

Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

Rachel M. Jones

Date

Approval Sheet

Approval Sheet:

The approval sheet should be designed according to the plan below. See next page for several comments. This form should be turned in to your ADAP with requisite signatures on hard copy. Electronically submitted form requires no signature. Due the same date as Thesis Submission deadline.

The Impact of Religion in Relation to Stigma and Access to HIV Services for Key Populations in Kenya

By

Rachel M. Jones
MPH

Global Health

_____ Dr. John Blevins
Committee Chair

Abstract Cover Page

Abstract Cover Page

The abstract cover page should be designed according to the plan below. See next page for several comments. This page should be attached to the electronic submission only. ADAP does not need a hard copy.

The Impact of Religion in Relation to Stigma and Access to HIV Services for Key Populations in Kenya

By

Rachel M. Jones

BA in Religious Studies, Music; College of William and Mary, 2011

Thesis Committee Chair: John Blevins, ThD, M.Div

An abstract of

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of Master of Public Health in Global Health
2016

Abstract

The Impact of Religion in Relation to Stigma and Access to HIV Services for Key Populations in Kenya
By Rachel M. Jones

Background: HIV prevalence among key populations – men who have sex with men (MSM), sex workers (SW), and people who inject drugs (PWID) – represents a concentrated epidemic in Kenya. Faith-based organizations (FBOs) provide large amounts of HIV care and are a focus for capacity strengthening by PEPFAR. It is important, therefore, that their capacities to reach key populations are explored.

Goal: To gauge the influence of religion on HIV support programs for, and in the lives of, key populations members, and to identify core elements of effective FBO work with key populations.

Methods: In the summer of 2015, 18 in-depth interviews were conducted with FBO and community-based organization (CBO) staff. Further, 10 focus groups were conducted with members of key populations. A modified Delphi technique was used in the design and MAXQDA was used to identify themes.

Results: FBOs saw religion as a foundation that could be used for the empowerment of key populations members. FBOs used strategies of interpreting religious scriptures, using a belief in the “image of God” and capitalizing on various structures of organizations to reach the larger community. The elements identified that characterized effective FBO work with key populations included: Accepting all, providing psycho-social support, maintaining confidentiality, involving key populations members in the process, and being present in spaces key populations are. Community-based organizations saw religion as a potentially positive or negative force. Some believed services should be kept separate from religious interests, while others described how they blended faith with their work and strove to reduce stigma with religious leaders and communities. Many CBOs took a harm reduction approach as an alternative to religion. Key populations members themselves saw religion as positive and negative—many had their own religious beliefs/practices and saw the potentials for FBO work, while others expressed that trust in religion was difficult because of stigma.

Recommendations: In order for key populations members to receive the care they need, participation and leadership from religious communities and organizations is critical. Service providers should consider ways to reach religious leaders to reduce stigma and connect key populations members to psycho-social support and HIV care.

*The Impact of Religion in Relation to Stigma and Access
to HIV Services for Key Populations in Kenya*

By Rachel M. Jones

BA in Religious Studies, Music; College of William and Mary, 2011

Thesis Committee Chair: John Blevins, ThD, M.Div

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master in Public Health in Global Health

ACKNOWLEDGEMENTS

Thank you, first and foremost, to the people who fight against all types of stigma every day in Kenya, as well as those who experience it firsthand. You showed up to share your experiences, knowledge, and stories, without which this project would not have been possible. Your immense bravery, insight, and faith humbles me and gives me hope for a better future. Thank you to Dr. Esther Mombo from St. Paul's University in Kenya, who provided an amazing cultural and theological foundation for this work, and took on difficult logistical challenges in the process. You are not only one of the funniest people I have met, but are an inspiration to all who know you. I am incredibly lucky to witness your deep understandings of human rights and religion. I also want to thank my fellow student researchers, Blaire Hamilton and Charles Barber, who were instrumental in executing and transcribing the interviews, as well as my academic advisor Dr. Mimi Kiser for her support, and Susan Landskroener, who assists with so much of IHP's work behind-the-scenes. I thank my parents, who let me travel across the world and support me in all things. I also thank the Global Health Institute (GHI) and the Christian Health Association of Kenya (CHAK) for their funding support. Finally, I completely owe this project and opportunity to Dr. John Blevins. I thank him immensely for his foresight in preparing this project, insight and patience in executing it, and amazing dedication to the challenge of working within religious systems to bring marginalized people to the center.

DEDICATION

For the sex workers, drug users, and MSM/LGBT people in Kenya who see more clearly than most both sides of religion and continue to find their own ways to worship anyway.

TABLE OF CONTENTS

- I. Introduction- pg. 1
- II. Literature Review- pg. 11
- III. Methods – pg. 25
- IV. Findings – pg. 29
- V. Discussion- pg. 66
- VI. Conclusion- pg. 76
- VII. Bibliography- pg. 78

FIGURES

- Figure 1: HIV Prevalence Among Key Populations in Sub-Saharan Africa- pg. 2
- Figure 2: Research Conceptual Model – pg. 8
- Figure 3: Table of Interviews and Focus Groups – pg. 27
- Figure 4: Conceptual Model of Findings- pg. 31

I. INTRODUCTION

- A. Introduction and rationale
- B. Problem statement
- C. Purpose statement
- D. Research question
- E. Significance statement
- F. Definition of terms

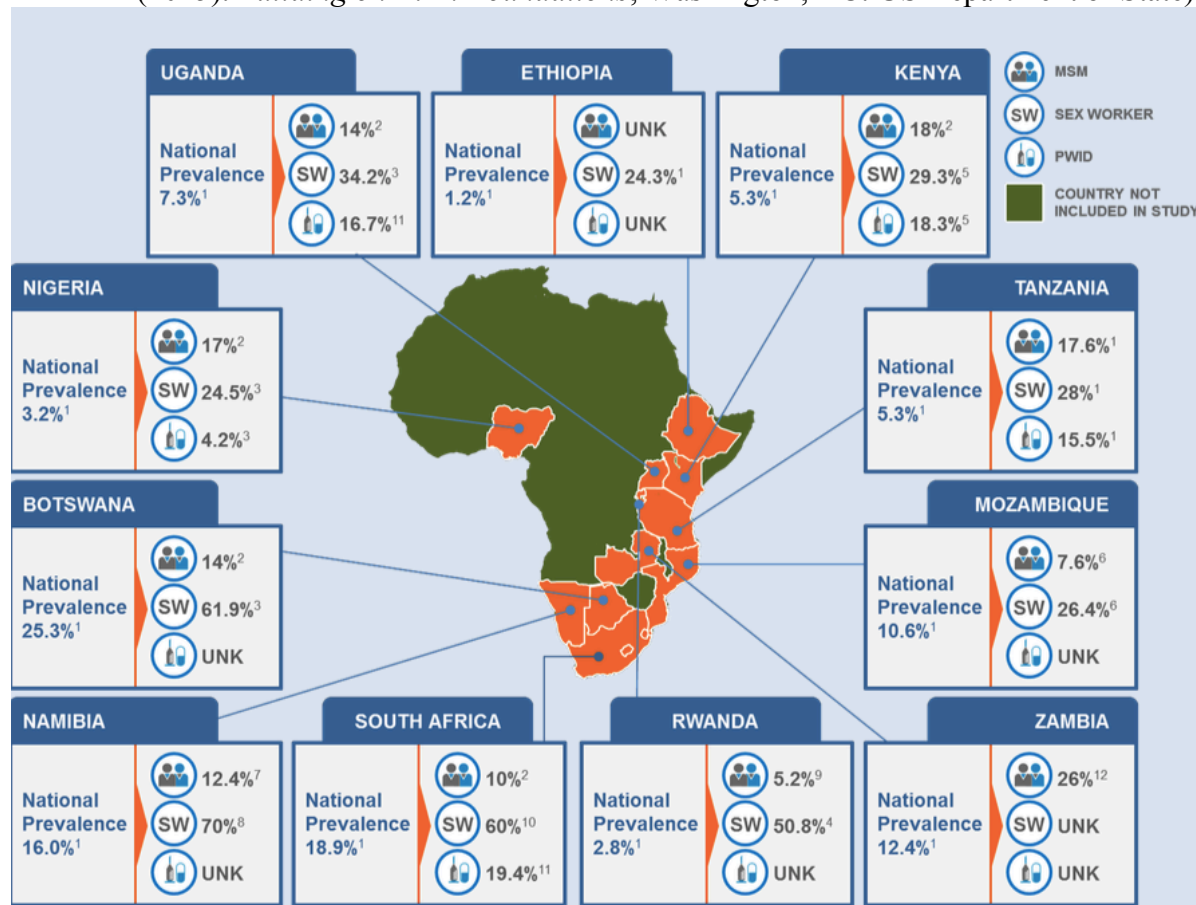
A. Introduction and rationale

Around the world, key populations (as defined by the President's Emergency Fund for AIDS Relief [PEPFAR]) bear a disproportionate burden of HIV/AIDS (WHO, 2014). Throughout Eastern and Southern Africa, these groups – men who have sex with men (MSM), sex workers (SW), and people who inject drugs (PWID) – have HIV prevalence rates between 1 to 7 times higher than their respective national prevalence rates (See **Figure 1**). Additionally, accurate data for these sub-populations are often missing or incomplete, despite the fact that key populations have been identified as important populations in stemming the HIV epidemic (PEPFAR, 2012). These populations can become somewhat invisible in their national contexts and also encounter high levels of stigma, an additional barrier to HIV prevention, treatment, and long-term care. Such discrimination has been linked with a lower likelihood to seek HIV treatment and to adhere to care (Neuman, 2013). Further, laws criminalizing homosexuality, sex work, and drug use in many countries in Sub-Saharan Africa complicate efforts to reach key populations with care.

Using Kenya as the focus country of this project, key populations members there bear around three times the HIV burden of the general population. According to UNAIDS, HIV prevalence among MSM and PWID in Kenya in 2011 was 18%, compared to the national adult prevalence of 5.3% (Bhattacharjee, McClarty et al. 2015). The Integrated Biological and Behavioral

Surveillance Survey in 2010 estimated HIV prevalence close to 30% for sex workers (NACC, 2014). Additionally, key populations in Kenya experience stigma from health providers,

Figure 1: HIV Prevalence Among Key Populations In Sub-Saharan Africa (Source: PEPFAR (2015). *Building on Firm Foundations*, Washington, DC: US Department of State)



- 1 Joint United Nations Programme on HIV/AIDS. (UNAIDS) Prevalence data, 2014. (<http://aidsinfo.unaids.org>).
 2 United Nations Joint Programme on HIV/AIDS. (2014). The gap report. Geneva, Switzerland: Author.
 3 Joint United Nations Programme on HIV/AIDS. (UNAIDS) Prevalence data, 2013. (<http://aidsinfo.unaids.org>).
 4 Joint United Nations Programme on HIV/AIDS. (UNAIDS) Prevalence data, 2011. (<http://aidsinfo.unaids.org>).
 5 National AIDS Control Council. (2014). Kenya AIDS progress report: Progress towards zero. Nairobi: Author.
 6 Conselho Nacional de Combate ao HIV e SIDA. (2014). Global AIDS response progress report: Mozambique country report. Maputo: Author.
 7 Ministry of Health and Social Services. Global AIDS response progress reporting 2013. Windhoek: Author.
 8 UNAIDS Namibia. (2011). Sex work and HIV in Namibia: Review of the literature and current programmes. Windhoek: UNFPA Namibia and UNAIDS Namibia.
 9 Binagwaho, A. (2009). Exploring HIV Risk Among MSM in Kigali, Rwanda. Chapel Hill, NC: MEASURE Evaluation.
 10 South African National AIDS Council. (2013). National strategic plan for HIV prevention, care and treatment for sex workers. Pretoria, South Africa: Author.
 11 Harm Reduction International. (2014). The global state of harm reduction 2014. London: Author.
 12 Mwansa, C.C. & Musonda, M.L.K. (2014, July). Sexual risk behaviors of gay and MSMs in Zambia. Poster session presented the International AIDS Conference. Melbourne, Australia

religious communities, and legal structures (UNAIDS, 2014; van der Elst, 2015; Muranguri, 2015; Okal, 2011; Otolok-Tanga, 2007). Internalized and external stigma on top of legal barriers lead to situations of overlapping risk behaviors for survival and coping. For example, people who

use drugs may engage in sex work to continue their habit (compounded by a lack of drug treatment options) and men who have sex with men may engage in drug use to deal with isolation and shame. These behaviors increase HIV risk for key populations and, eventually, the societal burden of HIV care. Additionally, key populations members do not exist in isolation, and are connected through sexual and other networks to the broader population, increasing the public health implications.

In light of the epidemic among key populations, the United States Department of State released the *PEPFAR Blueprint: Creating an AIDS-free Generation* in 2012. In this document, PEPFAR committed to achieving an AIDS-free generation and to ending stigma and discrimination for “people living with HIV and key populations, improving their access to, and uptake of, comprehensive HIV services” (PEPFAR, 2012). PEPFAR’s approved funding for fiscal year 2012 alone was over 3.5 billion dollars, with the majority of funds going to Sub-Saharan Africa, and over 200 million dollars going to Kenya (US Global AIDS Coordinator, 2015). Thus, PEPFAR’s funding priorities have strong relevance for health practitioners, development organizations, and researchers when shaping their agendas and applying for PEPFAR funds. PEPFAR created specific action steps for achieving the goals laid out in the 2012 *Blueprint*, including:

- Increase coverage of HIV treatment both to reduce AIDS-related mortality and to enhance HIV prevention by, working with countries to prioritize key populations (e.g., MSM, SW, PWID) for ART, ensuring ART programs support a non-stigmatizing clinical environment that affords all individuals meaningful access to treatment services, including both facility and community-based care and support.
- Increase access to and uptake of HIV testing and counseling, condoms and other

- evidence-based and appropriately targeted prevention interventions. PEPFAR will support efforts to create enabling environments for key populations and address the stigma, discrimination and violence that increase their risk for HIV infection and often prevent them from entering, or being retained in, health services.
- Increase access to and uptake of HIV services by key populations. To implement this action step, PEPFAR will...expand the evidence-base for effective interventions for key populations through implementation science awards linked to country programs to facilitate rapid scale-up of high-impact innovations; support civil society and faith-based work best able to address the epidemic in key populations through mechanisms such as country small grants.

Therefore, included in its efforts to deliver on the commitments in the *PEPFAR Blueprint*, PEPFAR is strengthening the capacity of civil society and faith-based organizations to provide HIV services. In 2012, a PEPFAR Consultation (convened by Emory's Interfaith Health Program [IHP] and St. Paul's University in Kenya), recommended that faith-based organizations (FBOs) should draw on the existing trust they have built in communities to provide more comprehensive, less stigmatizing HIV services, as well as holding ineffective FBOs accountable, furthering PEPFAR's goals.

Following the 2012 consultation, the Centers for Disease Control and Prevention (CDC) and PEPFAR asked the IHP at Emory to develop resources that would enable FBOs to reduce stigma for people living with HIV/AIDS (PLWHA). Some of that work (including this project) specifically focuses on stigmatized key populations, where the role of religion is more complicated than a simple platform to build on existing trust. For many key populations members, faith communities have been a source of stigma, and are therefore do *not* necessarily

provide the positive social resources traditionally associated with FBOs. Therefore, further knowledge and evidence is needed to inform FBO programming with key populations.

