“It is not a sin going for the test”: A qualitative study of attitudes towards HIV testing in Pentecostal churches in Mombasa, Kenya

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Abstract

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In sub-Saharan Africa, religious leaders are highly revered. They are in a position to play an important role in response to the HIV epidemic. This study explored the attitudes of religious leaders towards HIV testing in Pentecostal churches in Mombasa, Kenya. Individual in-depth interviews with seven Pentecostal religious leaders and four focus group discussions (FGDs) with congregation members were conducted. The in-depth interviews highlighted the range of views of the religious leaders towards HIV testing, while the FGDs illustrated the religious community norms that shape the congregations attitudes towards testing. Religious leaders were important in influencing the congregants' decisions about whether or not to seek HIV testing. Some religious leaders address HIV in their interactions with congregants and actively promote testing. However, many religious leaders do not talk about testing because of the stigma associated with HIV as a sexually transmitted disease. Religious leaders cited numerous barriers to advocacy for HIV testing in the church. These included conformity

to religious norms on faith and righteousness, belief in faith healing of HIV, and a perception of the disease as God’s punishment. A notable exception to the religious leaders’ resistance to discussing HIV was the widespread acceptance of HIV testing prior to marriage. Focus group discussions highlighted the role of religious leaders in motivating congregants’ decisions to seek HIV testing. Many FGD participants expressed desire for their religious leaders to advocate for HIV testing. These results highlight the importance of religious leaders in influencing HIV testing decisions among religious adherents. If barriers to discussion of HIV testing in Pentecostal communities could be addressed, religious leaders could play a key role in motivating church members to seek HIV testing.

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DEDICATION

To my loving parents,
Mr. Johnsy Caen and Mrs. Prudence Elizabeth Masha

INTRODUCTION

Over the past 20 years, Pentecostalism has become the fastest expanding Christian religious movement in the world [1, 2]. Like many countries, Kenya is experiencing a proliferation of Pentecostal churches. The Evangelical Alliance of Kenya (EAK) reports membership of approximately thirty-eight thousand Pentecostal churches [3, 4]. Other Christian bodies including the Organization of African Instituted Churches (OAIC) and the National Churches Council of Kenya (NCCK) also include Pentecostal churches as members [5]. No central body regulates the formation of Pentecostal churches in Kenya, so the actual number is difficult to establish. However, it has been estimated that religious adherents to Pentecostalism and related charismatic religious groups may account for more than half of Kenya's population [3, 6].

The foundational principle of all Pentecostal churches is the belief in benevolent powers, faith healing, and the trinity of God, Jesus Christ, and the Holy Spirit [7, 8]. Beliefs in the divine healing power of the Holy Spirit have been described as the driving force behind the growth of the Pentecostal movement [8-11]. Emphasis is also placed on salvation, being "saved" or "born again." Pentecostals feel renewed after being born again, an experience that provides them with a feeling of holiness and purity [8]

Studies in sub-Saharan Africa have shown religion to play a profound role in the lives of many people [12-14]. The lifestyles and health seeking strategies of the African people are impacted by their religion [11, 15, 16]. Despite the potential importance of Pentecostalism in Kenyans' views and actions in relation to the HIV epidemic, limited attention has been given to understanding the role of Pentecostalism as a facilitator or barrier in efforts to control the spread of HIV.

In resource-limited settings, data regarding Pentecostalism and its influence on health behavior are conflicting. It has been argued that Pentecostalism may reduce the spread of HIV because of emphasis on salvation and conformity to religious beliefs including abstinence before marriage and mutual monogamy with a married partner [17]. However, strong religious beliefs do not always correlate with HIV protective behaviors [18]. One common theme in studies of Pentecostalism is a high level of adherence to strict moral codes and religious values such as abstinence, fidelity, and faithfulness [3, 8, 17, 19]. Because these values may seem to conflict with risk behaviors for a sexually transmitted infection, it is particularly important to explore how Pentecostal religious beliefs may influence church members' attitudes and actions in relation to HIV testing.

