status | continuous | All |
| Review meeting | -plan meetings, receive reports and way forward | quarterly | All |
| Train senior religious leaders on SDD | Plan | September | IRCK |

## 5.0 Results

1. Two (2) qualitative baselines on Stigma, Denial and Discrimination (SDD) were accomplished within the faith community in Mbita sub county, Homabay County.

2. One (1) Faith Based Messages on HIV and AIDs Stigma, Denial and Discrimination booklet was produced and disseminated

3. 16 members of Homabay Inter Faith Network (IFN) sensitized on HIV and AIDS related Stigma, Denial and discrimination

4. Four (4) Homabay Inter Faith Network (IFN) religious leaders were able to facilitate formation of support groups within their worship facilities

5. All the Sixteen (16) Homabay Inter Faith Network (IFN) religious leaders disseminated HIV related SDD messages to their congregants by allocating time within their worship activities.

## 6.0 Projected impact

1. By engaging religious leaders as champions in HIV related SDD intervention its envisaged their role will empower faith communities with right HIV information which will bring about a reduction on experienced HIV related SDD in the long run. The empowered faith community will utilize HIV services more leading to a reduction in HIV prevalence in Mbita Sub County.

2. Formation of support groups within Mosques/Churches with a wider mandate of meeting holistic needs (psychosocial and economic) for PLHIV within faith communities. In these groups PLHIV will develop new skills to relate with other people and provide for their mutual needs. This is expected to further reduce SDD within faith communities.

3. The faith community will feature HIV related SDD activities in the calendar and worship events to continually empower the faith communities. Further, HIV education and awareness will empower congregants with right information to challenge exiting myths and beliefs around HIV. This will lead to uptake of HIV services in Mbita as the awareness crated through faith forums provides information which empowers and calls for action towards HIV related SDD reduction

4. The engagement of the Inter Religious Council of Kenya (IRCK) in this project as a champion for HIV related SDD reduction will provide leadership for the sector in HIV related SDD activities

5. The developed Faith Based Massages booklet on HIV related SDD will form a reference ground for project sustainably and future engagements on HIV for the faith sector

6. Religious leaders will have the capacity to challenge and provide leadership on cultural beliefs and norms which hinder effective response to HIV such as wife inheritance, faith healing and resistance faiths.HIV testing for those who are marrying, remarrying and inheriting a partner

## 7.0 Lessons learnt

1. Religious leaders are influential opinion shapers and respected members of in faith communities and instrumental in eradicating the stigma and discrimination against people living with HIV and AIDS.
2. Stakeholder analysis and engagement throughout the project cycle is important for the success of push project models. Project buy in at project inception and consensus building is key for projects in the faith sector due to the divergent views held by ea h stakeholder.
3. There's need for synergistic integration Stigma, Denial and Discrimination (SDD) activities within the biomedical, behavioral and structural interventions being offered by various stakeholders within Homabay County.
4. HIV related Stigma, Denial and Discrimination (SDD interventions should have a funding components within the available HIV treatment and Care programs.
5. Implementation of the Faith based Action plan on HIV and AIDS (2017) will bring to fore faith activities on HIV at par with National HIV activities. This will further enhance monitoring of Faith based activities and provide motivation in the faith sector as their efforts will be quantified and measured.
6. PLHIV need financial and technical support in setting up and operations of support groups within faith communities. The existing support groups were not able to meet holistic needs for PLHIV as they lacked spiritual, logistical support such as meeting places and Income generating elements to facilitate acquisition of better nutrition for the affected. The existing support groups met under individual auspices and the religious leaders showed interest in facilitating them within their congregations with available resources within their reach. Jamia Mosque in Mbita had a support program which supported PLHIV and the affected with material support irrespective of their faith.
7. The national government and County government structure needs to provide funding for the devolved HIV structures in Homabay County. It was expressed that Community Health Extension workers (CHEW) had a key role in tackling HIV prevalence in Homabay through accessing key populations such as the fisher folk and Sex workers.

Subsequently, their funding and deployment to the key populations has been hampered due to lack of funds.