It is in this context, of overlapping PEPFAR priorities of key populations and building civil society and FBO capacity, that in 2013, at the request of CDC/PEPFAR, IHP published a report of FBOs that work with key populations (Blevins and Corey, 2013). In 2015, CDC/PEPFAR asked IHP to further this work by identifying core elements of FBOs that work effectively with key populations, with the eventual aim of training additional FBOs. IHP partnered with St. Paul's University in Kenya, as well as the Christian Health Association of Kenya (CHAK) in this effort. This thesis is a result of the qualitative fieldwork carried out over the summer of 2015 in Nairobi, Kisumu, and their surrounding areas within Kenya by researchers from Emory and St. Paul's. The goal was to identify the elements of FBOs that work effectively with key populations, as well as to understand the impact of religion in general in the lives of key populations members and the organizations that reach them. Funding was provided by the Global Health Institute (GHI) at Emory, as well as CHAK. While this project uses evidence in the cultural and religious context of Kenya, the implications may be wider reaching within Sub-Saharan Africa and answer to the requests made by CDC/PEPFAR to IHP.

This project has the potential to impact public health in several key ways. Faith-based organizations and religious communities are present in places where government resources do not reach, and already work with many hard-to-reach populations (PEPFAR, 2012). Therefore, by enhancing the capacity of existing organizations, it can reduce the direct costs of providing HIV care from the Kenyan government, international aid donations, and other funders.

Additionally, as there is a lack of available services for key populations, which currently reach a small proportion of key populations members, increasing the knowledge base about

effective programs will assist in the design and implementation of additional services. Especially lacking is the provision of psycho-social and mental health services for key populations members, which FBOs may be particularly suited to provide. If FBOs can provide these services, it will ultimately reduce risk behavior, the spread of new HIV infections, and adherence to treatment, all of which impact the health of key populations themselves as well as the communities in which they live. Further, in the context of Kenya (and indeed much of Sub-Saharan Africa), religion plays a huge role in communal life. For public health professionals to deny its power and influence within every sector of life (including HIV/health/sexuality) would be a mistake. Instead, by drawing on positive contributions to public health from existing resources within religious traditions, there is the potential to create grassroots and sustainable solutions in Kenya and beyond. Most immediately, the findings of this project will help inform a curriculum that can be used to sensitize and equip FBOs to work with key populations as part of the continuing partnership between IHP (Emory), St. Paul's University, and CDC/PEPFAR. The FBOs trained by that curriculum will be able to serve key populations in their own cultural and religious contexts to reduce their risk to HIV, to reduce their risk of transmission, and to retain them in care.

B. Problem Statement

Key populations' HIV prevalence remains at a level of a concentrated epidemic in Kenya and many other Sub-Saharan African countries. At the same time, efforts to reach key populations with HIV prevention, treatment, and long-term care have often been ineffective in contexts where stigma is high and cultural and religious norms prevent sensitive and effective care. Faith-based organizations provide a substantial proportion of the HIV prevention and treatment in Sub-Saharan Africa, receive funding to do so, and are a focus for capacity

strengthening by PEPFAR. FBOs are also able to tap into a huge cultural influence in religion. Therefore, it is important that their potentially unique capacities to reach key populations are investigated. Currently, there is very little evidence about how FBOs may work with key populations, and very few resources to equip those that wish to.

C. Purpose Statement

The purpose of this project is to gauge the influence of religion on HIV prevention, treatment, and support programs for, and in the lives of, key populations (men who have sex with men, sex workers, and people who inject drugs) in Kenya. Key populations are especially important to the global fight against HIV because of their increased HIV incidence and prevalence, and are in need of particular attention because of the religious, cultural/social, political, and legal barriers that they face in regards to prevention and treatment in almost every part of the world.

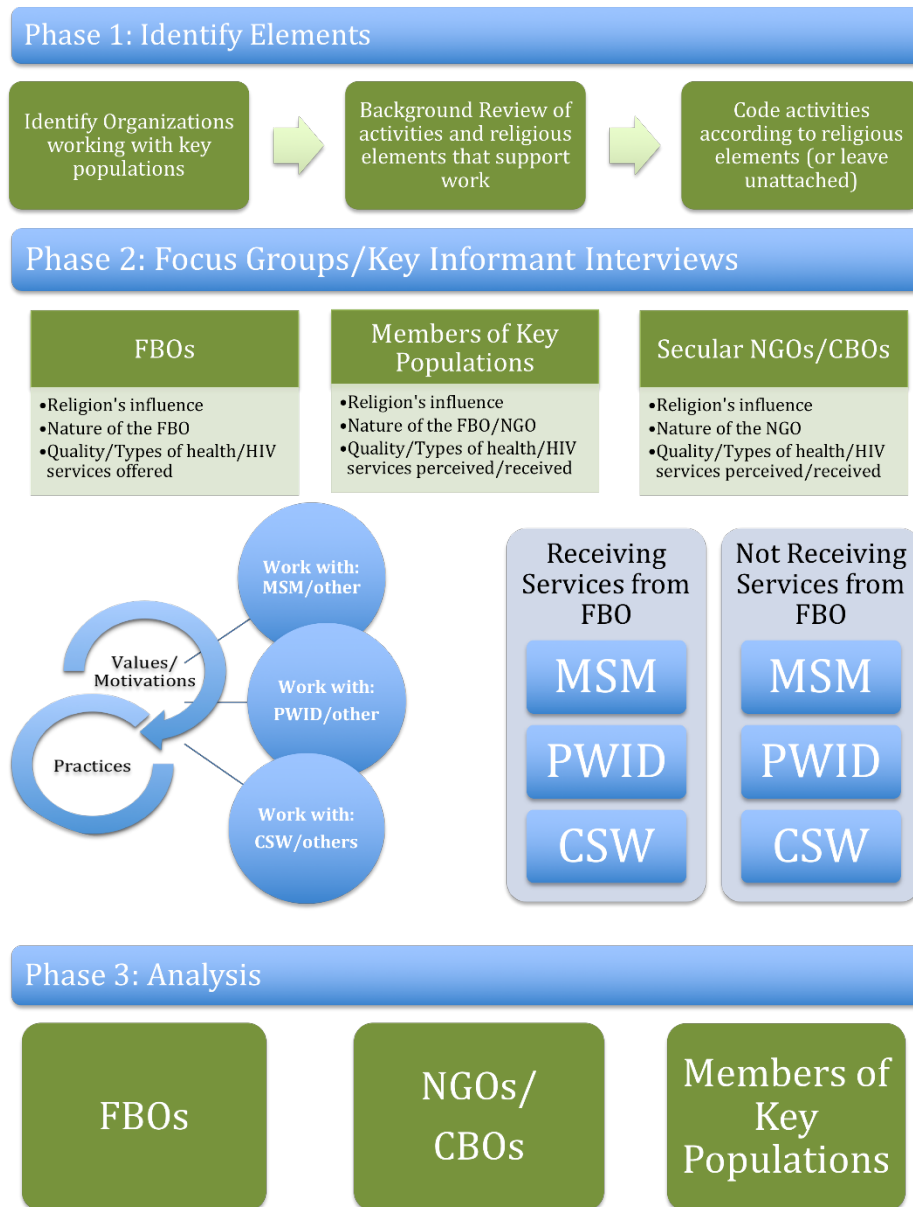
D. Research Question and Research Conceptual Model (see Figure 2)

Overarching: What are the effects of religion in relation to stigma and access to HIV services for key populations members in Kenya?

Sub-Questions:

- 1) What are distinctive elements of faith-based organizations that work effectively with key populations?
- 2) How do civil society organizations that work with key populations perceive religion's influence on their work?
- 3) How is religion used and/or experienced in the lives of key populations members?

Figure 2: Research Conceptual Framework



E. Significance Statement

Through the process of in-depth interviews with the staff of FBOs and CBOs and focus groups with key populations members themselves, this project will produce results that:

- Serve to identify common elements of FBOs that provide effective HIV services to one or more key populations;

- Produce knowledge that can be used to design a curriculum to be used with FBOs to improve their services for key populations and to increase their capacity to carry out those services effectively and;
- Expand the knowledge on the effects of religion in relation to cultural norms, laws/policies, and barriers to HIV services for key populations.

Together, these will contribute to the body of literature around HIV and religion, as well as the resources for organizations working with key populations members. If faith-based organizations that work with key populations members effectively can be identified in Kenya, and the resources that religion provides for them understood, it can be used as model for other FBOs seeking to increase the effectiveness of their work. Additionally, if the role that religion plays in the lives of key populations can be better understood by both community-based organizations (CBOs) and faith-based organizations alike, it will help in the design of programs that are holistic and connect key populations members to psycho-social support, which are sorely lacking in Kenya and Sub-Saharan Africa more broadly. Finally, if the role that religion plays (or doesn't play) in the work of CBOs is understood, it can help identify the unique benefits of CBOs compared to FBOs or how their work may overlap, which can in turn identify funding priorities. As noted above, FBOs may be located in areas where other services are not available, making their capacity to provide comprehensive and effective services even more important.

G. Definition of Terms/Acronyms

CBOs: Civil-Society Organizations- The "aggregate of non-governmental organizations and institutions that manifest interests and will of citizens." (*dictionary.com*)

CHAK: Christian Health Association of Kenya

FBOs: Faith-Based Organizations- "An organization that is influenced by stated religious or spiritual beliefs in its mission, history and/or work" (PEPFAR, 2015)

HIV/AIDS- HIV (Human Immunodeficiency Virus) is the virus that weakens the immune system, ultimately leading to AIDS (Acquired Immune Deficiency Disease).

IHP: Interfaith Health Program (at Emory University)

KPs: Key Populations- Key populations are those who are at higher risk for HIV than the general population. In most contexts these consist of men who have sex with men, sex workers, transgender people, people who use/inject drugs, and serodiscordant couples. PEPFAR defined its key populations as men who have sex with men, sex workers, and people who inject drugs. For the purposes of this thesis, key populations includes MSM, SW, PWID, LGBT people, and non-injection drug users.

MSM: Men who have sex with men

NGOs- Non-governmental Organizations. Organizations that are not part of the government or traditional for-profit business.

PEPFAR: The US President's Emergency Plan for AIDS Relief- Announced by George W. Bush in 2003 with the majority of funding going to Sub-Saharan Africa to fight the HIV epidemic.

PLWHA: People Living with HIV/AIDS

PWID: People Who Inject Drugs

SW: Sex worker/s (may be male or female)

II. Literature Review

- a. Background of the issue
 - i. HIV Prevalence Among Key Populations
 - ii. Non-Injection Drug Use
 - iii. Structural and Legal Barriers for Key Populations
 - iv. Stigma in Key Populations
 - v. Influence of Religion on Stigma and/or HIV
 - vi. Islam, HIV, and Stigma
 - vii. Equipping Health Providers around HIV Key Populations
- b. Overview of previous work on this topic

a) Background

i. HIV Prevalence Among Key Populations

The fact that, in most or all countries, certain groups of people bear a disproportionate risk of contracting HIV compared to the general population has been well-established and acknowledged (World Health Organization 2014) (Needle, Fu et al. 2012). Among these groups are what President’s Emergency Plan for AIDS Relief (PEPFAR) names as “key and vulnerable populations,” including men who have sex with men (MSM), sex workers (SW), and people who inject drugs (PWID). The reasons for the increased risk of HIV among these groups are complex, and their membership is sometimes overlapping (Blevins 2014). For example, a sex worker may also engage in drug use, or a man who has sex with men (MSM) may also sell sex. Some of the reasons that these key populations bear an increased HIV prevalence are external stigma, internalized stigma, and high-risk behaviors, as well underlying factors beyond individual control such as poverty and structural and legal barriers to prevention and care (Neuman and Obermeyer 2013, World Health Organization 2014).

In Kenya, key populations have been shown to carry HIV infection burdens around three times the 6.0% prevalence among the general adult population (UNAIDS 2014, Bhattacharjee, McClarty et al. 2015). In Nairobi, a biologic survey conducted by the National AIDS and STI

Control Programme (NAS COP) in 2010-11 estimated that MSM had an HIV prevalence of 18.2%, female SWs had a prevalence of 29.3%, and PWID had a prevalence of 18.7% (Bhattacharjee, McClarty et al. 2015).

A national monitoring survey conducted in seven sites throughout Kenya in 2013-2014 provided baseline data for key populations and HIV-risk behaviors. This survey was conducted by the NAS COP under KNASP III (Kenya National AIDS Strategic Plan)(Bhattacharjee, McClarty et al. 2015). The survey called attention to many ways in which high-risk behaviors were associated with pressure, lack of access, and/or violence: “Nearly one-third of FSWs (female sex workers) and almost one-quarter of MSM reported an occasion in the past month when they wanted to use condoms during sex, but their sex partner refused.” While sex workers and MSM may have adequate knowledge about condoms, their consistent use may be out of the control of these groups. For PWID, the survey found that “over 1/3 of PWID reported that there had been an occasion in the past month when clean needles were not available,” which emphasizes an issue of access to preventative materials. And perhaps most strikingly, it reported that “22.4% of FSW, 16.7% of MSM and 7.7% of PWID reported being physically beaten or physically forced to have sex in the past 6 months” (Bhattacharjee, 2015). The threat of physical violence, here exhibited among all three key populations, has been linked to increased HIV vulnerability (Sexual Violence Research Initiative, 2013). The estimates for this study of risk among key populations in Kenya were based on seven urban sites. Therefore, there may currently be a lack of information about these key populations in rural and semi-urban contexts, where they may face the same or even more severe challenges.

Additional information about baseline statistics for key populations has been established in Kenya. Along the coast, where drug abuse is most prominent, an estimated 18.7% of incident

HIV cases are among PWID compared to 7.5% nationwide (Kurth, 2015). Further, among PWID in Kenya, the National AIDS Control Council found that 29.8% reported sex without a condom in the past month and only 51.6% reported use of sterile injecting equipment the last time they injected (National AIDS Control Council, 2014). Therefore, the coast demands special HIV prevention attention for PWID, and the expansion of programs that address condom use and sterile injection equipment are needed.

While the “full realization of all human rights and fundamental freedoms for all” is a crucial element in the global response to HIV and should be fought for on their own behalf, key populations are also important to the HIV epidemic because are not isolated from the wider society (UN General Assembly, 2011). In fact, they may serve as a bridge for HIV transmission into the general population in many cases. Among LGBTI persons, which include MSM, a report by the Kenya Human Rights Commission from 2011 noted that most engage in sexual activities with members of the opposite sex as well as with the same sex. In fact, “At least one in every four LGB persons alluded to having a heterosexual relationship to serve as a distraction for family and neighbours” (Kenya Human Rights Commission, 2011). Additionally, a sample of over 800 men who sell sex to men found that 34% of them had also had intercourse with a woman in the past 30 days (Mannava, 2013). Both male and female sex workers interact regularly with married and partnered clients in the broader population. Drug users have also been identified as a bridge population, as they may share syringes and have unprotected sex with citizens outside of user circles (Beckerleg, 2005). Approximately 86% of female injection drug users also engage in sex work, furthering connections between key populations and the general population (National AIDS Control Council, 2014). Therefore, the epidemic in key populations has broad public health consequences.

ii. Non-Injection Drug Use

Drug users who do not inject are also at increased risk for HIV, though prevalence generally remains higher among injection drug users because of the efficiency of transmission (Mayer, 2009)(National Research Council, 1995). However, as non-injection drug use is more wide-spread than injection drug use, it should still be considered as an important risk factor for HIV transmission. The key pathways through which non-injection drug users may become infected with HIV include impaired decision making under the influence of psychoactive drugs, increased sexual activity as a result of increased perceived pleasure (for some drugs), and through exchanging or selling sex for drugs or money to purchase drugs (Decker, 2012)(Gu, 2008). A study of PWID and non-injecting drug users in Myanmar found that injection drug users were more likely to have been tested for HIV than non-injection users, which could also compound the risk of HIV transmission for non-injectors (Saw, 2013). Also, as transitioning from non-injection drug use to injection drug use has been associated with increased likelihood of sexual risk behavior, treating non-injection drug users could reduce the risk for transitioning to injection, thereby also reducing HIV risk through two causal pathways (injection and sexual intercourse) (Mackesy-Amiti, 2013).