Testing for HIV is a vital entry point to prevention, treatment, and care [20]. For the HIV infected, the test serves is a necessary step towards engaging in HIV care and services to reduce the risk of secondary HIV transmission. For those who test negative, the testing procedure and result can serve as powerful tools to motivate personal risk assessment and reduce exposure to the disease [20-22]. Kenya, with a national HIV prevalence of 6.3% has a low proportion of people having tested for HIV [23]. Nearly 1.2 million HIV-infected Kenyans are not aware of their status [24]. According to the Kenya AIDS Indicator Survey 2007, approximately two thirds of the population between 15 to 64 years old has never tested for HIV [24]. These statistics highlight the importance of understanding the motivations and barriers that influence people's choices about having an HIV test.

The qualitative research described in this manuscript was carried out to explore the attitudes of Pentecostal religious leaders towards HIV testing. The following questions guided the study:

(1) Are the Pentecostal religious leaders addressing HIV testing in the churches?

(2) Are there differences in HIV testing advocacy in the Pentecostal churches in urban versus peri-urban settings?

(3) What influences Pentecostal religious adherents decisions about whether to seek HIV testing?

We chose to focus on HIV testing because this initial step is a critical entry point to prevention and treatment.

METHODOLOGY

Study Design

A qualitative approach utilizing in-depth interviews and focus group discussions (FGDs) was employed to address the research question. Individual in-depth interviews with Pentecostal religious leaders and FGDs with women and men adherents (in gender-matched groups) were conducted. The FGDs allowed triangulation of findings from the in-depth interviews and added methodological rigor in the context of this qualitative data analysis. The depth of understanding that is obtained using qualitative methods would not be possible with data available in surveys like the Kenya Demographic Health Survey or in quantitative research questionnaires. We utilized a modified “social space” perspective as our conceptual model for the study [25].

Churches were viewed as interactional contexts that construct and influence the behavior of their adherents.

Study Setting and Selection of Participant Churches

The study was conducted in Mombasa District, in Kenya's Coast Province between August 2011 and March 2012. Urban churches attended mainly by middle class communities and peri-urban churches attended primarily by poorer communities were included. The selection of the churches in these two distinct parts of the Mombasa District was meant to capture the differences that exist in Pentecostal churches.

It is estimated there are approximately six hundred Pentecostal churches in the Mombasa District [5]. Selection of ten churches to participate in the study was performed using a defined random sampling framework after a survey of the churches in the region. We acknowledge there could be differences in the churches that are not captured by this sample. However, we felt that a sample of ten churches was sufficient to provide insight into our research question, as well as giving us an indication of the variability between churches in the region.

Our initial survey of Mombasa town and the surrounding peri-urban areas identified 79 churches. The survey involved physical mapping of Pentecostal churches in the different divisions of Mombasa so as to get a representative sample for the study. From this group, we created separate lists of 20 urban and 59 were peri-urban churches. This categorization was meant to capture broad demographic differences in the churches, and their congregants. From each list, five churches were selected using

a spatial numbering system. Every fourth church in the list was selected for participation until the required number of churches for the study was achieved.

Study Participants

Semi-structured in depth interviews were conducted with seven out of the ten Pentecostal religious leaders approached. The remaining religious leaders did not confirm interview dates, so the final 3 interviews were not conducted. In addition, four FGDs with a total of 29 participants were conducted to understand the influence of religious community in shaping adherents' beliefs. Participants were recruited either before or after church services. All FGD participants were approached after seeking concurrence from the religious leader. The study inclusion criteria were;

1. Above 18 years of age
2. Belonging to one of our target groups, including
    a. Pentecostal religious leaders
    b. Women attending the churches
    c. Men attending the churches
3. Living in Mombasa District
4. English or Swahili speaking
5. Able to understand and provide informed consent

Participant Recruitment

The researcher approached religious leaders from selected churches, with the initial discussion guided by a recruitment script. If the religious leaders were willing to learn more, the researcher explained the study in detail. After answering all of their questions, the religious leaders were invited to participate in an in-depth interview. The

researcher also requested that they introduce the study to their congregation and invite interested people to volunteer for participation in FGDs. Women and men who volunteered to participate were selected using purposive random sampling. Every second woman or man from the pool of volunteers was considered eligible to participate in the FGDs.