## 8.0 Conclusion

1. HIV related Stigma, Denial and Discrimination (SDD) is a barrier to effective national HIV response with outcomes such as non adherence to ART, treatment failure, delayed treatment, delayed HIV testing, resisting faiths and faith healing. HIV related SDD happens in all levels of the society .It was noted SDD thrives on myths and misconceptions and it is crucial for HIV projects to empower PLHIV and the non infected with correct HIV information. This provides for both PLHIV and the non infected to challenge existing their belief systems which stigma thrives.
2. Religious leaders should empower their congregants with knowledge by giving accurate information about how HIV is transmitted .The fears and misconceptions around HIV will diminish thus reducing SDD among the faith community.
3. Wife inheritance is cultural and hard to eradicate but the key message is encourage testing before marriage and when re-marrying
4. Religious leaders should embark on skills building by teaching PLHIV and the affected coping skills, communication skills, counseling and decision making. PLHIV will be able to cope with stigmatizing attitudes and challenge stigmatizing social norms.
5. Religious leaders should support formation of support groups by helping with startup sessions, provision of meeting space and linking of the groups to health centers. This will ensure the psychological and emotional needs for PLHIV are met and awakes the capacity of PLHIV to solve challenges within themselves.
6. Religious leaders should contribute to the protection of PLHIV, orphans, widows and associates which deters discrimination of PLHIV. This will deter deprivation of social and property rights towards the infected and affected groups. This further restores dignity of PLHIV.
7. Religious leaders can encourage participative interaction by bring the non infected people into contact with PLHIV. This will make communities change their attitude when they interact with PLHIV

8. Religious leaders should offer pastoral and spiritual counseling to meet emotional and psychological needs of PLHIV. This restores their dignity and restoring PLHIV self esteem further reducing stigma and denial.
9. Religious leaders should challenge the myths and misconceptions around HIV for the faith communities to increase uptake of HIV services.
10. The religious leaders should send weekly messages on HIV to encourage the infected people and encourage others to abstain and being faithful
11. Segregating the VCT should be changed to avoid shyness and reduce stigmatization
12. Religious leaders should discourage negative cultural practices which contribute to the spread of HIV pandemic

# 9.0 References


1. Academy for Educational Development, International Center for Research on Women and

   International HIV/AIDS Alliance (2007), Understanding and Challenging HIV Stigma; Toolkit for Action, retrieved from www.aidsalliance.org/publications
2. Christian Aid (Unknown) *Reducing SSDDIM and Multiplying SAVE*, Nairobi
3. County Government of Homabay (2013), *First County Integrated Plan 2013 - 2017*
4. Religions for Peace (2008) Combating HIV and AIDS Related Stigma, Denial and Discrimination, *A Training Guide for Religious Leaders*, USA
5. National AIDS Control Council (2017) Faith Sector Response to HIV and AIDS in Kenya Action Plan 2015/2016-2019/2020, Nairobi
6. The Holy Bible for religious citations
7. The Holy Quran for religious citations

**ANNEX 1: IRCK-UoN SDD FOCUSED GROUP DISCUSSION GUIDE**

| | |
|---|---|
| 1. | **QUESTION/FOCUS** |
| 2. | What are some of the key challenges do you face as a group? |
| 3. | Why it is crucial to address the problems identified? |
| 4. | In your own opinion, do you believe that religious leaders have a role in addressing these problems? |
| 5. | If yes, which one? |
| 6. | How best can RL play this role? |
| 7. | Have you experienced any form of ----- ever since you knew about your HIV status? |
| 8. | If yes, list the various forms of this problem you have encountered? |
| 9. | If yes, who has been involved in stigmatizing you and how? |
| 10. | If yes, in which ways have you been stigmatized? |
| 11. | Would you say that religious leaders and congregations are part of this problem? |
| 12. | If yes, in which ways have religious leaders and their congregations stigmatize you? |
| 13. | What are the key problems that hinder the youth from accessing key service? |
| 14. | Can existing religious structures be utilized to support the you to achieve your endeavors |
| 15. | What are some of the efforts by religious leaders to solve these issues? |
| 16. | What existing religious avenues can we utilize to address this problem? |
| 17. | What religious myths and or misconceptions does exist relating to this issue? |
| 18. | What could be the greatest barrier for religious leaders in supporting you to address this problem? |
| 19. | Who are the best influencers around this issue? |
| 20. | What would recommend as the best way for? |