Kenya has some of the world's highest rates of alcohol abuse, including heavy episodic drinking (Hahn, 2011). The behaviors that come with alcohol use/abuse can contribute in significant ways to HIV risk, as well as the progression of HIV (Pithey, 2009) (Jaquet, 2010). In fact, a "substantial portion of the burden of the HIV epidemic in Kenya and elsewhere in Sub-Saharan Africa may be attributable to unhealthy alcohol use" according to Braithwaite, et al's work on the impact of unhealthy alcohol use on HIV transmission in Kenya (Braithwaite, 2014).

However, there has not been a substantial effort to integrate alcohol treatment with HIV prevention and the treatment of other substance abuse (Hahn, 2011) (Fritz, 2010). While PEPFAR does not name non-injection drug users (for example, people who abuse alcohol) as one of its “key and vulnerable populations,”, for the purposes of this thesis, we felt that the treatment of non-injection drug users was still relevant to HIV prevention. These treatment efforts could be (and sometimes are) offered in concert with treatment for injection drug users by the same organizations.

iii. Structural and Legal Barriers for Key Populations

Key populations members around the world experience structural and legal barriers that hinder access to HIV testing, support, and care. In most African countries, including Kenya, homosexual acts are illegal. In Kenya, a ““person who ... has carnal knowledge of any person against the order of nature ... or permits a male person to have carnal knowledge of him or her against the order of nature’ commits a felony, punishable on conviction by a fourteen-year prison term” (Law Library of Congress, 2014). While the Kenya Human Rights Commission reports that few convictions take place under the penal code, harassment by police is a regular occurrence, including being held without charges, requests for bribery and favors, and trumped up charges. The MSM who face these barriers believe that they cannot safely report inappropriate behavior from government officials and expect any results (Kenya Human Rights Commission, 2011).

For sex workers, the law also poses a barrier to health services. While Okal et al. purport that 5.5% of Kenyan women have exchanged sex for money, goods, or other favors in the past year (Okal, 2011), sex work is a grey area in Kenyan law. The Penal Code names “living off the

earnings of sex work” and “soliciting or importuning for immoral purposes” as offenses, and municipal by-laws criminalizing sex work through articles such as “loitering for the purpose of prostitution,” “importuning,” and “indecent exposure” (FIDA, 2008). In practice, the “offences relating to sex work in municipal by-laws provide police officers with broad justification to arrest sex workers,” where they face similar issues of harassment from authorities as MSM, according to the Federation of Women Lawyers (FIDA, 2008). Moreover, sex workers must often conduct their negotiations with clients quickly for fear of police attention, leaving little time to discuss condom use (Okal, 2011). The same study found that many FSWs encountered clients who refused to pay after services were given. Of these, 92% of respondents felt they had no recourse to address this issue (FIDA, 2008). While sex workers generally know how to prevent STIs and HIV transmission, they have little power to use their knowledge, with pressure of more pay for unprotected sex, and the threat of physical force from male clients (Scorgie, 2013).

For those who use illegal drugs the law also poses a barrier to access to care. Yet, in an important move to curb HIV among PWID, the government of Kenya implemented a needle and syringe exchange program (NSP) country-wide in 2013 (Kurth, 2015). Despite this progress, as well as a methadone treatment program through the government, PWID still face stigma from their communities, who associate them with criminal activity since many PWID resort to stealing to maintain their drug habit. Additionally, police sometimes use track marks and possession of drug paraphernalia as sufficient evidence for arrest (Muraguri, 2015). As with most countries in Sub-Saharan Africa, Kenya has harsh legal punishments for drug use (National Council for Law Reporting, 1994). These penalties increase stigma, marginalize PWID, and make accessing services and treatment for addiction more difficult (Affinnih, 2002).

iv. Stigma in Key Populations

Stigma has been recognized as a factor that drives the HIV pandemic. It may result in social judgment and the association of certain types of people with HIV (Otolok-Tanga E., 2007). Stigma affects individuals at multiple levels, including in their home life, their employment prospects, and their health care access (Neuman, 2013). Stigma also increases vulnerability to interpersonal discrimination and “internalized feelings of low self-worth” (Neuman, 2013). For persons with HIV, this discrimination can lead to negative health outcomes, such as a lower likelihood of seeking care and worse adherence to treatment (Neuman, 2013). Lau et al. (2007) also found that stigmatization towards vulnerable groups was associated with stigmatization towards persons with HIV/AIDS (Lau, 2007). For members of key populations living with HIV, this can mean double stigma of HIV and their key population status.

Sex workers report facing stigma from healthcare providers. A qualitative study of six urban sites in four African countries (including Kenya) found that sex workers described health providers as “abusive,” and “hostile”; at times, sex workers reported that providers withheld treatment or blamed them for their illnesses (Scorgie, 2013). This discriminatory behavior was even sometimes extended to the family members, including children, of sex workers (Scorgie, 2013). Lack of confidentiality was also a common theme, with male and female sex workers having providers share their private information with other staff, and the asking of inappropriate questions (Scorgie, 2013). Male sex workers may feel that homophobia is an even bigger barrier to their care than their being a sex worker (Scorgie, 2013). Because of these reasons, many sex workers do not choose to disclose their profession to health providers (Scorgie, 2013).

MSM face similar stigma from health providers. MSM have reported stigmatizing attitudes and the hesitance of providers to discuss sexual issues as increasing their fear to seek health services (van der Elst, 2015). Okall et al.'s study with MSM in Kisumu, Kenya found that 60% of participants were not very comfortable seeking services at public hospitals. The main factor they cited in their discomfort was people staring at them (Okall, 2014). While the 2010 Kenyan national constitution acknowledges that all citizens have the right to healthcare in accordance with non-discrimination laws, and several important bodies have included MSM in their policies (e.g., the Ministry of Health, the National AIDS and STI Coordination Programme, and the National AIDS Control Council), many healthcare providers do not have the skills and training to overcome their stigmatized views of MSM (Okall, 2014) (van der Elst, 2015).

For PWID, a lack of available drug treatment services prevents behavior change and contributes to stigma from communities. In 2007, there were only five drug treatment programs in Kenya. They relied heavily on volunteer workers and did not provide services specific to women (Sullivan, 2007). Today, some organizations do provide day treatment and residential services for women, such as the Muslim Education and Welfare Association (MEWA) in Mombasa, though female drug users remain difficult to reach (PEPFAR, 2015) (Nieburg, 2011). A lack of understanding among the public about the dynamics of addiction further stigmatize and place blame on PWID. Hendriksen et. al found that PWID's fears about how an HIV diagnosis would affect their families and communities led to a lack of HIV testing (Hendriksen, 2009). Moreover, the fear of having the additional stigma of HIV on top of the stigma of being a PWID may also contribute to lack of testing (Parry, 2010).

v. Influence of Religion and FBOs on Stigma

Religion, and religious leaders, hold a position of authority in Kenyan communities. Nonetheless, while FBOs have been “critical” in responding to the HIV epidemic in Sub-Saharan Africa, there is less scholarship on how FBOs have or have not contributed to reducing stigma (Keikelame, 2010). Religious doctrines and the messages perpetuated by religious leaders often convey the message that those infected with HIV have committed sins and therefore are justified in having such “punishment.” These messages further stigmatize people with HIV/AIDS (Otolok-Tanga E., 2007). At the same time, religious leaders have the ability to fight stigma and discrimination against people living with or affected by HIV, and many have proven effective at this (Otolok-Tanga E., 2007). These two roles related to stigma are held in tension in each of the major religious groups in Kenya—Christian (82.5% total: 47.7% Protestant, 23.3% Catholic) and Muslim (11.1%) (Central Intelligence Agency, 2015). Stigmatizing attitudes among religious people is “value expressive, or symbolic...which occurs when the core behavioral and moral values of a dominant group are threatened” (Miller, 2011). Therefore, by blaming people who acquire HIV for their own behavior, the uninfected feel they remain firmly part of the “in-group” (Miller, 2011). When HIV is associated with moral blame, it then often acts as a deterrent for disclosure (Keikelame, 2010).

According to a multi-country key-informant survey commissioned by the Catholic Medical Mission Board, FBOs “are at times criticized for failing to fully collaborate in providing a comprehensive prevention message” since they often perceived as only using abstinence and faithfulness as prevention strategies, which can be outside of the control of individuals in certain contexts (Woldehanna, 2005). The US policies that accompanied PEPFAR funding for fighting HIV globally reiterated these emphases. By placing value on abstinence in its ABC approach (Abstinence, **B**e Faithful, Use a **C**ondom), PEPFAR could be viewed as saying that condoms are

only for people who *cannot* be faithful or abstinent, which could fuel stigma against people using or seeking protection (Blevins, 2014). It is widely acknowledged that PEPFAR's policies were influenced heavily by evangelical lobbies in the US Congress (Dietrich, 2007) (Diven, 2010) (Rawls Jr., 2007).

Qualitative work in neighboring Uganda by Otolok-Tanga et al. found that faith-based organizations (FBOs) promulgated stigma against persons living with HIV through “use of stigmatizing language and messages; deeply-entrenched societal attitudes and norms; and limited involvement of persons living with HIV/AIDS” (Otolok-Tanga E., 2007). In Kenya, Miller et al. (2011) conducted 18 in-depth interviews with Christian religious leaders in Nairobi and analyzed their challenges to communicating about sexuality-related issues. For example, they identified that pastors felt the need to discuss HIV but found it difficult to do so from the pulpit because of societal taboos; they experienced tension between the traditional ideals of abstinence and fidelity and the lived realities of their congregants' sexual lives (Miller, 2011). These tensions do not necessarily lead to stigma (Miller, 2011), though the messages may be interpreted by congregants in multiple ways. What may be more important is how the FBO or church does outreach and contributes to the social support structures of PLWHIV (Miller, 2011).

Keikelame et al.'s in-depth interviews with key informants about perceptions of FBO's influence on HIV/AIDS stigma in South Africa provides insight into the role of FBOs in the fight against stigma. On the one hand, they found FBO's were perceived as having taken some action to fight HIV/AIDS stigma and discrimination in South Africa. But on the other hand, FBOs were seen as contributing to stigma through “conflating issues of sexuality and morality, and through associating HIV and AIDS with sin” (Keikelame, 2010). The informants felt that FBOs often lacked the skills, information, and confidentiality practices to deal with the challenges of stigma,

including self-stigmatization of PLWHIV, effectively (Keikelame, 2010). However, a key theme expressed by informants was that they felt that FBOs had a “moral and ethical responsibility” to fight stigma, as they were in honored positions in society, a position which few other institutions can claim (Keikelame, 2010). “As trusted entities within the community, FBOs were lauded for their significant potential—both untapped and realized—to positively influence social norms of their congregations,” they explain (Keikelame, 2010).

In Kenya, where public health services are often insufficient to serve PLWHIV comprehensively, FBOs are thought to “successfully utilize their existing networks of hospitals and clinics to serve the health-care needs of persons living with HIV/AIDS” (Woldehanna, 2005). Yet they may not be well equipped to work with key populations, specifically.

vi. Islam, HIV, and Stigma

According to the work of Memoona Hasnain, stigma against HIV/AIDS is more pronounced in Muslim majority countries (Hasnain, 2005). While Muslims in Kenya are not the majority, there are areas and communities that are primarily Muslim. In “Islam and AIDS: Between Scorn, Pity and Justice” edited by Farid Esack and Sarah Chiddy (2009), multiple authors describe the various streams of thought in the Islamic discourse on HIV/AIDS and how they might further either stigma or compassion. For example, Hashim Kamali discusses the determinist stream of Malik Badri, which sees AIDS as “a sign on divine justice towards homosexuals and others who disobeyed God’s limits.” For him, the “only remedy for everyone is to adhere to Islamic values.” In contrast, Kamali advocates for a “Theology of Compassion” based on general Shari’ah principles which include “protection of basic human values, and the

mustering of communal resources to prevent individuals from being stigmatized” (Esack & Chiddy, 2010).

There has been scholarship on the possibilities of using Islamic teachings for health promotion around HIV/AIDS, including by Maulana et al. (2009). These authors worked collaboratively with Muslim leaders in Lamu, Kenya and identified texts that applied to “sexual conduct, health, stigma, and the responsibilities of Islamic leaders towards their congregations” (Maulana et al., 2009). They concluded that Islamic texts can be a starting point to discussing and preventing HIV transmission and stigma, as well as promoting condom use under certain circumstances (Maulana et al., 2009).

vii. Equipping Health Providers around HIV Key Populations

Stigmatization from health care providers has been found to be a crucial issue that affects perceived discrimination and access to HIV testing and care (Rispel, 2011). There has been some evidence that it is possible to equip healthcare workers, whether at FBOs or secular organizations, to provide non-stigmatizing services through sensitization trainings. Van der Elst, et al. have used an online training program to help healthcare providers understand men who have sex with men in Kenya (van der Elst, 2013). At baseline, homophobia was expressed in provider attitudes, and there was a lack of knowledge about the sexual health needs of MSM. After the sensitivity training, more providers had adequate knowledge (49% vs 13%, $p < 0.001$) and homophobic attitudes had decreased (Rispel, 2011). However, a two-year follow-up found that the trained health providers experienced secondary stigma within their workplaces, as a result of “pressure to conform to the standards of Kenyan society and their health institutions, which continued to view male same-sex behavior as immoral and illegal” (van der Elst, 2015).

These findings led the researchers to conclude that sensitization is an innately social process (van der Elst, 2015).

A qualitative study of 16 service providers/clinicians in Kenya by Taegtmeier et al. (2008), found that providers wanted more familiarity with MSM in order to better understand the issues facing them and their origins (Taegtmeier, 2013). The providers felt that targeted training could increase their effectiveness when working with MSM, as they felt frustrated when trying to deal with issues such as poverty, sex work, and sexual desire, which felt nearly impossible to change (Taegtmeier, 2013). Moreover, the providers recognized a need to have training on how to discuss risk behaviors and risk reduction with MSM (Taegtmeier, 2013). The traditional model of HIV counseling in Kenya has focused on heterosexual transmission, to the exclusion of other avenues such as anal sex among heterosexual couples, or among men having sex with men (Marum, 2006). Moreover, because of the societal norms and stigma around homosexuality and sex work, counselors sometimes experience conflict between their duty to give non-judgmental services and the perception that homosexuality is a condition to be “fixed” (Taegtmeier, 2013). One method for increasing the effectiveness of healthcare providers, identified by Taegtmeier et al., is to include MSM and MSM groups as advocates and service providers. They explain that MSM are “well placed to face the challenges of HIV in their communities allowing solutions that are generated to be contextually appropriate to Africa” (Taegtmeier, 2013).

b) Overview of previous work on this topic and relevance to thesis

Much of the previous work around key populations and HIV has focused on either societal stigma, religious stigma, or access to HIV services and treatment. From this scholarship, explored in the previous section, we have good estimates of HIV prevalence among key

populations in Kenya and globally, as well as understandings about their specific needs and barriers to services. Additionally, previous research and current policies emphasize the importance of serving key populations in order to stem the HIV epidemic, as well as the importance of FBOs in HIV services.

However, there is a lack of scholarship around all these themes in conjunction—how religious narratives and institutions affect the lives of key populations through both stigma (negative) and services (potentially positive), and how secular organizations feel the impact of religion on their work as well. This thesis utilizes focus groups with key population members themselves, who experience religion in varied and complex ways—from personal empowerment to institutional stigma—to gain insight into the most effective ways of serving their needs. The purpose of this thesis is to further the understanding of how religion plays a role, which may help or hinder (or do both concurrently), HIV services for key populations in Kenya, who are especially vulnerable to religious stigma and HIV, while often desiring the kind of social support it could provide. By taking a well-rounded perspective that includes secular organizations, religious organizations, and key populations members themselves, this thesis aims to provide new information for organizations wishing to serve key populations. As religion is an undeniable force in the context of public health work in Kenya, understanding how it has been used to fight stigma and improve access, as well as the barriers to it doing so, is an urgent and relevant need.