Study Procedures

The study guides for both in-depth interviews and FGDs were pilot tested before use by having mock interview sessions with Kenyan colleagues who were Pentecostal adherents. The mock interviews were used to determine whether the questions were understandable and were eliciting the information we sought. We felt that the pilot testing enhanced the study tools by allowing us to fine-tune them to be culturally appropriate for the religious community.

Participants' socio-demographic information was collected prior to an interview or FGD session. We audio-recorded all the interviews and FGDs and took detailed field notes. We conducted data collection in English or Swahili, based on interviewee's preference, using semi-structured interview guides. Participants were compensated with a small monetary incentive in recognition of their time taken to participate in the research.

Topics covered in the interviews and FGDs included HIV advocacy by religious leaders, the importance of HIV testing, the influence of belonging to the Pentecostal denomination on people's willingness to get tested, and religious beliefs about HIV. We were also interested in the influence that adherents have on each other, and how this impacts the way they behave and make decisions.

Data Analysis

Preliminary analyses and ongoing adaptation of interview and FGD content were initiated during the interview and FGDs process through verification of field notes using a grounded theory approach [26]. Using this adaptive approach, information that emerged in preceding interviews and FGDs was explored further in subsequent interview and discussion sessions. Audio recordings were transcribed and translated verbatim. Data from both the in-depth interviews and the FGDs were analyzed using content analysis, which has been widely used in qualitative research [26, 27]. This involved multiple readings of the transcripts to capture context and meaning, followed by coding and categorization of recurring concepts and ideas. Transcripts were reviewed separately by two investigators (study Principal Investigator and qualitative consultant) for text element and key word coding. Four coding matrixes for the different sub-sets of study participants (religious leaders, women adherents, female and male FGDs) were developed. Categorization of overarching themes was developed and codes where compared, added, or removed based on consensus between the two investigators. This multiple coding ensured the qualitative analog of inter-rater reliability [28]. After coding, emerging themes were organized according to the research objectives. Quotations voiced by participants are included in this write-up. Qualitative software ATLAS.Ti (GmbH, Berlin Germany) and manual coding were employed to manage the coded texts.

Ethical Approval

All study procedures received ethical approval from the University of Nairobi, Kenyatta National Hospital Ethics and Research Committee and the University of Washington Human Subjects Review Committee. Written informed consent was obtained from all participants.

RESULTS

Baseline Characteristics

Table 1 describes key characteristics of the religious leaders (n = 7) and FGD participants (n = 29). The median age of the religious leaders was 40 (interquartile range [IQR] 36 – 51 years). They were all male, employed by the church, and married. The religious leaders reported a median of 20 (IQR13-25) years of church membership. Four (57%) of the leaders had attained Master degrees (graduates) and the minimum completed level of education was secondary school.

The median age of the FGD participants was 32 years (IQR 26-39), and they had a median of 6 (IQR 3-12) years of church membership. Fourteen (48%) of the FGD participants were single, one (4%) was widowed, and the remainder were married. Twenty-six (90%) of participants had attained a secondary school or higher level of education. There was no refusal to participate. However, three religious leaders' interviews were not scheduled due to failure to identify suitable dates during the period of data collection.

Table 1. Baseline characteristics of 7 religious leaders and 29 focus group participants

Characteristic	Median (IQR) or Number (percent)
Religious Leaders (n=7)	
Age (years)†	40 (36 - 51)
Length of affiliation to church (years)	20 (13 - 25)
Married	7 (100)
Education Level	
Secondary	1 (14)
College	2 (29)
Masters	4 (57)
Number of children	2 (2 - 3)
Focus Group Participant (n=29)	
Age (years)	32 (26 - 39)
Length of affiliation to church (years)	6 (3 - 12)
Male	13 (45)
Marital Status	
Single	14 (48)
Married	14 (48)
Widowed	1 (4)
Education Level	
Primary	3 (10)
Secondary	13 (45)
College	10 (35)
Masters	3 (10)
Number of children	0 (0 - 3)
Source of Income	
Employed	14 (48)
Casual Labor	2 (7)
Business	5 (17)
Unemployed	6 (21)
Other	2 (7)

