HEALTH, CULTURE and SOCIETY

In Their Eyes:

HIV prevention from an Islamic perspective in Lamu, Kenya

A. O. Maulana; A Krumeich; B. van den Borne

Volume 2, No. 1 (2012) | ISSN 2161-6590 (online) DOI 10.5195/hcs.2012.73 | http://hcs.pitt.edu

Abstract

Despite efforts to curb the spread of HIV amongst the youth and its positive indication of success in Kenya, the epidemic continues to pose serious challenges to these efforts amongst all demographic groupings across Kenya. This article presents findings of a qualitative study involving 45 youth and 23 Islamic leaders from Lamu, Kenya. The study looked at participant's perceptions of HIV/AIDS. It also explored participant's perceptions on what they see as the factors influencing HIV transmission amongst the Lamu youth. Additionally a literature review was used together with the study findings to identify elements for an Islamic based HIV prevention intervention.

Our findings indicated that both the youth and religious leaders' perceptions of HIV/AIDS comprise a mixture of facts and misconceptions. The participants identified idleness, drug abuse and premarital sex as key factors contributing to the risk of HIV infection amongst the Lamu youth. The symbiotic relationship between religious leaders and youth on various aspects of daily practices was evident throughout the study thereby suggesting the importance of working with both in addressing HIV/AIDS in Lamu.

Keywords: Islam; HIV/AIDS; Religious Leaders; Lamu; Kenya

In Their Eyes:

HIV prevention from an Islamic perspective in Lamu, Kenya

A. O. Maulana[1]; A Krumeich[2]; B. van den Borne[3]

1. Introduction

Though efforts to curb the spread of HIV are starting to show some positive results, there are still causes for concern, as reported by UNAIDS (2008, 2009). Young people aged 15–24 account for an estimated 45% of new HIV infections worldwide while Sub-Saharan Africa remains the region most heavily affected by HIV; accounting for 67% of all people living with HIV and for 75% of AIDS deaths in 2007 (UNAIDS, 2008). According to Gouws et al. (2008), in the nine southern Africa countries most affected by HIV, the prevalence among young women aged 15–24 years was on average about three times higher than among men of the same age. The situation did not change much in 2009 for young people in sub-Saharan Africa. The risk of becoming infected continued to be especially disproportionate for girls and young women (UNAIDS 2009). Closer to Kenya, in Tanzania for instance it is reported that females of the same age are four times more likely than males to be living with HIV (Tanzania Commission for AIDS et al., 2008).

In Kenya, the situation appears to conform to the Sub-Saharan HIV prevalence trend. According to recent reports, the prevalence amongst youth aged 15-24 years stands at 3% with no significant overall change between 2003 and 2007 (Kenya National Bureau of Statistics (KNBS) and ICF Macro, 2010). Results from this survey also show a variation in the demographic spread of HIV prevalence rates across the country (KNBS and ICF Macro, 2010). At currently 3.3% (KNBS and ICF Macro, 2010), the Islamic community continues to have the lowest level of HIV infection in Kenya and is a specific demographic group in comparison to the national figures studied between 2003 and 2007 (CBS, 2003; NACC, 2009a; KNBS and ICF Macro 2010). Paradoxically the Coast Province, a predominantly Muslim populated region of Kenya, has continued to report HIV prevalence rates higher than the national average for the entire population in studies conducted between 2003 and 2007 (KNBS and ICF Macro 2010). Looking at Lamu Town, a coastal community, with a predominantly Muslim population with HIV prevalence at 3.8% (NACC, 2005) and probably increasing in line with the rest of the region (KNBS and ICF Macro, 2010) one might conclude that national efforts to curb the spread of HIV are not regionally effective and possibly because such national efforts fail to address contextual factors such as predominant perceptions concerning HIV/AIDS in the community that may influence the epidemic spread at the local level (NACC, 2009b).

[1] Kenya Red Cross Society, Department of Health and Social Services, Nairobi, Kenya

[2] Maastricht University, Faculty of Health, Medicine and Life Sciences; Department of Health, Ethics and Society

[3] Maastricht University, Faculty of Health, Medicine and Life Sciences; Department of Health Education and Health Promotion

II. Design and Methods

In this paper we report results from a study exploring the existing perceptions of HIV/AIDS amongst the Muslim youth and the Islamic religious leaders of Lamu. We in turn propose elements of an Islamic HIV prevention intervention to augment existing efforts.

Study location

The study was conducted in Lamu Town in Lamu Island located off the Kenyan northern coastline. Lamu town, also known as Amu, has an estimated population of 17,000 (KNBS, 2010).

Study design

A qualitative study was conducted making use of focus group discussions (FGDs) and Key Informant interviews as the two main approaches for data collection. In addition, document reviews of various relevant empirical studies and observations noted by researchers during the study were used to triangulate findings gathered from the FGDs and interviews.