III.METHODS

Introduction

As the purpose of this project was to gauge the influence of religion on key populations as it relates to stigma and access to HIV services in Kenya, a qualitative approach was chosen to capture nuance, variety, and depth. Through in-depth interviews with FBO/CBO staff and focus groups with key populations members themselves, elements of effective work with key populations were identified, and individual/communal understandings of stigma and religion were explored.

Institutional Review Board (IRB), Consent and Ethical Considerations

This project was given approval under Emory's Institutional Review Board (IRB) in June of 2015. With Emory's IRB approval, both the CDC Country Office and St. Paul's University established a reliance agreement on Emory's ethical review. Additionally, each participant in interviews and focus groups signed an informed consent form, was given the opportunity to ask questions, contact the researchers, or withdraw completely at will. Because key populations are at special risk for stigma and violence, extra efforts to maintain confidentiality of respondents were undertaken. Except on consent forms, no names were recorded and all identifying information was removed from transcripts. Also, in the in-depth interviews, names were removed during transcription and confidentiality maintained.

Research Design

For this project, a modified Delphi technique was used (Okoli & Pawlowski, 2004; Adler & Ziglio, 1996). The Delphi method involves bringing together leaders and innovators in a field to describe in their own words the approaches they find effective. Then, the unique elements are identified and reiterated to the leaders for validation, eventually with the hope of "converging" on concepts. For this project, the leaders/innovators were staff of FBOs and CBOs who work effectively with key populations members. Because of time and funding limits, we were unable

to finish the iterative validation process. However, the key populations focus groups served to validate the findings from the FBO/CBO interviews and there are plans to share the work with Kenyan collaborators for further validation and feedback. See introduction section (**Figure 2**) for a conceptual framework of the project.

In-depth interviews and focus groups occurred over the same period of time (June-July 2015) with FBO/CBO respondents and key populations members gathered through a snowball process.

Population and Sample

The population chosen for interview consisted of three sub-samples: staff from FBOs, staff from non-faith-based organizations (CBOs/NGOs), and key populations members. Also included for the purposes of this project are data from non-injection drug users and women who have sex with women, as they also constitute marginalized groups in reference to HIV care. The staff members from FBOs were included to help illuminate effective elements and techniques of organizations that work with key populations using a religious motivation or frame. The staff interviewed generally had years of experience with these populations and with programming in the Kenyan context, and therefore were essentially experts in their particular field. The types of FBO staff interviewed included founders of FBOs, counselors, a refugee specialist and people in programming. The staff from non-FBO organizations were chosen in order to provide a comparison frame for working with key populations and to offer an outside perspective on the impact that religion has on key populations in Kenya. These CBO/NGO staff included national-level advocates, community-level up to national-level program managers, and outreach specialists. Both FBO and CBO staff were identified through snowballing and word of mouth, including through a topical lecture at St. Paul's University, a high-level meeting at Kenya's

National AIDS & STI Control Program (NAS COP), and connections of the research partners. In some instances, two or more staff members from the same organization were interviewed, either together or separately.

Ultimately, 18 unique in-depth interview sessions occurred within nine different secular and seven different faith-based organizations. The recruitment of key populations members occurred through connections with the organizations (though the organizations did not necessarily serve those KP members directly). Focus groups took place in “safe spaces” identified by the organizations (such as in a hotel conference room or the organization’s compound) and participants were either provided transportation reimbursement, lunch/tea, or both. No direct monetary incentive was provided for any participants in interviews or focus groups. Over the study period, 10 total focus groups took place—one with PWID, three with female sex workers, two with male sex workers, two with MSM, one with LGBT females, and one with non-KP HIV-positive adults. The selection criteria for focus group participation was simply identifying as a member in one of the key populations (except in the case of the non-KP HIV-positive adults group).

Figure 3: Table of Interviews and Focus Groups

	Faith-Based Organizations	Secular CBOs/NGOs	MSM/LGBT	Sex Workers	PWID
In-Depth Interviews:	7	9			
Focus Groups:			2 (males), 2 (females)	2 (males), 3 (females)	1

Procedures and Instruments

An in-depth interview guide and a focus group guide were developed by the author as a set of questions to be probed and expanded upon during the interviews. The guide for in-depth interviews used the broad categories of history, HIV services and the organization, and religion. The focus group guide included discussion of the ideal facility, religion in services and personal life, history, and HIV. In-depth interviews were carried out in as private spaces as possible, each lasting approximately 1-1.5 hours each. In some cases, multiple respondents (staff members) participated in an interview at one time (for example, three to four religious leaders discussing their collaborative work together). Focus groups also occurred in quiet/private spaces with eight key populations members each. Interviews and focus groups were recorded (after obtaining consent to do so) and transcribed later by the research team. In the case of Swahili-speaking respondents in the focus groups, staff members translated on the spot into English, and the English was later transcribed. All transcripts were uploaded into MAXQDA analysis software. Analysis took place by first creating memos within the data, then creating in-vivo and deductive codes to be applied throughout the transcripts. After codes were applied, common ideas emerged which were then synthesized into themes. The themes were finally fit into a conceptual framework for understanding the entirety of the results, which is presented in the following section.

IV. FINDINGS

- A. Introduction
- B. Findings
- C. Other Findings
- D. Summary

A) Introduction

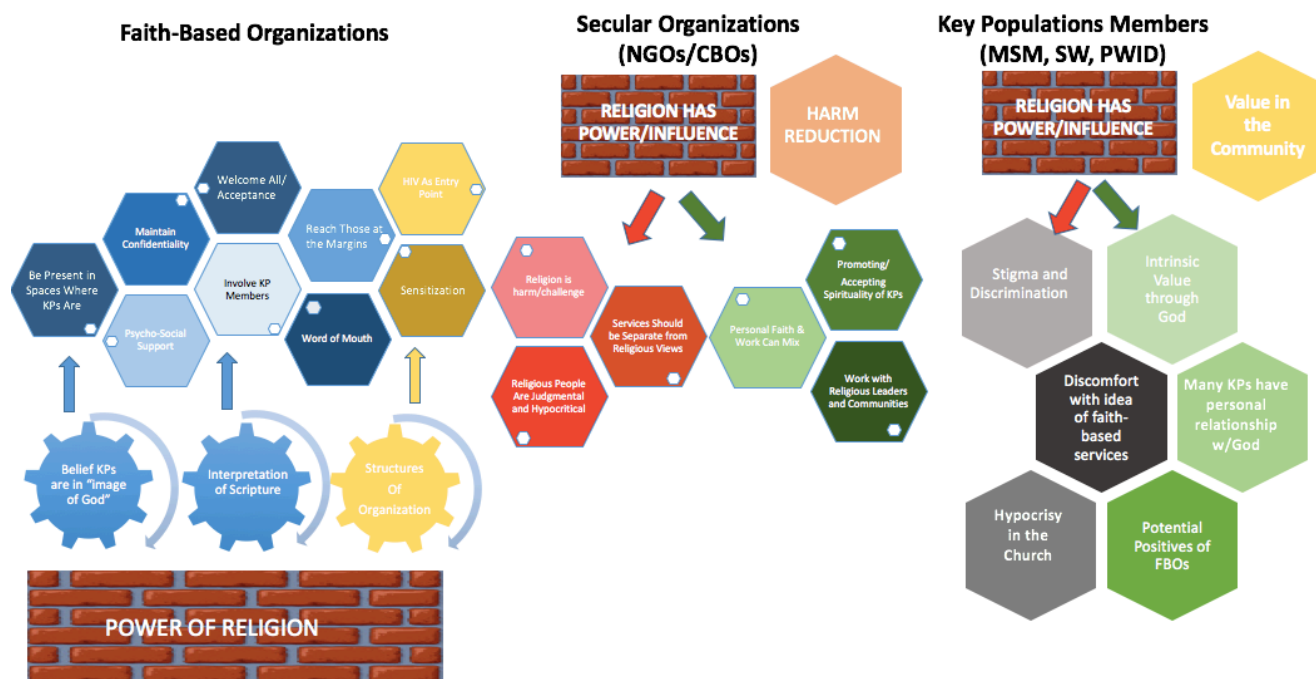
The findings from the three categories of interviewees (1. faith-based organizations, 2. NGOs/civil society organizations, and 3. key populations members themselves) illumine the fact that religion functions in a myriad of ways for key populations members seeking HIV/health services in Kenya. Religion for these groups is seen at once as a positive, negative, and nuanced influence, depending on the history, context, and approach in which it is used. All three groups acknowledged that Kenya is a deeply religious nation, and that religious leaders hold power in communities and all the way up to the national-level debates about homosexuality, drug use, and sex work. In the abstract, this power was often portrayed as adding to stigma, but many specific instances of change, resistance, and inclusion were also given.

Faith-based organizations, in particular, saw the power of religion as a necessary and positive force, one which informed and led to their ultimate goals for key populations members. From that foundational understanding of religion, FBOs identified important strategies/conditions that enabled their work—Belief in the Image of God in Key Populations, Interpretation of Scripture, and the Structures of their Organizations. The staff of faith-based organizations then described their approaches for working with key populations, including themes like Welcoming All, Maintaining Confidentiality, and Connecting key populations back to Spirituality/Religious Communities. The FBOs also discussed ways in which religion can be a social force in surprising ways, such as using the religious community’s experience with HIV as an entry point to discuss stigma against key populations, and using peer-led religious leaders’ sensitization as a way to circumvent rigid hierarchies and doctrines. For civil society

organizations, some staff described that they felt their religious views should be completely separate from their work with key populations, while others felt comfortable integrating their personal beliefs with their jobs. Certain civil society organizations actively promote the acceptance of key populations in religious communities, while others focus more intently on harm reduction or see religion as a significant challenge in their effort to serve key populations. Finally, key populations members themselves described ways in which religion has been used to condemn and stigmatize them, as well as the hypocrisy they regularly witnessed by religious persons. At the same time, many key populations members described a personal relationship with God and a deep commitment to remaining in religious spaces for their own spiritual reasons. Key populations members, in general, felt uncomfortable with the idea of faith-based services, though they perceived the discomfort coming more from faith-based providers who were uncomfortable with *them*. Additionally, the key populations members who were *already* being served by FBOs effectively were comfortable with the care they received. Finally, many key populations members believe they are valuable members of their communities and have the potential to bring skills and gifts beyond their “key population” labels.

The following is a conceptual model for understanding the findings (Figure 4, next page):

Figure 4: Conceptual Model for Findings

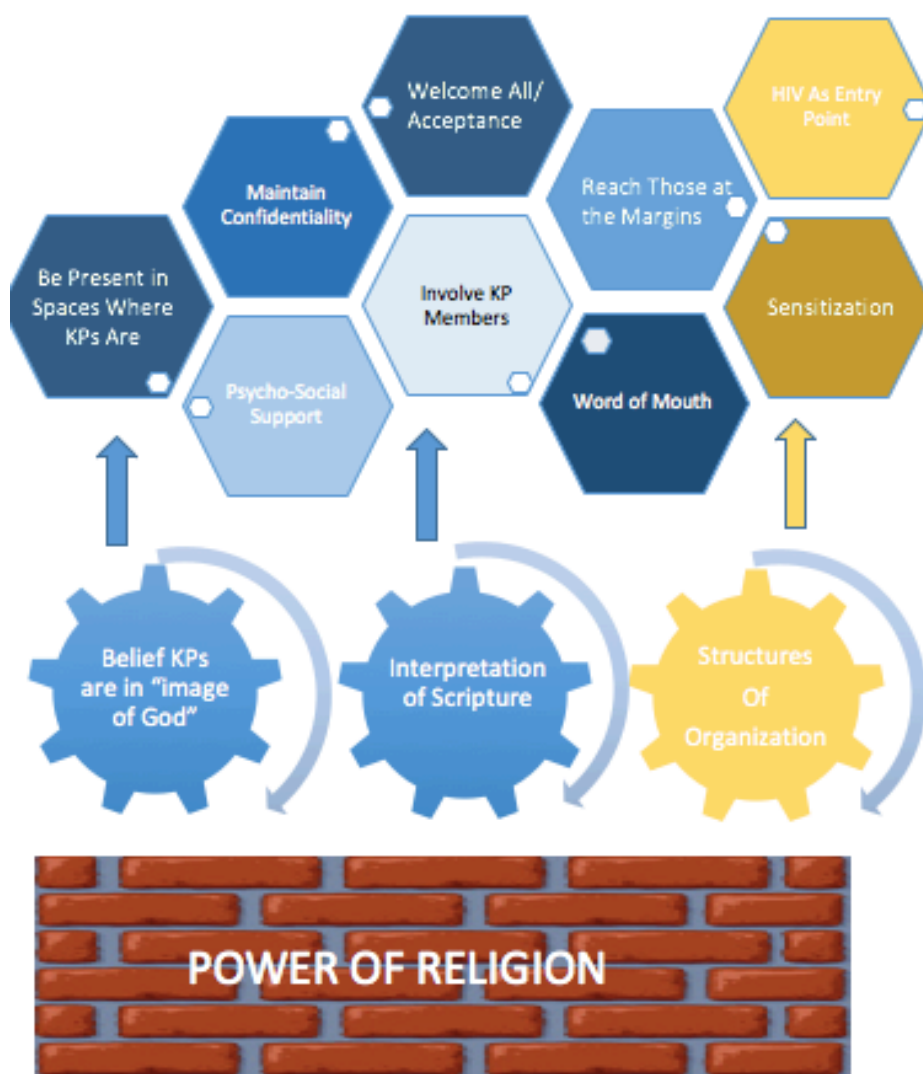


Description: The diagram above shows the three categories of interviewees—FBOs, NGO/CBOs, and Key Populations Members. For FBOs, religion plays a foundational positive function, whereas for the other two categories religion is a factor that can lead to positive or negative effects (represented in red/grey for negative and green for positive). The three “gears” for the FBOs represent features/drivers that allow for effective work. These enable the qualities/best practices represented in the hexagons (blue largely represents work with KPs directly, whereas yellow represents outreach in the community). These are further explored in the following pages. For the other two categories, the diagram shows how religion may lead to perceived positive or negative impacts (negative impacts are pointed to in red, positive by the green arrow). For secular organizations, there is a third category—Harm Reduction—which was seen as an alternative framework to religion for engaging in KP work. Similarly, for KP members, the hexagon “Value in the Community” represents the theme found that many key populations members see themselves as valuable in the community regardless of theology/religion/religious people’s perceptions of them.

B) Findings

Research Question 1: What are distinctive elements of Faith-Based Organizations that work effectively with key populations?

Faith-Based Organizations





Power

Something that was evident in all the interviews was that religion holds power, for better or for worse, in the context of Kenya. Faith-based organizations generally believe this power can be harnessed for positive change, whether as an empowering force in the lives of individuals or in linking KPs to religious communities where they can feel supported. FBOs also work to channel the existing power that religious leaders hold in communities to improve acceptance and conditions of KPs.

“One reason, we have seen the church is very influential. When the church makes a decision without proper knowledge, it can affect the whole population...So partly, we want to help leaders understand that they are leaders and they have a responsibility over everybody. Any careless remark leads to suffering of other members of the community.” (I007)

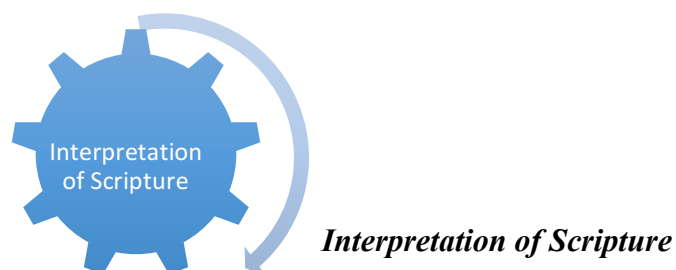
“That courage has been developed. That sense of trust, that sense of unity is there. So, it is really good. So like when people join the [FBO] we ask them ‘ok, read’ and they go ‘I can't even touch the bible, I don't know where to start.’ But now, it's really amazing...You can really see how people have grown, they are inspired, can take up challenges.” (I011)



A prominent element of the way that the FBOs interviewed approach working with KPs is a belief and strategy that services should be holistic. One way this was conceived was through the language of the “image of God,” which organizations believed was present in every person. FBOs rejected the notion that KPs should be cared for exclusively because of their economic potential, or because of their role in the HIV epidemic. Rather, KPs are seen as “children of God” who may need support to be restored to wholeness.