## ANNEX 2: IRCK/UON HIV RELATED SDD PROJECT - PRE TEST ASSESSMENT

1. What is HIV?_____
2. What is AIDS?_____
3. Mention ways of HIV Transmission

   _____
   _____
   _____
   _____

4. **Myths associated with HIV transmission:**

| **Tick whether you agree or disagree with the following statements:** | **Agree** | **Disagree** |
|---|---|---|
| AIDS is a curse from God | | |
| If a person gets HIV, he or she cannot live for more than 5 years | | |
| A moral and God fearing religious person cannot get HIV and AIDS | | |
| Morally upright can get HIV infection while the unfaithful/immoral people can escape HIV infection | | |
| All children of HIV positive parents are HIV positive | | |
| People who look healthy can be HIV positive while those who look thin and sickly may not be HIV positive | | |
| Mosquito and other insect bites cannot cause HIV | | |
| In order to control HIV effectively; people with HIV and AIDS should be separated from the rest of the community | | |
| I would feel uncomfortable eating from the same bowl with someone who is HIV positive | | |
| It is not proper for religious leaders to talk about safe sex. This should be left to health professionals | | |
| Young people are refusing to change their behavior. If they get HIV and AIDS, it is their fault because they have free will to choose what is right from what is wrong | | |
| a person goes for an HIV test, it is evidence that s/he has been involved in sinful behavior and fears that s/he might be HIV positive | | |
| A religious leader who becomes HIV positive should not be allowed to continue preaching | | |
| It is not proper to allow HIV positive people serve in our church/mosque. This is similar to validating or approving immoral behavior | | |

5. What is HIV stigma and discrimination?

6. What are the causes of HIV related stigma and discrimination in our communities

7. Give examples of stigma, denial and discrimination in our communities?

8. Give examples of Stigma, denial and discrimination in faith communities/places of worship?

9. What can you do to stop stigma and discrimination as a religious leader?

**Annex 3: Homabay Inter Faith Network Sensitization Program 15th – 16th March 2017**

| Topic | Time | Facilitator |
|---|---|---|
| **Day 1 15th March 2017** | | |
| Registration | 8.30 am – 9.00 am | Maliyun |
| Pre test | 9.00 am – 9.20 am | Gabriel and Maliyun |
| PLHIV Focused Group Dissemination | 9.30 am – 10.00 am | Linus |
| **Tea Break** | **10.00 am – 10.30 am** | **All** |
| HIV Over view | 10.30 am – 11.30 am | Gabriel |
| Myths and Misconceptions of HIV | 11. 30 am – 12.30 pm | Gabriel |
| **Lunch** | **12.30 pm – 2.00 pm** | **All** |
| Stigma, Denial and Discrimination | 2.00 pm – 3.00 pm | Linus |
| Plenary Discussion | 3.00 pm – 4.00 pm | Maliyun |
| **4 O' clock tea** | | |
| **Day 2 16th March 2017** | | |
| Recap | 8.30 am – 9.00 am | Maliyun |
| Stigma Reduction Approaches | 9.00 am – 10.00 am | Gabriel |
| **Tea break** | **10.00 am – 10.30 am** | **All** |
| Role of Religious Leaders in Tackling SDD | 10.30 am – 11.30 am | Gabriel |
| Key Messages | 11.30 am – 12.30 pm | Gabriel |
| **Lunch** | **12.30 pm -2.00 pm** | **ALL** |
| Action Plans | 2.00 pm – 3.00 pm | Linus |
| Plenary discussion and Closure | 3.00 pm – 4.00 pm | Linus |
| **Tea** | | |

**ANNEX 4 : UoN_IRCK WORK PLAN AND FINANCIAL REPORT**:

| | Activity | SPECIFIC ACTIVITIES | OUTPUT | RESPONSIBILITY | TIMEFRAME | FINANCIAL REPORT |
|---|---|---|---|---|---|---|
| 1 | Develop Stigma ,Denial and Discrimination (SDD) booklet | Review of SDD manual and development of SDD booklet | Draft SDD messages | UHIV fellow | September 2016-November 2016 | 151,400 |
| | | Consensus and validation meeting with theologians ,standing commissioners and IRCK secretariat | Final SDD messages draft | Work with religious leaders to identify relevant texts | November 2016 – January 2017 | |
| | | Drafting and Validation of developed SDD messages | Booklet with SDD messages | Religious leaders IRCK secretariat | 14th – 28th February 2017 | |
| | | Edit and design of SDD booklet | Booklet with SDD messages | UHIV fellow | 4th week February 2017 | |
| | | Printing of SDD booklets | 30 SDD booklets | UHIV Fellow | 4th week February 2017 | |
| 2 | Monitoring field visit | Set targets and benchmark | Field visit report | UHIV fellow and IRCK M&E Manager | 26th February 2016<br>13th -14th March 2017 | 234,050 |
| 3 | Build capacity of Inter Faith Network (IFN) leaders on SDD reduction | Sensitize 25 members of Homabay Interfaith network as TOT's on HIV stigma and discrimination reduction | 25 IFN religious leaders trained | UHIV fellow and Medium term fellows | 15th – 16th March 2017 | |
| | | Support 25 religious leaders to cascade SDD messages | 25 IFN religious leaders supported | UHIV fellow | 3rd week March 2017 | 16,000 |
| 5 | Project reporting | Documentation of lessons learned | Project Implementation report | UHIV fellow | 4th week June 2017 | 0 |
| | **TOTAL** | | | | | **401,450** |