Participants

Eight focus groups discussions were held consisting of in and out of school youth. Each group had four to eight members within an age bracket of 15 to 24 years. A total of 45 youth participated in the FGDs, 22 being male and 23 females. Separate interviews were held for both men and women as well as for in and out of school youth. A total of 23 religious leaders drawn from the local community were interviewed as Key Informants. With a total of 37 mosques and 15 Islamic schools in the study area, the religious leaders who were interviewed represent two thirds of those who either teach in Islamic schools and/or lead congregational prayers in mosques.

Independent interviewers drawn from outside the participants' community conducted the FGDs and interviews. These were assisted by research assistants drawn from the community who did not participate in the study but helped with translation and transcribing duties in addition to arranging local logistics.

Data processing and analysis

Both the FGDs and religious leader interviews were transcribed and analyzed using NVIVO, a qualitative software, with emerging themes put into three main overarching topics. The first, focused on participants' understanding of HIV/AIDS. The second, on the enabling factors perceived to influence the spread of HIV and finally the third, on elements for a possible Islamic based HIV prevention project.

Findings

Using the three broad topic categories resulting from the analysis, we first present the findings of participants' perceptions with regards to *what* HIV is and *how* it is transmitted. We then present findings on participants' perceptions with regards to enabling factors influencing HIV transmission amongst the youth of Lamu. Finally, based on suggestions gathered from the study participants and the literature review, we present a proposal for a possible Islamic based HIV prevention intervention targeting the youth of Lamu.

III. HIV/AIDS in Their 'Eyes'

We started with gathering an understanding of where participants access HIV information to gain insight into what may have influenced their perceptions. Our findings revealed that although national television is not broadcasting in Lamu, access to 'free to air' satellite television channels were almost universal for all participants. The available satellite channels, however, do not offer any direct HIV/AIDS information or health education, and

sooner used for social entertainment and access to world news. Findings from our study also indicated that video rental in the form of DVDs and VCR are available and used as a means for social entertainment as well as access to information on subjects of interest, but do not include relevant information on HIV/AIDS.

Part of the entertainment aspect of this particular medium (DVD/ VCR rental) was reported by the youth to include access to highly sexually explicit materials on demand. According to the youth the easy access and viewing of such materials influenced sexual behavior and exposed persons to the HIV infection, rather than proving a useful medium of information on HIV/AIDS. As described by one group during the FGDs: 'Watching pornographic movies or pictures, can lead to curiosity of knowing how sex is, which can lead to HIV infection' (FDG:1). National newspapers were mentioned as possible platforms of HIV/AIDS information. While the information accessed through the mass media channels do not seem to do much in terms of educating youths as to the risk of HIV/AIDS, youth nevertheless procure and access information on sexual reproductive health, including HIV/AIDS. They receive this primarily from school teachers; religious leaders; parents; peers, and via workshops/seminars organized by non-governmental organizations such as the Kenya Red Cross Society and health professionals from the local government hospital. We noted, with regards to access to the national newspapers, that there were only two vendors selling: collectively they sold only 215 copies daily of which only 45 were in Swahili, the local language. Likewise, national HIV prevention campaigns in Kenya utilized National Multi Media channels such as these newspapers (NACC, 2009b). However, the audience remained limited and several national TV channels (NACC, 2009b) were not broadcast in Lamu. Thus the point of reference for such information and awareness, remained the school teachers, religious leaders, parents, peers and workshops/seminars organized by non-governmental organizations and health professionals.

Despite the obvious limited access to information with regards to HIV and AIDS, several of the youth in the FGDs correctly reported on what HIV and AIDS *is* and *how* HIV is transmitted as well as what testing measures exist.As one participant asserted:

> There is HIV and there is AIDS, when you have HIV, you don't have AIDS. AIDS is when your body is not capable of fighting diseases anymore, so other diseases develop […] It is a virus which is transmitted through sex, blood transfusions, from mother to child, from sharing personal tools [sic], like needles, blood, injections and so on […] AIDS is a lack of the immune system in the body and the virus fights with the white blood cells and then they make your body weak and all diseases can come into your body (FDG:7)

As the statement shows, Lamu Islamic youth clearly have a rudimentary awareness of HIV/AIDS. This, is most likely the result of direct and in-direct access to information from seminars and workshops organized on the subject by NGOs as indicated by participants during the FDGs. However, we also noted that this awareness was limited to basic information on HIV/AIDS and as we went deeper into the FGDs, our findings indicated that the youth nervertheless have a tendency to mix this information with a variety of other cultural notions, at times conspiratorial. This was particularly evident when discussing the the origins of the HIV virus. Some of the youth held the belief that HIV is a virus manufactured by scientists who, in turn, failed to find a cure. Eslewhere, HIV was created as a weapon by an American laboratory in order, "to fight the enemy". Tourists are also mentioned as those who brought the disease to Lamu, and according to some, homosexuals play a role in the existence of the disease. The two most common explanations for the existence of HIV and AIDS mentioned, however, are sexual intercourse with animals or HIV/AIDS as punishment from God for adulterous and illicit actions. The common reasoning is 'the fact that almost all diseases are curable except for this one, which is transmitted through sexual intercourse […] its a punishment from God' (FDG: 1). Such punishment is weilded for immorality which, as described by the youth in all FGD sample, include adultery, beastiality and homosexuality. The latter as a cause of HIV infections was also cited

Volume 2, No. 1 (2012) | ISSN 2161-6590 (online) | DOI 10.5195/hcs.2012.73 | http://hcs.pitt.edu

by all the religious leaders interviewed.