“We have had Christians and also Muslims in the program. For me, that image, God's image, or whatever it is, whatever you call your God, is critical...I go to the Catholic church, I am Catholic, she (nods to other) is Anglican, and others are AIC, we are all scattered, and we also have Muslim women in another town and a member of staff. The thing is about the bigger picture of holistic development for human dignity.” (I001)

“Because at the end of it all we are not just economical gains, we are spiritual beings as well.” (I011)



For FBOs, interpreting religious scriptures can be a way to re-think societal norms around what constitutes sin, how faithful people should respond to KPs, and how KPs should value themselves. One FBO described sessions where MSM went through Bible verses that dealt with homosexuality and discussed their own understandings. FBOs also used scripture to connect KPs with stories and narratives in the Bible/Quran that emphasized mercy, forgiveness, and love. Several FBOs mentioned using scripture to call for non-judgment, such as John 8, where a woman is caught in the act of adultery. She is brought before Jesus, who says that whoever among them is without sin can cast the first stone. Furthermore, an FBO mentioned that after sensitization trainings about key populations, religious leaders were eager for new ways to understand scripture.

“P1: Tomorrow, on Sunday, will be the fourth session, where we take each and every verse that we feel is used in church to discriminate or to say how homosexuality is bad, like the Sodom and Gomorra, in Genesis,

P2: and Leviticus...

P2: And Romans and 1st Corinthians. So we take them through each and every verse and we let them talk about how they hear, how they feel about those verses, and what they can keep from those verses.” (I011)

“You have to come up with hermeneutic ways to understand the Bible. The old testament, the new testament, it's all about the culture. The culture and the Bible, to me, they are twins. So if you don't know how to harmonize, you will not be at peace with whatever you are doing. So we use that method of dialogue, not debate.” (I006)



Be Present in Spaces Where KPs Are

In order to effectively work with KPs, many FBOs described that they had to physically put themselves “in their shoes” (I002) and meet KPs where they worked or relaxed. Three interviews mentioned that they went to bars where KP members frequent, for example, or drank with them. Going to those places (and not asking KPs members to first come to them) builds trust in the FBO—one interview described the image of religion as “tainted” for KP members, meaning it can take more time and effort to regain trust, and meeting KPs in their space can be one way to do that.

“So, putting yourself in their shoes, drinking with them, doing what they are really doing, going to their parties and things like that builds your trust. But, if you just say, ‘I am with an organization, I am working with so and so, I am doing some religious health stuff,’ none [of the KPs] would show up.” (I002)

“I called upon the priests, the provost, and whoever else, and the Imam to ask, ‘Can we have the meeting in the bar?’ And some of them were in shock...I said, ‘You know what? We cannot keep preaching to people who come to church every other day, we have got to go to where the others are.” And we did have meetings at the bars quite a lot of times.” (I001)

“We want to embrace... Wasn’t it a sex worker that kissed Jesus? This I love...And I decided to go to each and every bar to talk to prostitutes.” (I006)



Maintain Confidentiality

A sentiment expressed by KP members themselves, and understood by FBOs, was that confidentiality is an extremely important characteristic in a place one receives services. As with many of the best practices themes, a need for trust underlies this theme of confidentiality. Most KP members have experienced stigma in religious spaces and/or health services, so knowing that confidentiality about their work/lifestyle/sexuality will be maintained is a necessary step to gaining trust and comfort. Understandably, KP members want to protect themselves against the types of negative experiences they may have previously encountered related to FBOs.

"We have to keep their secret; we have to love them. Humans want to damn, but don't tell others!" (I006)

"Even health workers also stigmatize patients. Sometimes they take your file and maybe a nurse has another nurse and they start discussing and opening, and it is to stigmatize the patient because they are discussing about his information. Yet it is supposed to be confidential between the patient and the health provider...So confidentiality should be adhered to 100%." (I003)



Provide Psycho-Social Support/Connect KPs to Religious Communities

The most prominent reason for having a faith-based organization, as opposed to a secular one, seemed to be the types of psycho-social support that spirituality and/or religious communities could provide. FBOs described how health and legal services may be covered by other organizations, but that things like community, encouragement, and the strengthening of coping mechanisms come from a spiritual basis. Some FBOs saw their role as more exclusively in this realm, such as an LGBTI church, or groups of religious leaders who encouraged acceptance of KPs in their communities while also integrating HIV prevention. Other FBOs focused more on health services and HIV care but with counseling build into the model.

“We have to check how are their emotions, how are they relating with their community out there, and how is their spiritual life because they need God. They need that power, that divine power in their lives.” (I004)

“The reason why it is important to bring LGBT people to the church is because within the country it falls under the psychosocial and mental support. We have the health and legal support, which has already been taken care of...We have people who are on some sort of medication, not just HIV but Hepatitis and things like that. Some of them, at some point they stop, they tend to stop, because they don't have this hope to take their medication, to keep on going. But, when you involve the aspect of religion it gives them some hope...” (I002)



Welcome All and Acceptance

For the FBOs that work with KPs, there was a belief that all people should be welcomed by the organization and accepted as they are. While some KP members (as explored in the focus groups) would rather have their own separate services, others desired to be treated as any other person in “mainstream” services. In the sample for this project, there were both approaches; most targeted services specifically for KPs, but there were also organizations that served all people equally, including KPs. Either approach requires that staff buy-in to the belief that the space is for all and that services should begin from a place of acceptance of where individuals are at that moment.

“So, they come— they will not tell you that ‘I am this’— you will identify that as time goes on through the counseling sessions... We have not segregated them, the key populations, probably that is what makes our work easier. We can talk about the MSM when we have the couple in the room, but we do not announce anywhere.” (I003)

“God wants those people the way they are. You know changing somebody isn’t the work of the bishop.” (I006)



Involve Key Populations Members

Some of the faith-based organizations described involving KP members as an effective approach to reaching other KPs while simultaneously empowering the KPs already reached. The specific methods of this approach included: using peer mentors for outreach and education,

getting input from KPs throughout the programming process, and using testimonies of KP members to share the stories of key populations members.

“We work with peer mentors and practical health precautions. The peer mentors are a group of women who are trained as educators. They gave information. They facilitate sessions...They engage other women in the transformation process... And that's how they end up departing from sex work” (I001)

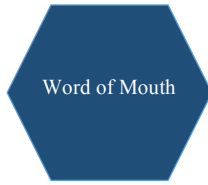


Reach Those at the Margins

Faith-based organizations often saw their role as reaching those who are most marginalized in society and meeting them with acceptance. Along with that role came the belief that this was justified by their religion and that they should not continue to marginalize KPs.

"Is the gospel for saints? No, it is for those you are despising." (I006)

“We don't close our doors. Whatever door it is... So what happens is, a woman will get tired, go out and be anything that she wants to be in this life, and then she comes back. And the first question is, "oh, can we move on? do you want us to move on? From you left off, from where you are?" And we continue. So we don't close doors. Otherwise we'd be doing the same thing, marginalizing. They're marginalized. It doesn't make sense.” (I001)



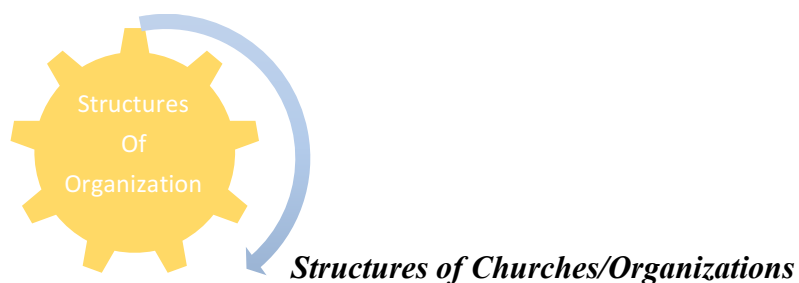
Use Word Of Mouth

One of the best practices identified by FBOs was using the trust built between key populations members being served and the organization to encourage other KPs to be involved through word of mouth. There were times when this crossed the boundaries of the groups. For example, there were stories of female sex workers who brought MSM for services. When asked how one organization, which operates in secret, was able to recruit KP members, the interviewee answered, “*Word of mouth, word of mouth, word of mouth.*” (I011)

“So, when they come to [org] and they realize they are too many, they really get excited. And, eventually they will bring more.” (I002)

“Interviewer: And how do you gain the trust of the people that you're working- like the refugees- - so that they disclose to you?”

“Respondent: Well it's a relationship. It takes a while, and mostly it's through referral. Like I help somebody or referred somebody to get assistance somewhere and he got the assistance then he tells others or the faith leaders who I'm already in contact with, when they come into contact with an [LGBT] refugee they call me.” (I005)



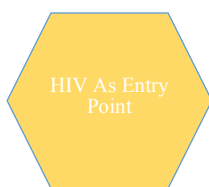
The 2012 report “A Firm Foundation: The PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS” (PEPFAR, 2012) outlines various types of faith-based organizations. It also outlines the roles that FBOs take on in response to unique challenges and capacities. There are six types identified, which include: National and International Religious Bodies; National or International Ecumenical Networks; International and Affiliate NGOs; National Interfaith Networks; and Local Grassroots Responses. In the interviews for this project, many of these types of FBOs were also present. An international religious body ran a hospital in this sample, but the funding was structured in a way that allowed for care for KPs that might not have been directly approved by church leaders. Also, an international ecumenical network allowed for a program protecting LGBT refugees in Kenya, despite an environment locally which makes work with LGBT issues difficult. Grassroots responses included religious leaders who took advantage of a loose organizational structure for their denomination to do work not popular in the denomination. Another grassroots response came from a dedicated Catholic parishioner who came into conflict with her religious leaders about handing out condoms, but felt she had the individual agency to continue to do so after winning over her priest and other local religious leaders. And finally, a group of LGBT people chose to create their own religious space as a grassroots response to a need in their community. For these FBOs who serve KPs, organizational structures can both help

and hinder their work, and creative means are sometimes needed to work within their existing structures.

“We have pillars of the church. We have taken one of them, which is reasoning. So, we are bringing people together to reason. If you pin me down, I will tell you our reason. We feel that reasoning is part of the doctrine of the Anglican church. But we start small.” (I007)

“Work is work. Religion, we go to the church. Here we are just working. But now the little challenge will come in like these things that are both, like condoms. Some churches will be, like, completely sworn off them, but they don't talk about it in church. We talk about it here. If a patient comes to the facility, we do discuss it.” (I003)

“One time the priest came to my office...and he found...a carton of condoms. He looked at me and asked me... ‘Are you still a Catholic?’ and I say, ‘Yes I am. In fact, I am very very much a Catholic,’ and then he asks me what about these...Then I say, ‘You know what father, one thing, if a new girl comes in here and she is going to sell her body tonight and immediately I am done with her, and I cannot stop her from selling her body, then she must learn how to use a condom.’ ...I would rather have the Pope excommunicate with me from the church... He later became, you know, the most outstanding collaborator.” (I001)



HIV as an Entry Point

The evidence from the literature, and the stories from FBOs, describe how severe the stigma around HIV *used to be* in Kenya. Before the widespread availability of ARVs, there was widespread fear and misinformation around the disease. Today, interviewees still described patients who were lured by religious leaders falsely promising cures, discouraging testing, or adding to stigma. Certain communities still associate HIV infection with promiscuity and sin. By no means is the stigma of living with HIV completely gone, but for those who were alive at the start of the epidemic, and the following peak of HIV-related deaths around 2002, there appears to be much progress in reducing both HIV deaths and stigma. In many ways, the HIV crisis necessitated and allowed discussion around issues of sex and sexuality that had previously been taboo. For some FBOs, discussing HIV prevention can also serve as a gateway to discussing issues like homosexuality and sex work. KPs are some of the most vulnerable individuals to HIV infection and among the most likely to spread HIV in the epidemic today. Therefore, as KPs are a priority for both Kenyan government and international funding, FBOs work to point out that what effects KPs ultimately effects the entire community. One FBO described this as a “submarine” approach—starting with HIV, which can effect anyone, and then moving to the agenda of having compassion for KPs. Multiple interviewees said that they have hope that stigma can eventually diminish for KPs, since they have lived through the change of stigma around HIV.

“With the faith communities having the dialogue of inclusivity of LGBTI persons you have to use the background of HIV/AIDS. And that is sad because that sort of affirms the stereotype. But, that is what the faith communities understand because they have been fighting HIV/AIDS for such a long time and that is such an easy comparison. So, you have to make a comparison to

HIV and you have to link you know, hey if you don't do something, chances are HIV/AIDS prevalence will get high.” (I005)

“When you are starting, we bring HIV/AIDS, something very familiar. That was our entrance point. Now, we are getting to it. We get a natural way of getting to people, from below. They will reach the conclusion by themselves. But we don't just hit it hard!” (I007)



Sensitization

Many FBOs and civil society organizations who work with KPs spent considerable amounts of time working to change attitudes in their communities. FBOs are often particularly well situated to reach out to faith communities and religious leaders with information on issues concerning KPs. Sensitization was described as a process of freely allowing and answering questions, correcting myths, giving people a chance to hear from KPs themselves, and explaining the vocabulary and needs of KPs. Some sensitization workshops added an element of surprise, where LGBT people, for example, intentionally acted like all the other participants until everyone was comfortable, then revealed that they were in fact the very people the other participants thought they feared. Other sensitization techniques included providing spaces where religious leaders could sensitize *each other* in the theological language, or making it mandatory that all the health workers at a facility undergo sensitization training on health issues KPs might encounter along with confidentiality. Sensitization also often uses HIV as a starting point for

justification of why KPs are important, explaining how their health is linked to that of the larger community.

“What we do is that we partner with other international organizations, like [censored], to facilitate workshops to train religious leaders and help organizations, particularly organizations which are not LGBT organizations. So, they are sensitized on language and the need to include the LGBT community in their programs...and it has been very successful.” (I002)

“Last year we had two dialogues sections where we brought all the faith leaders...we brought them together so they could actually deliberate the issues and just ask questions that come up. So that person who has a question says ‘Okay, THIS is what the Bible says,’ then somebody was there touching the issue that says ‘Okay, but there is another approach you can use...’” (I005)

Research Question 2: How do civil society organizations that work with key populations perceive religion's influence on their work?





Religion Has Power and Influence

CBOs acknowledged that religion holds an important place of power and influence in Kenya. CBOs saw very clearly how this power could be harmful for KPs, but also understood that progress against stigma and progress towards more available services for KPs meant having to acknowledge the power held by religious leaders/communities. With that lens, some CBOs chose to engage with religious communities, while others worked completely apart from them.

“Choose your words...Because you are changing the minds, you are responsible for the minds of Kenyans. Your congregants. We don't want to change what you do, but we don't want you to harm us.” (I017)

“The church is a very very important part of our lives. Cause I...for example, myself as an atheist, I still go to church...I am just forced to go there...Cause that is the only thing you have left. And then the church, controls like everything. The pastor knows everybody in the village. Eh, the church!” (I016)



Religion as Harm/Challenge

Multiple CBO interviewees explicitly see religion (doctrine, leaders, communities) as a challenge to their work with KPs. They described religion as effecting the way that KP members see *themselves* as well as how they are seen by society, which in turns effects whether or not KPs are comfortable and welcome to access HIV services.