†N= 6 One participant declined to give his age

MAIN THEMES

Four main themes were categorized from the qualitative data, including (i) barriers that hamper testing efforts in the Pentecostal churches; (ii) pre-marital testing for HIV; (iii) role of religious leaders in HIV testing promotion and (iv) efforts of religious leaders' to increase HIV knowledge to the congregation members with an aim to influence testing behavior. Summarized findings of these themes are highlighted here.

Theme I: Barriers to HIV testing promotion by religious leaders

The majority of Pentecostal church leaders we interviewed expressed difficulties in addressing HIV because of the underlying association between the disease and immorality. One of the religious leaders stated:

> Unfortunately, I wouldn't say that there is anything that is happening regarding HIV/AIDS education in [church X], very little if any. One, this is a subject that is very shame based and so even the church here has that shame based view of HIV/AIDS. (33 year old religious leader, urban church)

Despite this common view among many of the religious leaders, many Pentecostal adherents felt that their church leaders should address HIV and encourage people to go for testing. This sentiment is illustrated by several quotations from the FGDs:

> Another thing that I can add is that in churches they mostly consider spiritual growth. Issues to do with health, sex, no. It's all about spiritual

> issues. So the biggest problem is with the leaders, the pastors and all the others. So anything to do with sex, NO! They believe in the Holy Spirit, and in reality these things happen, and a lot of people come to church disguising themselves. Yet they (leaders) avoid such topics, they just believe in spiritual, spiritual matters. Not everybody is perfect, you see…
> (28 year old male, FGD peri-urban church)

Another focus group participant stated:

> I think we don't have enough knowledge to get [to] know that it's good to know your status and all of that. So there's that issue of 'until my leader tells me, if he doesn't tell me I'll just keep away from testing.'
> (25 year old male, FGD urban church)

Another barrier in advocating for HIV testing in most of the churches is the strong conformity to the strict moral codes and religious beliefs. Pentecostals view of themselves as being free of sin. The salvation they have gone through by being “born again” is believed to have set them apart from the “people of the world” who are regarded as non-believers. Seeking the HIV test was a sign of not believing, as illustrated by one of the religious leaders who stated:

> … also some people kind of believe that testing is a sign of not believing, you know! If you believe in God why go for testing?
> (40 year old religious leader, urban church)

The sentiments shared by religious leaders regarding conformity to religious norms and how they impede HIV testing advocacy parallel the views of congregation members. The following quote is from one of the FGD participants:

> It's difficult [to talk about testing] because, the first thing they will say is that you are promiscuous…It's very difficult because we are gathered there as born again women. There's no one there who is not born again, most of them are born again…Therefore, it's difficult to tell someone 'let's go and get tested.' How will you begin? (28 year old female, FGD urban church)

To address HIV testing, religious leaders have to come to terms with some of the religious interpretations of HIV. HIV was interpreted by some religious leaders as God's punishment for sexual transgressions and was a barrier to promoting testing. A religious leader stated:

> So if this [is] anything to go by we should look at even untreatable diseases today as God's judgment and although not many people will say this, I do see HIV/AIDS as one of them because of people's hardness of

> heart, that people have refused to be faithful to their spouses, [and] faithful to God, people have failed to maintain chastity. God releases these things, you know biblically speaking when someone hardens their heart, when people reject God in one way or the other for a very long time, God releases you to the thing that you love most and he releases it to you to act as a judgment to you. (33 year old religious leader, urban church)

Other religious leaders believed those who interpret HIV as God's punishment were incorrectly interpreting the Bible. An alternative view, expressed by another of the religious leaders, highlights one of the common interpretations of HIV:

> Malaria is a killer disease also, and I think in Kenya we should be more scared of malaria than HIV, but because people are able to explain it…Nobody talks about malaria being a curse, but because they do not understand HIV/AIDS, the human mind goes wild looking for all kinds of reasons, but I don't think HIV is a religious curse, a religious mind would look for a religious explanation, a man that is not religious would look for another explanation. (39 year old religious leader, urban church)