The Islamic religious leaders in the study also considered that HIV and AIDS was a result of increasing immoral sexual behavior, and likewise a "punishment from God" (RLI[4]: 3). They frequently referred to homosexuality and *zina* as the two types of immoral sexual acts propogating the spread of HIV. *Zina* is a Swahili refering to sexual intercourse between a man and woman out of wedlock and also includes situations when one or both parties are married, flagging adulterous behavior. In discussing *zina* and its association to HIV transmission, the religious leaders expressed warned to not 'go near to zina, because zina is a dirty deed" (RLI 4, 7, 10 and 19). Others expressed, "Allah doesn't like unlawful sexual contact' (RLI: 3 and 15) and that, "the Quran said about this disease that it has no cure and it is caused by zina" (RLI 21). Several stated specifically: "HIV and AIDS is a punishment from God" (RLI: 3, 4, 6, 9, 10 and 13) – a divinely ordained disease and in being so, retributive in measure. Supporting this, were the wider community in the nadlaing of corposes of previously HIV positive persons, as well as HIV being a biological weapon created by the West for the ends of supremacy and control (RLI10,15,19, 20, 21 and 23).

Yet the religious leaders mentioned several other means of contracting HIV, which displayed a more balanced scientific reasoning, such as blood to blood contact with an infected person in assisting with an accident, the use of unsterilized equipment in hospitals or barbershops or the use of unsterilized equipment for circumcision. The religious leaders also mentioned blood transfusion and mother to child transmission as possible transmission pathways. Such reasoning, is, however, cut short when the influence of the West is mentioned as a general cause for HIV and AIDS. One of the religious leaders claimed that the Americans brought HIV/AIDS to countries such as Saudi Arabia and Afghanistan in times of conflict. While before HIV and AIDS did not exist, because of the many Muslims following Islamic law and the protocols of religious teachings (RLI 10). This gives rise to strict comparatives in the mindset of communities, especially concerning the Western minded Nyanza province and the North-Eastern region where many Muslims live. As one of the religious leaders made clear:

> HIV and AIDS cases in the North-Eastern region are low compared to Nyanza and Nyanza has so many educated people and the only reason could be that Nyanza is big and Western minded while North-Eastern province follows the principles of Islam… (RLI 21)

From these findings we can conclude that both the youth and the Islamic religious leaders' perception of HIV is a mixture of scientific truth and misconceptions (see Figue 1), the latter being modern, traditional and reactionary in nature. In our next section we discuss the perceptions of the enabling factors associated to the increase of reported HIV cases.

[4] RLI (Religious Leaders' Interview)

Volume 2, No. 1 (2012) | ISSN 2161-6590 (online) | DOI 10.5195/hcs.2012.73 | http://hcs.pitt.edu

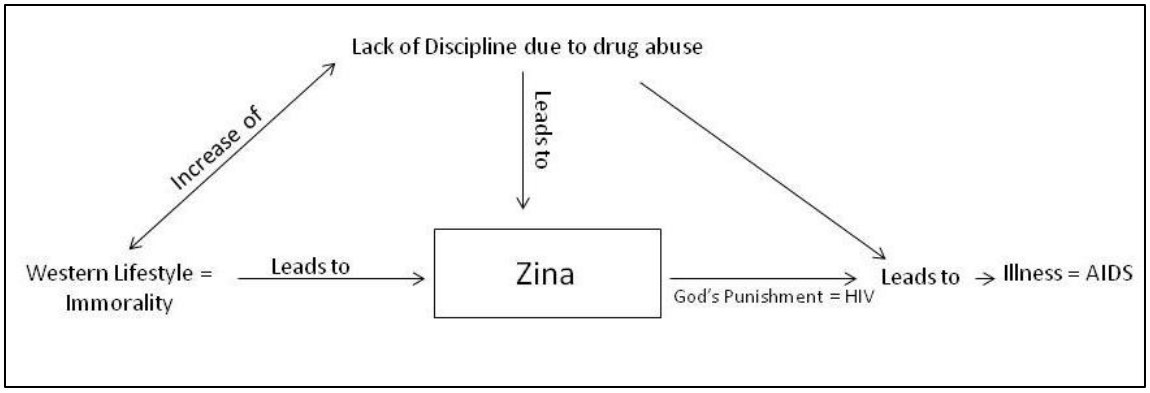

Figure 1: phases in accessibility continuum

IV. Enabling Factors Associatied with the Increase in Sexuality amongst Lamu Youth

As previously mentioned, the increase in sexual activities was considered the key factor influencing the spread of HIV infection in Lamu amongst the youth by both the youth and religious leaders. They considered such sexual activities as "immoral" and provided further explanation as to why such "immorality" was on the increase in Lamu.