“[Religion is] a big challenge in the sense that, most of the members here they are Christian. So when they go to church, they are told they are evil, what you are doing is wrong, and you are given examples. So they have nowhere to learn from, and you know, religion is where you go to do prayers and ...so they have that guilt. You think you’re this evil person...that you are not even allowed to live.” (I016)

“The law says Kenya is a secular state, but it believes so much in what religious leaders have to say. So then, religious discrimination comes from that point of view. If you were to get into a discussion about homosexuality, first thing that comes to mind is, ‘but it’s against the Bible!’ and that is basically the biggest challenge.” (I017)

“Interviewer: Yeah. So are there any people who you are not comfortable working with?”

Participant 1: We are comfortable with working with everybody. Everybody.

Participant 2: It’s only the churches which are not comfortable working with us!” (I010)



Religious People Can Be Seen as Judgmental and Hypocritical

While CBOs acknowledged that religion is a force that must likely be addressed, CBOs were also very quick to understand the reasons why KPs might want services that were free from an explicitly religious backing. One of these reasons was the explicit hypocrisy of religious people, including MSM who preached from the pulpit against homosexuality, or people who “sinned” in other ways but felt compelled to condemn others’ sins.

“Even those women who are going to church and they’re not a sex worker, they do nothing in the community— their work is just to put on the white clothes and go to church.” (I008)

“When you are reaching out to [the drug user] you must also take care that you are not part of the institutions that isolate him. Because to religion he’s a sinner. He does not need to come near the priest or the father, he needs to be far away because he’s going ‘to infect other people with his alternate way of doing things’. So he has to go away.” (I012)



Services Should Be Separate From Religious Views

Many interviewees discussed the fact that when they are working, they think personal biases should not impact the way in which key populations are served. These potential biases may come from religion, though also from personal or societal discomfort, or lack of familiarity/information. Some CBO staff may personally believe that sex work/drug use/homosexuality are immoral, for example, but know that their work necessitates a certain approach, which is generally one framed in a language of human rights.

“So when I came here for my job, I'm a Christian, but when I came to the organization there are values... so when I came here, the values that I have in my house, when I go inside it's now the organizational values that rule what I do.” (I008)

“I: So but is it possible that a religious outreach worker could be successful? Or do you think it's better to not be faith-based?”

P: That religious outreach worker should leave that religious faith out. He should just go there as an outreach worker working with them. Perhaps religion would be at the level of organization, the people planning that. But if you go there, you should not go there as a Christian or Muslim. You should go there as somebody going to work.” (I012)



Personal Faith and Work Can Mix

On the other hand, many individual CBO staff are themselves religious and see faith as a part of their work, though not necessarily explicitly. Faith is seen as providing a motivating factor for individuals, and one that can make the organization better.

“Most of what matters is not the organization being faith-based, it's the individuals. Since I could be working for the faith based organization but I have poor customer language or client language...But what I feel is like, if you have people who have spirituality in them and the

correct things in the right way...they will always be wanting to put themselves in the situations of the clients they are serving, in all dimensions.” (I014)

“This sex worker who goes out at night and helps members of the community, sex workers do cleaning in [censored]...We go to a slum we clean the whole slum with sex workers and MSM, we do a tent, we do food and music and in the evening we are home. So that kind of work in the community, for me that is my faith.” (I008)



Promoting Acceptance/Spirituality of KPs

While CBOs did not include religious programming, many of them did approve of, or work to connect KP members to religious communities of the KPs' choosing. Included in that work was an understanding that all varieties of religion should be accepted by the CBO—that they should not judge. Interestingly, both CBOs interviewed that worked specifically with PWID/drug users promoted a “spiritual,” but non-religious approach to their work.

“Most of the girls we work with go to church on Sundays. They have their own churches that they go to. It's just we always tell them you should not try to look unique because you are gay or look unique because you are a sex worker. I mean, Sundays everybody goes to church. Just go to church and pray to your God. As in, don't make yourself unique or important.” (I008)

“You see, there are some approaches we have, we have some spiritual approaches, where the spiritual approach does not bind you to religion.” (I012)



Work with Religious Communities/Leaders

A corollary to the theme of promoting the spiritual/religious lives of KPs was a theme of working to create acceptance by religious communities and leaders themselves. While not always successful, the effort to engage religious communities/leaders was essentially community outreach in some cases, while in others it was through meetings within formal structures, such as the World Council of Churches (which is an international body).

“We have some meetings which we call community health dialogues. And in community health dialogues we bring around the religious leaders— Muslim, Christian, whoever is operating within those areas, the catchment areas... So any religious people in those areas, if we have found them and they have time we invite them to talk to them and also to discuss, because issues like [needle exchange] are very very difficult for them to deal with it.” (I012)

“In community there is no service provider, there is no church leader, we are all members of this community. If we stigmatize these women, and the sex workers, they will never change. How will you tell them, what they are doing like having multiple partners is not fair, its not acceptable, when you are still on this end and they are on the other end? They will have to...come to a

meeting point where you can sit down and discuss. And unless you do that, you still have the challenges.” (I015)

“Interviewer: So have you had some successes with reaching out to pastors or churches or police?”

Participant 1: Reaching out to health facilities, we went to a health facility around here, the in-charge accepted them to access treatment.

Participant 2: But pastors, police...no. It has not been successful, but we are not giving up!” (I010)



Harm Reduction

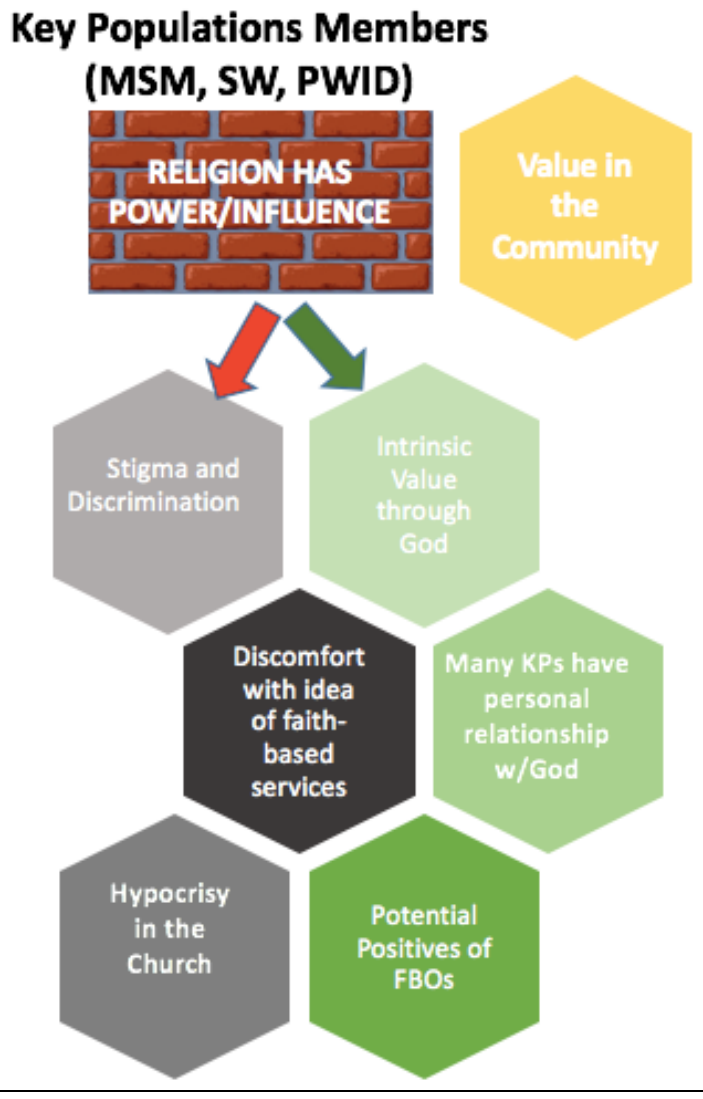
Instead of operating under the framework offered by religion, many of the CBOs discussed their work in terms of harm reduction. Harm reduction was often related to the idea of human rights or the idea that helping KPs was good for the entire community. This frame did not necessarily use the idea that helping KPs is a moral obligation or moral in itself, but rather that it makes sense from a communal, epidemiologic, economic, or human rights standpoint.

“So that is what our model is, even when we teach sex workers, even when we teach the police and others we are like ‘this is a sex worker, if you feel it is immoral, leave that to God, do not harm her, do not assault her, do not rape her because she's in the streets at night, do not beat her when she comes to your pub.’” (I008)

“Our main issue is effective access to treatment. Not that we support the key population alternative, but we fight for them to access treatment. And that's why we also work with health centers so that at least they get that avenue in order to get treatment. What we are doing, if you go to the churches, they will tell you that, we are not supporting MSM, we are not supporting any other key population like the drug users, but whenever they are sick can they be accepted and get treated? Because if they are not treated, the disease will explode.” (I010)

“It's not really to change their [religious leaders] beliefs, it's more of 'don't harm us'. Because what you are saying is harming us. It is a bad situation... Don't preach against us, all that kind of stuff, and we will not in turn.” (I017)

Research Question 3: How is religion used and/or experienced in the lives of key populations members?



One complicated aspect about pinpointing how religion is experienced in the lives of KPs is that there are a lot of things that may be connected to religion in their root, but are very much under the surface (such as police harassment, self-discrimination, etc.) and therefore not discussed directly in relation to religion in the focus groups. Some of the situations the KPs are

in (like being a gay man who leaves his community, becomes addicted to drugs, and then enters sex work...) are the chicken or the egg dilemmas—they are both the results and causes of stigma. For the purposes of the findings for this research question, the focus is on the direct discussions of religion. However, it should be noted that the background environment for many KP's lives include shame, stigma, fear, and painful experiences as a result of their KP status.



Stigma and Discrimination Related to Religion, From Others and Self

Some KP members described shame that was placed upon them (or attempted to be placed upon them) by others. At the same time, other KP members described self-selecting out of religious environments because they *themselves* felt their actions excluded them from being in good religious standing. Either way, almost all KP members were able to recall and discuss ways that they had seen or experienced stigma or discrimination from churches, mosques, or religiously-based services.

“Being pushed out of church does not only involve physical; it involves the attitudes, it invokes a lot. When they realized that I am gay, the attitude was very very negative on me. Anyone I went to talk to, even my close friends, were now keeping themselves away from me.” (F004)

[translating] “So even him, he used to go to church. But when he got now into business he continued, but he asked himself what if the church elders or the people in the church discover

what he does? What do they say? And then he felt that he is not fit there. He stopped going to church.” (F008)

[translating] “So he is saying, one reason [a service facility] should not be religious, it should not be from any religion, is because of that respect of God. God's commandment is against all that they are doing. So to bring an organization of this, under the umbrella of that, it is like bringing a curse to yourself because at the end of the day they respect God.” (F007)



KPs experience discomfort with idea of faith-based services

One of the questions that was asked in the focus groups was about an “ideal” facility to receive HIV services and other services. We then asked if this ideal facility would be faith-based or not, and why. Across the board, KP members responded that the ideal facility would likely not be faith-based, though some mentioned it would be possible with certain characteristics (see next theme).

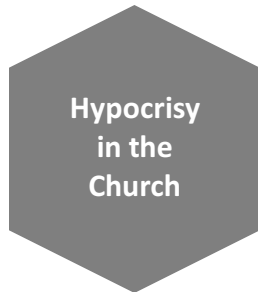
“I would prefer a more public health facility. I am just a Kenyan like anybody, I should have the ability to walk into a public place and seek treatment like a straight [Kenyan]. I do not want to have to go somewhere separate, because of my orientation. But because of the current stigma and discrimination, I have to.”(F004)

“I: Would it be faith based, or not? (Referring to ideal health facility)

Multiple women: NOT!!!

I: Ok, why not?

P: Because we come from different religions. It takes a lot for us to come, and if they are religious, we can be blocked from getting different services. It is harder for us to come.” (F003)



Sin is Sin/Hypocrisy in the Church

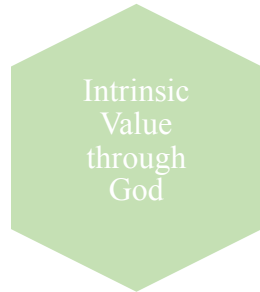
Many KPs were keenly aware of a certain hypocrisy in the theology of those who condemn them. The fact that they are called “sinners” as a justification for stigma is hypocritical to the theology that all people are sinners (including those who condemn) and therefore need redeeming, and should be welcomed in church.

“We humans are not all perfect. So anyone can be religious and yet has his weakness. We can say that there will be no religious person who does not have a weakness.” (F010)

“Church is a community of sinners, but everyone goes to church on Sundays. Why not me? Why do they need to go, if they don’t sin? I sin, I am a creature of God, and I go to church.”(F006)

“To me, I go to church, they know me as gay, a sex worker, but that does not stop me from going to church because if gay is sin, other orientations also have their weakness which is a sin. Also, I am currently dating a priest...I go to church as a normal person, I give 10%, and am currently

teaching youth. I want my sexual orientation to be the last thing. If you talk that way about me in church, I will respond.” (F006)



Intrinsic Value As Children of God

In the same way that many KPs maintained a spiritual practice, many KPs also saw themselves as valuable in the same way that any “child of God” would be. Contrary to the rhetoric of sin and discrimination, these KPs used religious language instead to express that were equal beings.

“Whatever I am is the same thing you are, because we are all created in God's image.” (F003)

“I know who I am, I know I am pure. God will judge. I am gay, I have my weakness, but nobody can judge us. Let us look at the church. We are all children of God.” (F006)



Many KPs Have a Personal Relationship with God and/or the Church

Despite, or perhaps because of, the stigma and discrimination that KPs experienced with regards to religion, many KPs described their *own* ways of connecting with God which did not rely on others' approval. Some KPs described standing firm in their belief that the church should be for all or that Jesus came for people *like them*, for example. These KPs continued to go to church/mosque despite stigma, as they had a personal theological justification. In at least one instance, a participant revealed that he himself was both a male sex worker and a priest, and multiple sex workers described knowing or serving church leaders. In these instances, the KP member's understandings of their relationship to religious spaces becomes quite nuanced.

"I feel at peace in church. I have my own relationship with God. I don't care what you say, if I am going to hell. Unless God comes and tells me 'stop being gay' I will continue to go." (F003)

"Most of us, we are the same, we are not going to church. But according to me, we need church. There is no need to judge me...I know who I am, I know I am pure. God will judge." (F004)

"Sometimes you're there [at church] and he starts preaching and you go, 'Ugh this guy's preaching about me!' That's ok. God bless you." (F001)

"The way religious people look at us... that's who they are. That is their religion. As for me, I don't care. If you want to crucify every LGBT person, just remember that Jesus was also crucified." (F003)

“P: Yeah, I am still a priest... Ok by the time I was an adult, I went to a seminary school...I was at the altar, every Sunday...They [the church members] don't know, only my mother knows I am a gay man.” (F004)



There are potentials and positives about faith-based services or churches

While most KPs assume that FBOs or churches would stigmatize or be uncomfortable with them, they also shared examples where that was not the case, or where they saw the need/potential for faith-based services. For the few KPs who already receiving services from an FBO, they saw and appreciated the positives of that approach.

“So for me, [this FBO] is a place that welcomes anybody, a place where you can open up. It is a place where you feel that you're not being judged, not being stigmatized, that is according to God... It is making you know that you are part of the community and you're valuable.” (F002)

“If we can, get something spiritual, because when we have something spiritual with us, we have power. And we are raising our children to like them, not to be like...but to bring up good people. Not tell us that we are bad, but to bring them in a way...You know most of us don't attend churches, but we want our children to be going to churches. At least, you know, when we have something spiritual we can have good parenting.” (F002)

“I: What would the perfect facility be? Would it be religious? ...