Belief in faith, miracles, and healing of diseases including HIV was another barrier to addressing HIV testing in Pentecostal churches. Importance is placed on relying on faith and the power of healing as opposed to seeking the HIV test as illustrated by some of the religious leaders. One of them stated:

> And because there are those who just believe God heals and if you don't get healed you don't have faith. Now that is where you don't need to go for testing because that means you don't have faith. (40 year old religious leader, urban church)

In such contexts where there is a strong belief in faith healing, it is challenging to address HIV testing in the churches. However, some religious leaders and congregation members agree on the importance of both faith healing and seeking the test. One of the religious leaders stated:

> Yes it's good to pray, it's good to believe that, but it is good to get tested. (37 year old religious leader, peri-urban church)

It is also interesting to note that some of the congregation members were of the opinion a confirmatory HIV test should be undertaken to make sure the divine healing of HIV had occurred. This is illustrated by a FGD participant who stated:

> It is like this, because this person has been prayed for and they say he/she is healed. It is good for that person to go for and get tested in these, what do we call them? The VCTs! Now there is where he/she will get confirmation that he/she no longer has the HIV virus. Although this person will be prayed for, it is also important for him/her to go and get

> tested so as to confirm that he/she is truly healed. And after it has been confirmed there we can now say that he/she is now alright. (40 year old male, FGD peri-urban)

Theme II: Pre-marital HIV Testing

While many of the Pentecostal churches seemed hesitant to address HIV testing in general, it was interesting to note that all of the churches in this study applied a mandatory HIV testing policy for couples before marriage. This is illustrated by a religious leader who stated:

> It was agreed from our [church] leaders that before we marry people we have to encourage them to go for testing and I have done that for many people here, even those who are already married [and] they want to legalize their wedding. I encourage them to go for tests…and they bring me the paper, they do it voluntarily.
> (63 year old religious leader, peri-urban church)

Many of the religious leaders mentioned that it was a rare occurrence for couples who go for the test before marriage to have discordant results, but they acknowledge it happens. This creates a difficult situation for church leaders, as illustrated by the following quote:

> We normally do not prefer marrying them [couple] when one is positive knowledgably, although we haven't put down our feet on this, but also

> rarely have we come across those who have gone and tested then one of them is positive and the other is negative and they have gone ahead to get married. (40 year old religious leader, urban church)

Our FGD discussions further supported the in-depth interview responses in confirming that premarital HIV testing of couples was the only time that many religious leaders encouraged people to go for the test. However, not all religious adherents were in agreement regarding the importance of seeking the test before marriage, since the Pentecostal religious beliefs discourage pre-marital sex. One of the respondent s stated:

> The church has deemed abstinence as the only way a man can remain pure sexually before marriage which is very compatible to Biblical teachings so if I have been faithful and I have been abstaining or I have not been engaged in any risky sexual behavior then I don't need to know my status before marrying, you know. (33 year old male, FGD urban church)

Theme III: Involvement of religious leaders in HIV testing advocacy

Religious leaders seem to have strong rapport and substantial level of trust from their congregations. In this context, addressing HIV testing in churches is viewed by some of the religious leaders as an important step in dealing with the epidemic. This minority

opinion among religious leaders in our study is illustrated by one of the religious leaders who stated:

> We are informing them that it is good to know your status and we are not forcing them, but we are telling them it's a voluntary thing to do, so that they can know their status, because it is not only through sex that they can get AIDS but through many things like if they are cut by a sharp thing and many other things. So we are informing them that it is very, very vital for them to go and be tested so that they can know how they are. (37 year old religious leader, peri-urban church)

Some religious leaders who advocate for HIV testing have also tried to create opportunities for dialogue about the challenges of HIV. In some cases, religious leaders have established testing centers and promoted testing drives in churches. For example, one religious leader stated:

> We started a VCT center, [and] started an NGO that seeks to just offer awareness and help to those who are infected and affected and also just seeks to mobilize society to deal with the issues of HIV/AIDS. So the NGO does a lot of that, among many other things…It does also training to people and organizations and such and seeks to deal with the problems as well associated to HIV/AIDS. (39 year old religious leader, urban church)

In many churches, there are important generational differences in attitudes towards authority and religious ideology. While the older generation may be more conservative, the young feel liberated. These youth in Pentecostal churches tend to keep up with the changing times in the way they dress, act, and worship. To reach out to this young and dynamic population, some religious leaders have devised ways to address HIV and testing in the churches. A religious leader stated:

> We have to put in some video; we have to put in some music…The purpose is to ensure we are not just communicating to one sense, because this generation is used to communication from all the five senses, so they say. So, we need to ensure we are at the forefront of that. Now that generation has so much information at their fingertips but yet in some areas like your specific question about HIV/AIDS they tend to be in some ways very ignorant. (39 year old religious leader, urban church)

Promotion of HIV testing by religious leaders was a strong motivator for adherents to go for the test. The involvement of religious leaders in fostering testing discourse in the churches played an important role in shaping adherents decisions about whether or not to seek HIV testing. This is illustrated by a FGD participant who stated:

> At that time, I didn’t make that decision out of my own because the pastor stood up and preached, he told us not to be afraid to go for testing.

> 'Testing is not a sin,' he told us. 'It is knowing your status, and if you are positive we will know what to do.' That is what the pastor told us when he stood up. He further said ' some of us are too saved to the extent that we consider ourselves to be too holy and therefore cannot sin, but HIV is not transmitted through sex only, it can also be spread through other means. So don't just sit there telling yourself that you are just safe yet nobody knows about their status. So be free.' The pastor, therefore, opened up our eyes saying; 'it's not a sin going for the test, it's a matter of you opening up.' And so I decided; 'let me go and get tested too. (44 year old female, FGD urban church)

Theme IV: Increase in HIV knowledge in the churches

In some churches, there is an effort to address HIV and de-stigmatize the disease. Many religious leaders are highlighting the potential for non-sexual transmission of HIV that would be defined as non-sinful. One of the religious leaders stated:

> You know some people think that this one, AIDS, is only gotten from, you know, sleeping with somebody who is infected but, so when you are talking about that they don't think that there are some other things that can make them to get AIDS. So they are thinking that it is only through sleeping together or having sex, so we are telling them, “no”. There are many other things that can make you to have AIDS. When you make a sermon for that, some of them they don't understand, so we are having those challenges but with time we are going to make it.

(37 year old religious leader, peri-urban church)

Umbrella bodies like NCCK are encouraging HIV and testing discussions. Religious leaders who belong to these associations may feel that they have a mandate to addressing HIV. This is illustrated by one of the religious leader who stated:

> I think it was last year around October at NCCK whereby we were called all the [religious] leaders in Mombasa, I think in Coast also, we were told and advised to be having a sermon of either ten to twenty minutes to talk about AIDS only. So after that, I informed my preachers and they are doing it.
> (37 year old religious leader, peri-urban church)

Recommendations by study participants

To seek the way forward in promoting HIV testing in Pentecostal churches, we elicited views of both the religious leaders and adherents. Some religious leaders were inclined to change with the times. One of the religious leaders summarized:

> We seek to take the church out to society…by seeking to engage our members in such a way that they are relevant to the ever changing culture that we live in and are able to be witnesses are able to do what we believe God would want us to do. (39 year old religious leader, urban church)

Many of the FGD participants expressed the opinion that religious leaders should take the lead in efforts to increase HIV awareness and testing in the Pentecostal community. A focus group participant stated:

> Because if leaders, our church leaders were to talk of HIV as a disease, you know, a disease like any other that anyone can get, just the same way they talk about cancer you know, and talk about it with facts and tell people what they need to know and talk about it with facts as opposed to giving their own personal opinions then I think that would make people take up testing more. (32 year old male, FGD urban church)