During the FGDs the youth mentioned drug use as the main reason for what they expressed as "immoral sexual activities". In elaborating this, one group stated that, *"*the drug addicts get HIV easily because they loose their memory at that time and they can have sex with an infected person, when they are intoxicated," (FGD:2) whilst another expressed, *"*they take drugs which may lead to having unprotected sex and that can lead to HIV*"* (FGD:1). The youth pinpointed several reasons as to why young people in Lamu would take up drugs. The most prominent reasons given include following parental behavior: *"*if the parents are doing what is not right like taking drugs, drinking beer, smoke marijuana, prostitution so would the child*"* (FGD:2). Or as another group stated, *"*getting married in our society is a lot of money, so the ones who can not afford it get themselves into other things like homosexuality and drugs and this leads them to HIV" (FGD:3). Yet another group expressed, "All of this is caused by a lack of education, if you are not learned and you are grown up and you are idle, not doing any job, is when you do things like sex or prostitution and is when you get HIV/AIDS" (FGD: 5).

Digging deeper during the FGDs the youth indicated "idleness" as the main reason their generation engage in drugs. It is said among the Lama community that idleness is mainly due to unemployment as well as due to the gross lack of extra-curricular activities. This, coupled with the inability to pursue higher education beyond secondary school, owing to poverty, paints a problematic picture.

The religious leaders considered the increase in immorality, or as they called it *zina*, as a principle consequence of modern life where previously held norms that restricted un-chaperoned gatherings of opposite sexes, have been abandoned. They also believe the increase of divorces has enabled the free socialization of sexes and consequently the increase in opportunity for *zina* to flourish. Poverty, likewise, necessitating the man to travel for work, far away from home, was also seen as opening up opportunities for zina, likewise for the wives during their husband's absence. For these leaders, who play an important role in the community, zina is gaining ground in a world where the norms of religion are slackening.

When describing *zina* in the context of Lamu youth, the leaders considered drug abuse as a major contribution to *zina* and the consequent spread of HIV amongst the young adult community. One held that, "those who do zina when not being drunk will tend to choose with whom and how to do zina and will know how to protect

Volume 2, No. 1 (2012) | ISSN 2161-6590 (online) | DOI 10.5195/hcs.2012.73 | http://hcs.pitt.edu

himself, either by using condoms or other ways. But the one who uses drugs or alcohol will not choose with whom and how to do zina, so its easy exposing himself to the infection*"* (RLI 17). Another leader asserted that, *"*sex is the main cause of AIDS and the main reason as to why youth are led to immoral sex is down to the use of drugs. Drugs do not cause AIDS itself; AIDS is caused by sex mostly. So, people are tempted to do immoral sex mainly by the use of drugs (RLI 4).*"* Others similarly voiced: *"*AIDS is brought by sexual intercourse and especially the drug addicts because you can see here in Kenya the rate of AIDS is so high due to drugs such as alcohol which nowadays are put in small packages and sold to the youth*"* (RLI 5). When discussing why drug abuse is common the religious leaders pinpointed idleness as the principle cause due to a lack of employment amongst the youth, this, coupled with the easy access to narcotics, highlights the main enabling factor for the adolescents and young adults to engage in immoral sexual behavior, increasing the spread and risk of HIV infection.

From these community discussions we drew the conclusion that the participants considered sexual intercourse as the main cause of HIV transmission amongst the Lamu youth. They also associated the increase in sexual activity to narcotic drug abuse, which according to them is on the rise because of idleness due to unemployment. Analyzing this further, our findings suggest that the interplay between idleness, drug abuse and sexual activity are perceived collectively to be influencing the spread of HIV infection amongst the youth of Lamu These three factors identified by study participants are also considered to be important drivers of the Kenyan AIDS epidemic across the country (NACC, 2009b; KNBS and ICF Macro, 2010) thereby suggesting findings from this study to be in line with the national AIDS situation, further flagging urgencies of outreach and education within the national picture and the disprotoption of access to information and health education.

With this conclusion we further explored what the possibilities are for a suitable intervention that will address idleness, drug abuse and unsafe sexual activities amongst the youth of Lamu, which is a complex context where social reality is meshed with community beliefs, religious codes and, at times, reactionary discourses independent of scientific fact.