P: Depends on confidentiality. If a FBO is confidential and gives me all the services, and I trust them, I don't mind. If it is accessible.” (F004)



Value in the Community

Many KPs also expressed that they understood themselves as valuable individuals and members of the community inherently. These KPs saw themselves as having potential and gifts to give the community, should they be given the opportunity.

[translating] “P: So he has said, one thing he would like the society to understand is that they are of great value. Yeah. And another one has said, that they are human beings like other human beings.

“I: Mmhm. So you know you are of great value?

P: Yes. And also they should understand that you are doing a business, just like they are.” (F007)

“P1: Ok, I would like the community to look at me positively. Yeah, in life. Just to look at me positively.

I: What else?

P1: Ok, apart from the business that we go to, some of us we have talents, you know. Like me, I'm in artist, and that is what I want the community to know about me. The other part of me.

I: Anybody else?

P2: And also to join us in developing the community.” (F008)

“We concern ourselves with other communities, not just the LGBT. We should be involved with things like tree planting so that they can see we are more than gay.” (F003)

C) Other Findings

Characteristics of what an ideal facility would have, and not have:

While not directly tied to religion, the focus group discussions included best-practices tips and qualities that KPs believed were necessary in a service facility. These are important considerations for FBOs, CBOs, and others doing programming with KPs.

*“To ourselves, what we look at is the **security, details, and the convenience, the message, how they portray their message and the channel they use to get us.**” (MSM--F008)*

*“I think we need to impress on everyone that walks in that it is a **safe space**, and that they do not have authority over the mind. So everyone is entitled to their own opinion, but if they walk into our space, they have to **conform to our rules**. Because that is a safe space.” (F003)*

“I: So, how does this [ideal] facility engage in the community, or do outreach? How do they interact with community outside?”

*P: They **provide programs, so that even church leaders can get involved** and talk to each other.*

I: So holding forums where they can discuss with church leaders?”

*P: Yes. **So they can see us in the community.** That we may be gay, but we are good people.”*

(F003)

*“Everyone is concerned with HIV and AIDS, and we need to show them that **this affects both of us.** So that they care for us.” (F003)*

*“There is this sense of them not wanting to talk to you. Because of Christianity...it is hard to talk to us. **But if they know our face, then it becomes much easier.** You can talk to someone, and they are ok with it.” (F003)*

*“P1: Someone needs to come speak to us. We cannot go to a straight counselor...she will try to change you. **We want someone who is gay, and trained as a counselor.***

*P2: Yes, **we don’t want to be told we are abnormal,** or need to be changed with the Bible- we don’t want those lines.” (F003)*

D) Summary

Within the realms of direct services, services for personal growth and empowerment, connections with the broader community, and work to reduce stigma, both faith-based

organizations and civil-society organizations have found ways of effectively working with key populations members. These organizations and key populations members themselves see religion and stigma as constant factors that must be addressed. Faith-based organizations work to use religion and spirituality in new ways that re-write societal assumptions about who belongs, and to bring holistic health to KP members. CBOs balance personal faith and outreach with religious leaders with a keen awareness of the harm religion has done, and continues to do, to many KP members. Key populations members have found their own ways of connecting with their faiths, but still feel nervous with the idea of faith-based service providers if they have not built up sufficient trust first. Finally, the findings show that by asking key populations members about what qualities are important to them in service facilities and organizations, those who serve them can be better equipped to provide effect HIV programs and empowerment.

V. DISCUSSION

Through the interviews for this project, it was evident that religious communities, leaders, and organizations are important forces in shaping the HIV response for key populations in Kenya. Nearly every single key population member that participated in the focus group process had been raised in a religious community, where their ideas about what constitutes sin and who could be accepted by the religious communities were shaped. Many key populations members continue to participate in their religious or spiritual tradition in one way or another, though many have also been hurt by the stigma and judgment they experienced from religious communities. Some self-selected, or were pushed out of religious spaces for this reason, while others created their own religious spaces, which were decidedly against all forms of discrimination. For faith-based organizations, religion, when used without judgment, was found

to be a tool for reconciliation with traditions, communities, and individuals, as well as a means of personal empowerment and change for those they serve. A major strength found in FBOs is in their ability to reach out to other religious people and speak in the same language of scripture and stories, and to use that language to re-interpret the prominent religious scripts and sensitize others to the needs of key populations. Effective FBOs tended to share similar qualities in their work, including physically going to meet key populations where they work or congregate, maintaining confidentiality, involving key populations members in the programming process, and providing psycho-social support.

For community-based organizations, religion was ever-present in its role of bringing stigma and challenges, but also provided an important avenue for reaching the wider community. Some CBOs and their staff felt that key populations were better served by removing religious elements because of the negative association many key populations members have with religion. Instead, these CBOs came almost entirely from a human rights perspective, which provided a basis for equality and harm reduction. Alternatively, other CBOs connected key populations members to spirituality, or encouraged them to find religious communities, but kept their mission focused towards health services. The CBOs interviewed that worked directly with people who use drugs used a “spiritual” rather than “religious” approach—a higher power without the structure of a denomination. These CBOs may have seen the spiritual approach as more personal – a drug user acknowledging his/her own inability to conquer the problem alone – rather than trying to mold to a predetermined religious doctrine within an entire community, which likely does not accept or understand them. This approach is somewhat similar to the step of acknowledging a higher power in the Alcoholics Anonymous program. It should be

mentioned, therefore, that different populations respond better to using spirituality versus formal religion because of the nature of the outcome sought.

Religious Leaders:

One thing that was clear, both from previous research on the topic and the interviews from this project, is that religious leaders have a crucial and often paramount role to play in forming attitudes about key populations within communities. High-profile religious leaders can shape attitudes towards key populations on the national level in Kenya, and those who are most ardently against things like homosexuality tend to use religion as a justification. Respondents in our sample discussed the fact that many lay people have had personal experience with key populations (for example, knowing a homosexual person or a drug addict in their family or community), yet they felt that the religious leaders were the ones who shaped the dialogue around, and response to, those experiences. While there is likely also a role for lay people to play in shaping the dialogue around key populations, it is generally the religious leaders who already hold power to shape the dialogue in congregations. This power enables them to mobilize communities, especially in locations where NGOs and/or government facilities may not be present (PEPFAR, 2012). From this project, it was identified that religious leaders *can* change their attitudes towards key populations over time – several of the respondents had personally experienced this change – which points to the potential effectiveness of outreach to religious leaders in efforts to curb stigma against key populations. There were certain experiences the religious leaders who came to support key populations encountered. In many cases, they met a “gatekeeper” in one way or another – either they came to realize someone they already knew was a member of a key population, who then helped further their understanding of key population

issues, or they attended a training or event where they were given the chance to debate, reflect, and hear from key populations members. In the case of at least two FBOs, staff served as this gatekeeper directly, inviting and challenging religious leaders to participate in interacting with key populations.

Support and Access vs Acceptance:

One distinction that appeared in the interviews was between levels of acceptance of key populations. For example, some clergy members described “loving” key populations members, but hoping for their redemption. Alternatively, other service providers, including some FBOs, intentionally refrained from moral judgment and worked towards healthy behaviors whether or not they “agreed” with the key populations lifestyles. One CBO made it clear that they did not promote or “support the key population lifestyle” and yet approached the issue as one of human rights and health. One could also make the distinction between key populations – drug use/addiction is conceived as a pattern of behavior and sex work is conceived by many as a livelihood, whereas men who have sex with men may or may not conceive of that behavior as part of their identity. Something that must be considered by organizations and religious groups is whether or not they are aiming to work towards HIV prevention/treatment and other health services or towards moral outcomes. As seen in this project, faith-based services can work towards health outcomes without aiming to change the *identities* of key populations members. Furthermore, this project identified that religious people need not “agree” with key populations’ lifestyles in order to serve them from a human rights perspective.

Building on the Experiences of HIV Stigma:

As we conducted this work more than 20 years after the start of the HIV epidemic in Kenya, many of the respondents had intimate knowledge and experience of seeing attitudes towards PLWHA change over time. Respondents described a time when fear and stigma around HIV was extremely high and how misinformation, false healers, and religion contributed to negative outcomes for PLWHA. Today, these are still very real issues, but several respondents commented that stigma has reduced greatly from what it was in the past (in 1990s-early 2000s). These respondents also saw hope in the potential parallel with the stigma that key populations members experience today and its potential to also change. Therefore, it is possible and promising that the methods that led to changing attitudes towards all PLWHA can also be used to reduce stigma towards key populations. From this project, it appears that an important first step to reducing stigma is opening up space for dialogue, information, and exposure, whether it is to reduce stigma for PLWHA or key populations.

Key Populations Members Themselves:

Finally, some of the major findings of this project were the perspectives of key populations members themselves. Key populations members described the effects of externalized and internalized stigma and the ways in which religion had been used to justify discrimination and harm towards them. Sharing these experiences themselves could be used to help others understand the relevance of sensitization as well as the humanity, needs, and struggles of key populations. Key populations members also identified characteristics of effective organizations. Especially important were feeling safe, that they would not be “preached” to, that their information would be kept confidential, and that their value in the community would be recognized. Many key populations members hoped that one day they could access health services

like any other Kenyan citizen would. Other key populations members wished for separate facilities where counselors were especially sensitized to their needs. Likewise with religion, many key populations members desired to be accepted in their faith traditions, while others formed their own. Though weary of faith-based services and keenly aware of hypocrisy amongst religious individuals, key populations members also saw the potential for religious elements to strengthen the services they receive. An important consideration is that for several of the key populations members who had been connected to a religious community, they had needed the support of another person to act as a “bridge” or liaison back to that community. In this way, it is possible that FBOs and CBOs alike can make efforts to initiate and sensitize religious leaders ahead of time before connecting key populations members to them.

Importance

The findings of this project should be placed in the larger context of international efforts to reduce stigma for PLWHA and reduce the prevalence of HIV amongst key populations. Relevant stakeholders such as PEPFAR and the CDC are aiming to identify civil society partners who can work with key populations, as well as develop resources that can help lower stigma for those living with HIV in contexts (such as East Africa) where discriminatory laws may impact government ability to effectively reach key populations. The Interfaith Health Program (IHP) at Emory University, under which the project was carried out, has been involved in this on-going process to build civil society capacity. From their 2015 consultation with faith leaders (along with St. Paul’s University, PEPFAR, and the Christian Health Association of Kenya [CHAK]), recommendations included: Leverage the trust developed between FBOs and communities; Develop capacity of FBOs to advocate for improved health; Strengthen capacity of FBOs to

develop proper systems and tools for gathering, sharing, and utilizing data at all levels; and hold ineffective FBOs accountable (PEPFAR, 2015). Following the 2012 consultation, CDC/PEPFAR asked IHP to identify the core elements of FBOs that work effectively with key populations with the eventual aim of creating a training curriculum and platform through which other FBOs could be trained. This project, therefore, is a meaningful and important step in identifying those elements and setting the groundwork for developing a curriculum. This will ultimately contribute to the recommendations in the 2015 PEPFAR consultation report by increasing FBO capacity to work with HIV vulnerable populations and increasing evidence for accountability.

Relation to Previous Research

The findings in this project both build upon and reinforce findings from previous studies. Similar to Neuman, M., & Obermeyer, C. M. (2013), the respondents in our sample described stigma effecting key populations' lives on multiple levels, including home life, health care, and religious lives. However, this project also found examples of organizations that were able to reverse the trend of "internalized feelings of low self-worth" described by Nueman (2013), instead furthering empowerment through things such as economic opportunity and peer mentoring. Similar to Otolok-Tanga et al.'s (2007) work, this project also found that religion was seen as furthering stigma against PLWHA, but also holds power to be effective in fighting it, especially if approached with increased openness about HIV status amongst leaders/congregants and leadership of PLWHA. In our case, this openness and leadership was effective when it included openness to learning about key populations' lives and needs, as well as involvement of key populations members themselves. Further, the key populations members in this project recounted negative experiences with health providers, which reinforces the work of Scorgie

(2013) and van der Elst (2015) with sex workers and MSM in Kenya, respectively. Combined, those studies along with this one make a strong argument for investing resources into sensitizing health providers while simultaneously working to include key populations members as advocates and/or service providers, as advocated by Taegtmeyer (2013). Van der Elst (2015) concluded that sensitization is an innately social process, and this project provides evidence that religious leaders and communities are important players in that process. Therefore, sensitization efforts for healthcare providers may be most effective if they also address religious norms and include outreach to religious communities. Finally, as observed in the 2012 PEPFAR Consultation Report, “A Firm Foundation” (PEPFAR, 2012), the varieties of structures in which FBOs operate (e.g., grassroots, ecumenical, international NGO) have impacts on the types of programs they are able to carry out with key populations. Our findings reiterate the consultation’s charge that grassroots organizations (whether faith-based or not) can be prophetic by working with governments or other structures to hold them accountable in responding to on-the-ground needs of key populations.

Alternative Explanations

One should consider the fact that part of the aim of this project was to identify FBOs who worked effectively with key populations and to identify how they did so. However, it should not be assumed that all FBOs work effectively with key populations, or that the characteristics identified in this sample are exhaustive. An alternative explanation for the findings here is that a very specific subgroup of FBOs and key populations (who were generally connected to FBOs and CBOs in the sample) were used and showed disproportionate openness/promise. The intentional bias of this project was to uncover and illumine positive contributions of religion.

While efforts were made to realistically describe the level of pain and harm that religion has also contributed in the lives of key populations members, it may come across that religious organizations, leaders, and communities can be more accepting than is actually possible in the current context. Further, because the respondents generally resided in or near urban areas, the reach of health services, the education level of service providers, and the responsiveness of certain religious leaders may not be representative of all of Kenya or may misconstrue the usefulness of the findings.

Limitations

Along with the alternative explanations for the findings, there were several limitations to this project. First, due to time and financial constraints, much of the translation for non-English speakers (focus groups only) was done on the spot. This may have resulted in some infiltration of the translator's input or interpretation. Secondly, in at least two of the focus groups, members of the organizational staff were present when the respondents were discussing the organization for translation purposes. This may have significantly impacted the ability of the respondents to be open and honest about their views of the organization in those instances. Third, while a focus group of drug users and two IDIs with organizations that work with drug users were included, these populations were relatively less well-represented in the sample than sex workers or MSM/LGBT. Fourth, the interviews and focus groups were organized through existing connections by the research team, "snowballing," and new connections made at forums about key populations. It is a possible limitation, therefore, that the sample was in no way designed to be random or represent a cross-section of organizations. Likewise, because the key populations members who participated in the focus groups were recruited by organizations that already have

trust in the community, the represented key populations members may have more connections to services than if the sample had been truly random. A final limitation is that the author of this thesis is relatively new to the Kenyan context. Therefore, some results may require (and deserve) more experience and cultural context than was able to be provided here.

Suggestions for Further Research

Further research should evaluate more directly the effectiveness of different sensitization techniques with religious leaders and communities, including delivery method, duration, involvement of key populations members, and status/role of person delivering the content. Efforts to improve the capacity of healthcare providers to give comprehensive care to key populations members should also continue to be studied and evaluated. Further research should also continue to examine the evolution of laws and policies that effect key populations and identify the stakeholders and mechanisms for influencing them, with an aim towards reducing stigma and improving services. Finally, further research should continue to explore the experiences and perceptions of key populations members themselves, including how they desire to receive information and services, and what matters most to them in the context of holistic care. For example, this project identified that many key populations members consider themselves religious, which may be important to them and to their HIV-prevention behavior change potential, even if they have not yet found accepting religious spaces. Further research can consider what role religion plays in empowerment and compare across programs the effectiveness of strategies.