Training of religious leaders was emphasized as a means of enabling them by providing basic HIV prevention information. Also since it is a challenge to reach out to the entire church because of gender and generational differences, adherents suggested working with the different ministries that exist in churches (women, men, and youth). This would ensure appropriate packaging of HIV information and messaging targeted for each group. This was summarized by one of the Pentecostal congregation members in the FGD who stated:

> I will suggest that maybe they rally the leaders. I believe that in every church we have different sects, that are ministries like the women's ministry, the young adults' ministry, the youth ministry. So, I suggest that maybe we target the leaders, we talk to the leaders, we train them so that

> they can go and train the others.   You know they lead by example, because maybe at times if we say the entire church it might not be easy… (43 year old female, FGD urban church)

Many of the Pentecostal congregation members in the FGDs expressed their willingness to incorporate HIV testing with their religious beliefs. This is highlighted by a FGD participant who stated:

> What I know is that in salvation, we call it salvation, or your belief, there's nowhere testing is prohibited. Testing is for your own good and salvation is not against it neither does it prohibit it. And so the issue of saying, 'I'm saved and so I cannot get tested,' should not arise. That [is] your own personal decision to make, and salvation is not against it. (27 year old male, FGD peri-urban church)

DISCUSSION

This study explored the attitudes of Pentecostal religious leaders in Mombasa towards HIV testing. We also examined the ways in which the Pentecostal leaders and community norms influenced congregants' decisions about whether to seek HIV testing. These unique data suggest that religious leaders play an important role in shaping congregants' decisions about whether or not to seek HIV testing.

One of the most important barriers to HIV testing advocacy by Pentecostal religious leaders was the stigma associated with the disease being sexually transmitted. This made HIV a taboo topic for discussion in the churches. Other important factors that may act as barriers to HIV advocacy in Pentecostal churches included religious norms on faith and righteousness, belief in faith healing of HIV, and a perception of the disease as God's punishment.

Despite these barriers, there were many exceptions to the 'rule' that HIV testing is not addressed by Pentecostal leaders. Both religious leaders and congregants in our study acknowledged the importance of getting tested and knowing their HIV status. Some religious leaders were actively engaged in addressing HIV, including promotion of HIV testing. In some cases, church leaders supported HIV testing campaigns, and one church had even incorporated an HIV testing center. Pre-marital HIV testing was widely practiced in this setting.

To our knowledge, this is the first study to focus on Pentecostal religious leaders' attitudes towards HIV testing in their religious community. We chose to focus on the influence of Pentecostal religious leaders in congregants decisions about seeking HIV

testing because testing represents the first step towards engaging in HIV prevention and treatment [29, 30]. The qualitative nature of the study provides insight into the complexity of addressing HIV testing in Pentecostal churches, and the way forward to promote testing efforts in this population.

Our findings indicating that HIV evokes feelings of sin and sexual promiscuity in the Pentecostal community parallel the results of other studies addressing this topic [2, 10, 11, 31]. The stigma surrounding a sexually transmitted disease presents a challenge in promoting HIV testing, because it is difficult for religious leaders and their adherents to openly identify with the disease. Despite these barriers, many Pentecostal church members felt their leaders should make a greater effort in advocating for HIV testing. Targeting of different age and gender groups with the correct messaging was advocated by church members as potential avenues to address the importance of HIV testing.

Our data add to those from other studies in sub-Saharan Africa, which demonstrate that religious leaders are respected and highly revered within their communities [9, 14, 32, 33]. Congregation members revealed that even in matters related to HIV testing, they would seek testing if their religious leaders advocated for it. This suggests the power and influence that the religious leaders have to make a significant difference in curbing the spread of HIV. We found that, where religious leaders were not addressing HIV testing in the churches the resultant outcome was disconnect between the leadership and congregation members. It may be possible that congregation members' attitudes towards the need for increased HIV awareness

suggests a shift of congregational norms from stigmatizing to affirmation of the disease in churches.