V. Pillars of an Islamic Based HIV/AIDS Prevention Intervention

Appreciating the findings documented so far and taking into consideration that designing effective interventions requires an understanding of the underlying factors (Bracht, Kingsbury and Rissel, 1999; Green and Krueter, 1999; Bartholomew et al., 2006; Fishbein and Ajzen, 2010), our proposed HIV prevention intervention will have to address the three key factors identified by study participants to be influencing the spread of HIV infection amongst Lamu youth. In this section we discuss how this could be achieved for the study area based on the insights gained from discussions with study participants and existing empirical evidence. Going by empirical studies and contemporary theories of health promotion we know that effective interventions are those that are in line with the local context, ivolving key stakeholders and the beneficiaries in both design and implementation (Austin, 1995; Tones and Green 2004).

Whereas there are several categories of people that can be considered to be influencing the beliefs, values and norms of the Lamu residents, religious leaders can be said to feature high on the list (Maulana, Krumeich Van De Borne, 2009; Keikelame, Murphy, Ringheim and Woldehanna, 2010) and therefore important key stakeholders for the proposed intervention and changes. In describing the possible role of these leaders in the dissemination of information related to HIV and AIDS, the youth pointed out that acceptance of their message is subject to an individual's faith, whether or not the youth are under the influence of drugs. Youth in the FGDs felt that "sinners" were unlikely to listen to religious leaders due mainly to their absence in the areas where religious leaders pass on such information. The youth also pointed out that free interaction with religious leaders in discussing issues of sexuality, depended mainly on the religious leader himself, his style of communication, and his accessibility

determining the ease of the youth to interact with them. These initial views would at first indicate that religious leaders are not suitable for being part of an HIV intervention programme targetting youth and the socio-cultural complexities that accompany this life phase (education; employment; peers). However, upon further questioning, the youth agreed that religious leaders are important community moderators and in fact facilitate information transmission: leaders have open and influential access to the public, this, enabling the communication of HIV messages during sermons and public engagement activities. For instance, it was expressed that these, "Religious leaders are the ones that lead us to good deeds" or, "[…] because they are the ones that translate [the] Quran [for] to us". One FGD went further by saying, "Yes, they're important in informing us how to live all aspects of life, telling us what to do or say and what not to do or say even at home when you are in bed with your wife". Throughout the discussions, according to the youths the leaders as a voice of the Islamic teachings function as a guide in all aspects of life: sexual, political, social. Therefore, an importance is alloted to their capacity to interpret anything new, consequently recommending its adoption or rejection based on Islamic teachings. As stated by one group: *"*they are important, because they have knowledge. In this life of ours, every day we invent new things. So we need to know, according to Islam what new things are appropriate to follow and what to avoid. So we need religious leaders in our daily life to guide us in how to live our life according to Islam." The religious leaders thus maintain a role of authority, guidance and truth to which the community turn.

The youth thus described the leaders as role models and responsible examples of good behavior, and who provide informed counsel when one is experiencing personal difficulties. Other than this, the leader is identified as an educator:

> they teach us good things and bad things, the good things you should follow and the bad things discard […] They spread knowledge in the Mosque or other places including on HIV/AIDS and anything bad coming up […] they give us advice, show us the right path, the right way and help us solve our problems.

From the discussions with the youth on the possible role and community importance of religious leaders in the proposed intervention we concluded that such leaders can be important stakeholders in the design and implementation of a proposed HIV intervention program in such cultural and religiously sensitive territories. This, according to our findings, is because of their understanding of Islamic teachings and the ability to interpret these teachings, validating what is acceptable within the Islamic context and discouraging what they consider unacceptable for community wellbeing.

From the interviews with these leaders our findings document a strong willingness among them to play an active role in an HIV initiative and to collectively curb an upward trend of infections, that is, to both curb its increase and increase awareness and education. As some religious leaders stated in interviews: "religious leaders have a bigger responsibility in fighting against HIV and AIDS because the spread of HIV and AIDS is the destruction of the communities", whilst another expressed: "my work is to lead the prayers and also sometimes we talk about the things affecting us, like the effect of HIV and AIDS, and the other things which affect the community". They identified their responsibility to inform their congregations on the teachings of Islam with regards to what is acceptable and what is not. As stated by some, *"*the bigger role that the religious leaders have is to educate and to restrict the community in accordance to what the almighty God wants" thereby affirming what the youth perceived to be a key role of the leader who councels and guides people of the community.

The leaders further emphasized that addressing all issues affecting the people signals an obligation and responsibility to engage with, and educate on, HIV and its causes. They based this on the emphasis throughout the Quran, the Islamic Holy Book, and other Islamic literatures, on acquiring knowledge and teaching it to others as an

Volume 2, No. 1 (2012) | ISSN 2161-6590 (online) | DOI 10.5195/hcs.2012.73 | http://hcs.pitt.edu

obligation to uphold the spiritual and worldly well-being of all Muslims – particularly those in religious and community authority.