VI. CONCLUSION

The varied experiences of the staff from FBOs, NGOs/CBOs, and key populations members themselves in relation to religion and HIV/health services provide examples of effective ways to work for the health and wholeness of key populations. In this work, religion is an important factor that should not be ignored. Religion affects how key populations are perceived and provided with health services in the Kenyan context, for better and for worse. Therefore, stakeholders at all levels should consider the religious attitudes, communities, and leaders present in the environments in which they are working, when trying to effect the HIV epidemic amongst key populations. After carefully assessing the religious landscape, stakeholders can make efforts to reach religious leaders and organizations with information on key populations' needs, as well as with sensitization trainings, dialogue, and face-to-face interaction with key population members, in order to ensure that these priority populations are met with the HIV prevention, treatment, and care that they need.

Key populations members hold the potential to be healthy, productive members of religious communities and society in general. Stigma, misconceptions, and discrimination in health services not only continue to harm key populations members, but also the entire society by reducing access to HIV prevention, treatment, and care. The result of this stigma is a continuing concentrated epidemic among these key populations due to lack of legal, structural and personal power, which spills into the general population in the form of increased infection and disease burden.

In order for key populations members to receive the care they need, leadership from religious communities and organizations is crucial. Key populations do not simply need direct health services, but also psycho-social support and ways of economically supporting themselves.

Religious leaders can engage in dialogue with others about interpretations of theology and reasoning, intentionally including key populations members in their discussions, and work to change from a paradigm of sin to one of love, or in some cases, at least harm reduction. Non-faith-based organizations are keenly aware of the challenges that religion poses to working with key populations, and continue to be important partners in educating others, reaching disillusioned, hard-to-reach, or non-religious key populations members, and connecting religious communities to resources. From the findings here, any organizations working with key populations members can likely be most effective if they approach their effort without judgment (and without immediately working to “change” the person), instead spending time in places where key populations members are, welcoming them, and coming to understand the intricacies of their experiences while providing a confidential and empowering environment.

A change in how people with HIV are viewed in Kenya has already occurred for the better, in the direction of less stigma. Today, the people most effected by HIV are also the most likely to be stigmatized by their community, religious home, and health providers. If we are to work towards the end of the HIV epidemic altogether in Kenya, we will need to first open dialogue, and then collaborate together on solutions that will not leave those most vulnerable behind, whether or not we like the behaviors they engage in. From a religious perspective, “*We are all children of God*” (Male Sex Worker, Kisumu) and from a human rights one, *Afya ni jukumu la wote* (Swahili for “*Health is everyone’s responsibility*”).

VII. BIBLIOGRAPHY

- Adler, M., & Ziglio, E. (1996). *Gazing into the oracle: The Delphi method and its application to social policy and public health*. Jessica Kingsley Publishers.
- Affinnih, Y. H. (2002). Revisiting Sub-Saharan African Countries' Drug Problems: Health, Social, Economic Costs, and Drug Control Policy. *Substance Use & Misuse*, 37(3), 265-290.
- Beckerleg, S., Telfer, M., & Hundt, G. L. (2005). The rise of injecting drug use in east Africa: a case study from Kenya. *Harm Reduction Journal*, 2(1), 12.
- Bhattacharjee, P., McClarty, L. M., Musyoki, H., Anthony, J., Kioko, J., Kaosa, S., . . . Moses, S. (2015). Monitoring HIV Prevention Programme Outcomes among Key Populations in Kenya: Findings from a National Survey. *PLoS One*, 10(8), e0137007. doi:10.1371/journal.pone.0137007
- Blevins, J. a. E. C. (2013). "Valuing Every Human Life: How Faith-Based Organizations Can Support Key Populations with HIV Prevention, Treatment, and Support." Interfaith Health Program, Emory University.
- Braithwaite, R. S., Nucifora, K. A., Kessler, J., Toohey, C., Mentor, S. M., Uhler, L. M., . . . Bryant, K. (2014). Impact of Interventions Targeting Unhealthy Alcohol Use in Kenya on HIV Transmission and AIDS-Related Deaths. *Alcoholism: Clinical and Experimental Research*, 38(4), 1059-1067.
- Decker, M. R., Wirtz, A. L., Baral, S. D., Peryshkina, A., Mogilnyi, V., Weber, R. A., . . . Beyrer, C. (2012). Injection drug use, sexual risk, violence and STI/HIV among Moscow female sex workers. *Sex Transm Infect*, 88(4), 278-283.
- Dietrich, J. W. (2007). The politics of PEPFAR: the president's emergency plan for AIDS relief. *Ethics & International Affairs*, 21(3), 277-292.
- Diven, P. J. (2010). US AIDS Policy in Africa: Balancing Competing Interests in PEPFAR Policymaking *Africa and the New World Era* (pp. 231-246): Springer.
- Esack, F., & Chiddy, S. (2010). Islam and AIDS: between scorn, pity and justice. *SAHARA J (Journal of Social Aspects of HIV/AIDS Research Alliance)*, 7(1).
- FIDA Kenya. (2008). Documenting human rights violation of sex workers in Kenya. *Open Society Foundations, Nairobi*.
- Fritz, K., Morojele, N., & Kalichman, S. (2010). Alcohol: the forgotten drug in HIV/AIDS. *The Lancet*, 376(9739), 398-400.
- Gu, J., Chen, H., Chen, X., Lau, J. T., Wang, R., Liu, C., . . . Li, Z. (2008). Severity of drug dependence, economic pressure and HIV-related risk behaviors among non-institutionalized female injecting drug users who are also sex workers in China. *Drug Alcohol Depend*, 97(3), 257-267.
- Hahn, J. A., Woolf-King, S. E., & Muyindike, W. (2011). Adding fuel to the fire: alcohol's effect on the HIV epidemic in Sub-Saharan Africa. *Current HIV/AIDS Reports*, 8(3), 172-180.
- Hasnain, M. (2005). Cultural approach to HIV/AIDS harm reduction in Muslim countries. *Harm Reduction Journal*, 2(23), 1-9.
- Hendriksen E, Hlubinka D, Chariyalertsak S, Chingono A, Gray G, Mbwambo J, et al. Coates T. Keep talking about it: HIV/AIDS-related communication and prior HIV testing in Tanzania, Zimbabwe, South Africa and Thailand. *AIDS Behavior*. 2009;13(6):1213–1221.

- Jaquet, A., Ekouevi, D. K., Bashi, J., Aboubakrine, M., Messou, E., Maiga, M., . . . Ba-Gomis, F. O. (2010). Alcohol use and non-adherence to antiretroviral therapy in HIV-infected patients in West Africa. *Addiction, 105*(8), 1416-1421.
- Kenya Human Rights Commission (2011). *Outlawed Among Us*.
- Keikelame, M. J., Murphy, C. K., Ringheim, K. E., & Woldehanna, S. (2010). Perceptions of HIV/AIDS leaders about faith-based organisations' influence on HIV/AIDS stigma in South Africa. *African journal of AIDS research, 9*(1), 63-70.
- Kurth, A. E., Cleland, C. M., Des Jarlais, D. C., Musyoki, H., Lizcano, J. A., Chhun, N., & Cherutich, P. (2015). HIV Prevalence, Estimated Incidence, and Risk Behaviors Among People Who Inject Drugs in Kenya. *J Acquir Immune Defic Syndr, 70*(4), 420-427. doi:10.1097/qai.0000000000000769
- Lau, J. T., Choi, K. C., Tsui, H.-Y., & Su, X. (2007). Associations between stigmatization toward HIV-related vulnerable groups and similar attitudes toward people living with HIV/AIDS: Branches of the same tree? *AIDS care, 19*(10), 1230-1240.
- Law Library of Congress, Global Legal Research Directorate (2014). Criminal Laws on Homosexuality in African Nations. Retrieved from <http://www.loc.gov/law/help/criminal-laws-on-homosexuality/homosexuality-laws-in-african-nations.pdf>
- Mackesy-Amiti, M. E., Boodram, B., Williams, C., Ouellet, L. J., & Broz, D. (2013). Sexual risk behavior associated with transition to injection among young non-injecting heroin users. *AIDS Behav, 17*(7), 2459-2466.
- Mannava, P., Geibel, S., King'ola, N., Temmerman, M., & Luchters, S. (2013). Male sex workers who sell sex to men also engage in anal intercourse with women: evidence from Mombasa, Kenya. *PLoS One, 8*(1), e52547.
- Marum, E., Taegtmeier, M., & Chebet, K. (2006). Scale-up of voluntary HIV counseling and testing in Kenya. *Jama, 296*(7), 859-862.
- Mayer, K. H., & Pizer, H. F. (2009). *HIV prevention: A comprehensive approach*: Academic Press.
- Maulana, A. O., Krumeich, A., & Van Den Borne, B. (2009). Emerging discourse: Islamic teaching in HIV prevention in Kenya: SHORT REPORT. *Culture, health & sexuality, 11*(5), 559-569.
- Miller, A. N., Kizito, M. N., Mwithia, J. K., Njoroge, L., Ngula, K. w., & Davis, K. (2011). Kenyan pastors' perspectives on communicating about sexual behaviour and HIV. *African journal of AIDS research, 10*(3), 271-280.
- Muraguri, N., Tun, W., Okal, J., Broz, D., Raymond, H. F., Kellogg, T., . . . Geibel, S. (2015). HIV and STI prevalence and risk factors among male sex workers and other men who have sex with men in Nairobi, Kenya. *J Acquir Immune Defic Syndr, 68*(1), 91-96.
- National Aids Control Council (2014). Kenya AIDS Response Progress Report: Progress Towards Zero Retrieved from http://www.unaids.org/sites/default/files/country/documents/KEN_narrative_report_2014.pdf
- National Council for Law Reporting (1994). Narcotic Drugs and Psychotropic Substances (Control) Act. *Laws of Kenya, No. 4*. Retrieved from http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/NarcoticDrugsandPsychotropicSubstances_Control_Act__Cap245.pdf.
- National Research Council, Institute of Medicine Panel on Needle Exchange and Bleach

- Distribution Programs (1995). In J. Normand, D. Vlahov, & L. E. Moses (Eds.), *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*. Washington (DC): National Academies Press (US).
- Needle, R., et al. (2012). "PEPFAR's evolving HIV prevention approaches for key populations--people who inject drugs, men who have sex with men, and sex workers: progress, challenges, and opportunities." *J Acquir Immune Defic Syndr* **60 Suppl 3**: S145-151.
- Neuman, M., & Obermeyer, C. M. (2013). Experiences of stigma, discrimination, care and support among people living with HIV: a four country study. *AIDS Behav*, *17*(5), 1796-1808. doi:10.1007/s10461-013-0432-1
- Nieburg, P., & Carty, L. (2011). *HIV Prevention among Injection Drug Users in Kenya and Tanzania*: Center for Strategic and International Studies.
- Office of the US Global AIDS Coordinator (2015). Congressional Budget Justification Supplement, Fiscal Year 2015. Available online at: <http://www.pepfar.gov/documents/organization/236283.pdf>.
- Okal, J., Chersich, M. F., Tsui, S., Sutherland, E., Temmerman, M., & Luchters, S. (2011). Sexual and physical violence against female sex workers in Kenya: a qualitative enquiry. *AIDS care*, *23*(5), 612-618.
- Okall, D. O., Ondenge, K., Nyambura, M., Otieno, F. O., Hardnett, F., Turner, K., . . . Gust, D. A. (2014). Men who have sex with men in Kisumu, Kenya: comfort in accessing health services and willingness to participate in HIV prevention studies. *J Homosex*, *61*(12), 1712-1726.
- Okoli, C., & Pawlowski, S. D. (2004). The Delphi method as a research tool: an example, design considerations and applications. *Information & management*, *42*(1), 15-29.
- Otolok-Tanga, E., A. L., Murphy C. K., Ringheim K. E., Woldehanna S. (2007). Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: A case study of Uganda. *African Health Sciences*.
- Parry C, Petersen P, Carney T, Needle R. Opportunities for enhancing and integrating HIV and drug services for drug using vulnerable populations in South Africa. *International Journal of Drug Policy*.2010;21:289–295.
- PEPFAR. (2012). PEPFAR blueprint: creating an AIDS-free generation. Available online at: <http://www.pepfar.gov/documents/organization/201386.pdf>.
- PEPFAR (2015). *Building on Firm Foundations: The 2015 Consultation on Strengthening Partnerships Between PEPFAR and Faith-based Organizations to Build Capacity for Sustained Responses to HIV/AIDS*. Retrieved from Washington, DC:
- Pithey, A., & Parry, C. (2009). Descriptive systematic review of Sub-Saharan African studies on the association between alcohol use and HIV infection. *SAHARA J (Journal of Social Aspects of HIV/AIDS Research Alliance)*, *6*(4).
- Rawls Jr., W. (2007). *Bush's AID Initiative: Too Little Choice, Too Much Ideology*". Center for Public Integrity.
- Rispel, L. C., Metcalf, C. A., Cloete, A., Moorman, J., & Reddy, V. (2011). You become afraid to tell them that you are gay: health service utilization by men who have sex with men in South African cities. *Journal of public health policy*, S137-S151.
- Saw, Y. M., Yasuoka, J., Saw, T. N., Poudel, K. C., Tun, S., & Jimba, M. (2013). What are the factors associated with HIV testing among male injecting and non-injecting drug users in Lashio, Myanmar: a cross-sectional study. *BMJ Open*, *3*(6).
- Scorgie, F., Nakato, D., Harper, E., Richter, M., Maseko, S., Nare, P., . . . Chersich, M. (2013).

- 'We are despised in the hospitals': sex workers' experiences of accessing health care in four African countries. *Culture, health & sexuality*, 15(4), 450-465.
- Sexual Violence Research Initiative (2015). Factsheet: The Link Between Sexual Violence and HIV. Retrieved from: <http://www.svri.org/factsheet.htm>.
- Sullivan L, Levine B, Charwarski M, Schottenfeld R, Fiellin D. Addiction and HIV in Kenya: A description of treatment services and integration. *African Journal of Drug & Alcohol Studies*.2007;6(1):17–26.
- Taegtmeyer, M., Davies, A., Mwangome, M., van der Elst, E. M., Graham, S. M., Price, M. A., & Sanders, E. J. (2013). Challenges in providing counselling to MSM in highly stigmatized contexts: results of a qualitative study from Kenya. *PLoS One*, 8(6), e64527.
- UN General Assembly (2011). Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS. *Adopted 10 June 2011*.
- U.S. President's Emergency Plan for AIDS Relief (2012). A Firm Foundation: The PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS. Washington: U.S. Department of State.
- Joint United Nations Programme on HIV/AIDS (UNAIDS). (2014). The gap report. *Geneva: UNAIDS*.
- van der Elst, E. M., Gichuru, E., Muraguri, N., Musyoki, H., Micheni, M., Kombo, B., . . . Operario, D. (2015). Strengthening healthcare providers' skills to improve hiv services for men who have sex with men in kenya. *AIDS*. doi:10.1097/qad.0000000000000882
- van der Elst, E. M., Kombo, B., Gichuru, E., Omar, A., Musyoki, H., Graham, S. M., . . . Operario, D. (2015). The green shoots of a novel training programme: progress and identified key actions to providing services to MSM at Kenyan health facilities. *J Int AIDS Soc*, 18(1), 20226.
- van der Elst, E. M., Smith, A. D., Gichuru, E., Wahome, E., Musyoki, H., Muraguri, N., . . . Sanders, E. J. (2013). Men who have sex with men sensitivity training reduces homophobia and increases knowledge among Kenyan healthcare providers in coastal Kenya. *J Int AIDS Soc*, 16 Suppl 3, 18748. r
- Woldehanna, S., Ringheim, K., Murphy, C., Gibson, J., Odyniec, B., Clerisme, C., . . . Keikelame, M. (2005). Faith in action: examining the role of faith-based organizations in addressing HIV/AIDS. *Washington: Global Health Council*.
- World Health Organization. (2014). Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, *World Health Organization*.