From a literature review, empirical evidence shows the existence of certain Islamic teachings that could be used to address various subjects related to healthy living, including teachings on safe sex practices (WHO, 1992; De Leeuw and Hussein, 1999; McGirk, 2008; Maulana et al., 2009), this confirming the importance of engaging religious leaders in HIV responses and community outreach (WHO, 1992; UNAIDS, 2001; UNICEF, 2003; McGirk, 2008; Maulana et al., 2009). In Uganda for instance the Islamic Medical Association of Uganda working with imams from 850 mosques included information about HIV and AIDS in religious lectures and Friday sermons (UNAIDS 1998; UNAIDS 2001). Similarly Islamic teaching on sexual ethics is widely used in educational campaigns, counselling sessions and advocacy work in various Islamic countries around the world (UNICEF 2003; Morrow and Barraclough 2003; Sachs 2008).

In analyzing our discussions held with youth and religious leaders, as well as our findings from a literature review, we conclude that an opportunity exists for implementing an Islamic HIV prevention intervention. Our findings suggest the possibility of an intervention to make use of both traditional communication channels, such as mosques, and other community platformsthrough which leaders operate and preside over. To this should be added the initiative to facilitate and promote non-traditional communication channels such as the holding of HIV prevention specific seminars and workshops, talks in schools and other venues that youth or at risk groups frequent. The existing Islamic teachings on poverty eradication and communal social responsibility (WHO, 1992; De Leeuw and Hussein, 1999; Maulana et al., 2009) could likewise play an important part in the development of content to address idleness and drug abuse in addition to safe sex practises for the proposed intervention.

Our research is the first step towards determining the feasibility of an Islamic based HIV prevention intervention in Lamu, and as to what structure the intervention could take. Our findings give us clues on what the intervention should include, the safeguards to be designed and the community encoding and sensitivity to issues. There are four specific clues that we identified and consider to be important to address when developing the content of such an intervention. These include 1) bridging gaps in, and ensuring the consistency of factual information on HIV and AIDS in both religious and youth community unities, 2) addressing idleness amongst the youth, 3) preventing drug abuse and, 4) preventing un-safe sexual practices.

As our findings have suggested idelness, drug abuse and unprotected sexual practices dovetail one another and outline the problem in Lamu. What's more, participants in our study had a tendency to mix facts with myths, at times reactionary and conspiratorial. The initial focus of the proposed intervention would require addressing certain gaps in the transmission of information, as a primary focus. With their willingness to take part in such an intervention and their extensive role in engaging with the public, the logical starting point would be the engagement and discussion with religious leaders in addressing existing knowledge gaps amongst core groups. Experience from other countries suggest the formal training of religious leaders in HIV/AIDS facts creates a basis for the religious leaders to correctly disseminate such information to their congregations (UNAIDS, 2001; UNICEF, 2003; Maulana et al., 2009). To enhance the scope of understanding and willingness to disseminate the information beyond the organized training session, we recommend the content of training materials be localized and include facts and statistics drawn for local communities. Local case studies to highlight the magnitude of the problem should be used where available. Bringing in a person living with HIV to share their experiences, would address some of the existing ideas that HIV is still a foreign problem not yet affecting the community, this will also help to break certain myths. The content would also benefit from using existing Islamic teachings that foster the seeking and spread of new knowledge and those Islamic teachings that foster the well being of the youth, encouraging safe sexual practices. As indicated in previous studies and initiatives elsewhere, Islamic teachings addressing the factors identified by study participants exist (Maulana et. al., 2009). The use of these Islamic teachings has been shown to increase ownership

to initiatives through familiarity of common notions to address contemporary issues such as HIV/AIDS (WHO, 1992; UNAIDS, 2001; UNICEF, 2003).

When looking at idleness amongst the youth, additional research is necessary to determine specific components for the proposed intervention model that would engage the youth productively as well as the social and educational initiatives which could be formulated. However, from the findings we conclude that the key factors contributing to idleness identified by the study participants are principally the lack of employment and recreational facilities – which would engage the youth meaningfully. As idleness is seen to be a critical enabler to risk behavior associated with drug abuse and unsafe sexual practices by study participants, engaging the youth to address this idleness would be a critical pillar of the proposed intervention program. In order to engage the youth, the intervention should look at possibilities to integrate recreational and income generating activities into the strategic design of the proposed intervention. Best practices existing elsewhere suggest a mix of educational and entertainment related activities are most likely to be well received by youth, especially if they are involved in their design and development (Austin, 1995). With religious leaders seen to be crucial in endorsing acceptable interventions within the community and its groups, their role in this aspect of the intervention would include mentorship support to the development and design process of the activities.

Furthermore, as influential and guiding members of the community, leaders can act as important advocates for the intervention within local government and private sectors for the youth to have easier and wider access to educational scholarship programmes and employment within these sectors as well as in curtailing the drug industry. By working closely with the youth, religious leaders can act as mentors and advocates for youth empowerment, and, as such, address the various causes and consequences of idleness.

VI. Conclusion

Despite the fact that over 98% of Kenyan youth are reported to have heard of HIV/AIDS and 92% had heard of or seen a male condom (Ministry of Health [MOH], 2005), they continue to engage in unsafe sexual activity at an early age which puts them at risk of sexually transmitted infections including HIV (Zaba, Pisani, Slaymaker and Boerma, 2004; MOH, 2005; UNAIDS, 2008; UNAIDS, 2009; NACC, 2009a; KNBS, 2010). In determining some of the factors that are contributing to this asymmetry between access of information and avoidance of risky behavior, our findings provide several pointers as to why this might be the case.

Firstly, the findings show that national efforts use information channels that are not generally accessible to the Lamu people. Secondly, although information on HIV/AIDS has been trickling through, participants still hold views in which facts are mixed with myths and misconceptions. Thirdly, our findings reveal that participants have identified concrete factors fuelling the local HIV spread that are supported by empirical evidence within the country. The study participants considered sexual transmission as the main mode of HIV transmission amongst the Lamu youth. They also attributed the increase in sexual activity to drug abuse due to idleness as a result of the inability to advance in formal education, the lack of recreational facilities and unemployment. We concluded that the interplay between idleness, drug abuse and sexuality amongst the youth are perceived collectively to be influencing the spread of HIV transmission.

Appreciating these findings from both our study and existing empirical evidence, we suggest a participatory development of an HIV prevention intervention that makes use of contemporary strategies with inclusion of Islamic teachings to augment existing knowledge on HIV and AIDS information and promote healthy sexual behaviour amongst the Lamu youth. The proposed intervention should make use of contemporary theories of health promotion

Volume 2, No. 1 (2012) | ISSN 2161-6590 (online) | DOI 10.5195/hcs.2012.73 | http://hcs.pitt.edu

that emphasize participation of key stakeholders in its design, development and implementation The youth of Lamu forms the target of the proposed intervention, the religious leaders are influential members of the community and together they form the key stakeholder base for an intervention program. Both youth and religious leaders are expected to actively inform the content of the proposed intervention through formal and structured discussions, soliciting their input throughout the process.

As suggested by our findings and existing empirical evidence, religious leaders are trusted and respected members of society who are listened to. They hold authority and the trust of the community, they are reference points of knowledge and counsel where their actions set an example through the confidence their congregations hold in their ability to interpret religious scriptures and teachings. These two facts highlight the unique (and indeed strategic) position of the religious leaders, in being able to shape social values, promote responsible behavior and influence public opinions including informing governmental policies and laws (UNAIDS, 2001; Parker, Aggleton, Attawell, Pulerwitz and Brown , 2002; UNICEF, 2003; Maulana et al., 2009). By so doing, such leaders can play an important role in altering the course of an already virulent epidemic. With this in mind, positioning religious leaders as key stakeholders signals two crucial roles in the proposed HIV intervention:

- they will be expected to act as mentors and educators of the youth through various formal and informal interactions and,
- they will be expected to take up an advocacy role to ensure youth empowerment by actively engaging with other stakeholders to influence policies with regards to drug abuse, access to financial support for education and the creation of employment opportunities in formal and informal sectors.

Noting, however, the existence within their ranks of information and the already widening knowledge gaps on HIV/AIDS, for these key roles to be meaningful, such leaders would need to be informed and acquainted with up to date information and tally scientific information accordingly with their community teachings, not disproportionately.

The active involvement of religious leaders and youth throughout the process is expected to assure that the content of the proposed intervention has an appropriate balance between educational and entertainment based activities that meet the intended objectives. To enhance ownership and acceptance possibilities, the youth should be engaged through formal structures and forums in the design, development and implementation of the proposed intervention. Only in this way, by considering all the social and cultural variables, can a cohesive program be implemented and clarity and direction brought to the situation and picture of Lamu.

Acknowledgements

The researchers would like to express their appreciation to the participants and community leaders who allotted time to participate in the research. Gratitutde is also expressed to the Kenya Red Cross Society, Nairobi, Kenya.

Bibliography

Austin, E. W., (1995). Reaching Young Audiences. Developmental Considerations in Designing Health Messages. In: E. Maibach and R. L. Parrott, eds. Designing Health Messages. Approaches From Communication Theiry and Public Health Practice. London New Delhi: International Educational and Professional, Thousand Oaks. SAGE Publications, 114-144

Bartholomew, L.K., *et al*. (2006). Planning Health Promotion Programs. An Intervention Mapping Approach. 2nd Edition. John Wiley & Sons, Inc.

Bracht, N., Kingsbury, L. and Rissel L., (1999). A Five stage Community Organization Model for Health Promotion. In Bracht, N (Ed.). *Health Promotion at the community Level.* International Educational and Professional Publisher, Thousand Oaks, California 91320. SAGE Publications, 83-104.

Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. (2004). *Kenya Demographic and Health Survey 2003.* Calverton, Maryland: CBS, MOH, and ORC Macro.

De Leeuw, E. and Hussein, A. (1999). Islamic health promotion and interculturalization. *Health Promotion International, Volume 14 No 4, 347-353.*

Fishbein, M. and Ajzen, I., (2010). Predicting and Changing Behaviour. The Reasoned Action Approach. Psychology Press. Taylor and Francis Group. New York Hove.

E. Gouws, K.A. Stanecki, R. Lyerla, P.D. Ghys., (2008). The epidemiology of HIV infection among young people aged 15–24 years in southern Africa. AIDS, 22 (suppl. 4) pp. S5–S16

Green, L. and Kreuter, M.W., (1999). *Health Promotion Planning: An educational and ecological approach (3rd ed.).* Mountain View, CA: Mayfield Publishing Company.

Keikelame, Mpoe Johannah , Murphy, Colleen K. , Ringheim, Karin E. and Woldehanna, Sara (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

Kenya National Bureau of Statistics [KNBS] and ICF Macro (2010). Kenya Demographic and Health Survey 2008-09. Calverton, Maryland: KNBS and ICF Macro.

Kenya National Bureau of Statistics [KNBS] (2010). 2009 Kenya Population and Housing Census

Maulana, Aisha Omar, Krumeich, Anja and Van De Borne, Bart. (2009). Emerging discourse: Islamic teaching in HIV prevention in Kenya. Culture, Health & Sexuality 11:5,559-569

Volume 2, No. 1 (2012) | ISSN 2161-6590 (online) | DOI 10.5195/hcs.2012.73 | http://hcs.pitt.edu

McGirk, J. (2008). Religious leaders key in the Middle East's HIV/AIDS fight *The Lancet* - 372(9635), 279-280

Ministry of Health [MOH]. (2005). Behavioural Surveillance Survey 2002: summary report, HIV/AIDS and sexually transmitted infection in Kenya. Nairobi: National AIDS/ STI Control Program, Ministry of Health; 2005. [online]. Available from: http://www.drh.go.ke/documents/BSS%20Kenya%20summary%202002.pdf [Accessed 17th June 2009]

Morrow, M. and Barraclough, S., 2003. Tobacco control and gender in south-east Asia. Part II: Singapore and Vietnam. Health Promotion International 18 (4), 373-380

National AIDS Control Council [NACC]. (2005). *Kenya HIV/AIDS Data Booklet 2005* [online] National AIDS Control Council, Division of Monitoring and Evaluation. Available from: http://www.nacc.or.ke/2007/default2.php?active_page_id=281 [Accessed 10th January 2007]

National AIDS Control Council [NACC]. (2009a). Kenya AIDS Indicator Survey 2007. Kenya National AIDS Control Council. [online] . Available from: http://www.nacc.or.ke/nacc%20downloads/official_kais_report_2009.pdf [Accessed 10th January 2010]

National AIDS Control Council [NACC]. (2009b). Kenya HIV Prevention Response And Modes Of Transmission Analysis. Kenya National AIDS Control Council. [online] VALIDATED AND APPROVED by the Kenya AIDS Research and Study Committee. . Available from: http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798110303715339 2/KenyaMOT22March09Final.pdf [Accessed 10th January 2010]

Parker, R., Aggleton, P., Attawell, K., Pulerwitz, J., Brown, L., (2002). *HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action* [online]. The Population Council. Available from: http://www.popcouncil.org/pdfs/horizons/sdcncptlfrmwrk.pdf [Accessed 17th June 2009]

Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc. 2008. Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08. Dar es

Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and Macro International Inc.

Tones, K and Green, J., (2004). *Health Promotion: Planning and Strategies*. London SAGE publications Ltd.

UNAIDS., 1998. AIDS education through Imams: A spiritually motivated community effort in Uganda. Geneva, UNAIDS.

UNAIDS. (2001). HIV Prevention Needs and Successes: a tale of three countries. An update on HIV prevention success in Senegal, Thailand and Uganda. Best Practice Collection.

UNAIDS. (2008). *2008 report on the global AIDS epidemic.* Geneva, UNAIDS.

UNAIDS. (2009). *2009 report on the global AIDS epidemic.* Geneva, UNAIDS.

UNICEF. (2003). *What religious leaders can do about HIV/AIDS. Action for Children and Young People* New York, UNICEF

WHO. (1992). *Health education through religion. The role of religion and ethics in the prevention and control of AIDS*. Egypt, WHO EMRO.

Zaba, B, Pisani, E, Slaymaker, E and Boerma, J Ties. 2004. Age at first sex: understanding recent trends in African demographic surveys. [Online] Sex Transm Infect 2004; 80(Suppl II):ii28–ii35. doi: 10.1136/sti.2004.012674. Available from: http://sti.bmj.com/content/80/suppl_2/ii28.full.pdf?sid=91b68c40-a900-452b-b89c-89ef18be04f8 [Accessed 2nd June 2009].