The importance of strict moral standards in shaping Pentecostal congregants views about HIV and testing was evident in our study population. The association of HIV with infidelity, promiscuity, sexual deviation and religious myths about the disease was a step-back in addressing HIV testing. However, there were varied views amongst participants regarding the extent to which their salvation and beliefs impact their decisions to seek HIV testing. On the one hand, salvation and issues related with HIV do not parallel in church because the disease arouses questions of immorality, sexual promiscuity, and infidelity which members try to avoid [2]. Alternatively, while the church stigmatizes HIV [7], participants noted the Bible does not prohibit HIV testing. The individual perceptions of salvation within our study participants account for these differing attitudes towards HIV testing amongst Pentecostals.

In sub-Saharan Africa, a number of studies have highlighted that faith healing can present a challenge when it comes to addressing HIV in the church [1, 15, 16]. In our study, faith healing of HIV was acknowledged as part of believing, and presented a barrier to seeking the test. It was particularly interesting to note that some Pentecostal religious believers may rely on HIV testing as a way of confirming the success of faith healing. This belief represents a unique interpretation of the importance of the HIV test in the Pentecostal community.

Pre-marital HIV testing, though controversial, is an exception in addressing testing in most of the Pentecostal churches in this study. Previous studies found that

the primary reason for pre-marital HIV testing promotion in churches is to ensure that couples take preventive HIV measures before marriage [3, 30, 34]. While the policy is a starting point to address HIV testing in the churches and demystifies the testing process [34], it is problematic and has potential to reinforce stigma. These pre-marital testing policies face resistance from some congregation members. The underlying resistance is attributed to the fact that Pentecostalism is strongly against pre-marital sex [32]. Therefore, some adherents believe the test is irrelevant if the teachings they adhere to have been discouraging engagement in pre-marital sex. Despite these reservations, the majority of Pentecostals in our study expressed a willingness to have an HIV test before marriage to ensure start of a union that is HIV free.

Although the major mode of HIV transmission in Kenya is through heterosexual contact, religious leaders in this study have adapted coping mechanisms to de-mystify HIV as a sexually transmitted infection. Specifically, they highlight other possible modes of transmission, such as through traumatic or other exposures. This is an exception to the rule that HIV as a taboo topic cannot be addressed in the churches [35], and may facilitate the promotion of HIV testing. Religious leaders' efforts in highlighting non-sexual transmission of HIV may allow for discussion of the topic in churches, but it is not clear whether this provides a net benefit since it seems to avoid the primary mode of HIV transmission in the region.

We structured our study so that recruitment included samples of both peri-urban and urban churches, as we had anticipated possible differences in HIV testing advocacy, knowledge about HIV, religiosity, and educational levels in these two broad areas. However, we did not find noticeable differences in Pentecostal leaders and

congregants decisions about HIV testing that were specific for churches in either of the regions. The study did not address rural areas, which would be another useful area for understanding the diversity in Pentecostal churches. Our non-inclusion of rural areas could limit study generalizability findings to Pentecostal churches in those settings.

This study took several steps to ensure qualitative methodological rigor. The use of individual in-depth interviews with the religious leaders provided a deeper understanding of the diverse church ideologies in addressing HIV testing. The FGDs with the male and female adherents allowed us to asses Pentecostal religious community norms. Triangulation of data from the in-depth interviews and FGDs allowed us to compare and contrast the responses, and to gain a richer understanding of perspectives towards HIV testing. In addition, the sampling framework employed to select churches and interview religious leaders may have helped us to capture the variety of Pentecostal churches that exist within the study catchment area. To minimize bias, the sampling of study participants for the FGD was also rigorous, with selection of every second volunteer for study participation. The study strengths are also evident in the data collection and analysis phase. The ongoing adaptation of the interviews and FGDs using a grounded theory approach allowed us to delve deeper into insights that were emerging in subsequent interview and FGD sessions. Finally, our use of paired coding by two investigators allowed consensus in the coding and categorization of emerging themes. This ensured accurate interpretation of the study data.

These results should be viewed in light of the study's limitations. The sampling of the focus group participants was based on volunteerism. Also, social-desirability bias could have influenced the responses of both the religious leaders and congregants. It is

difficult to ascertain the effect that social-desirability bias would have on these results because if the participants perceived in the interviews and FGD sessions that HIV testing was important they might have over-reported the extent to which it is promoted. On the other hand, it is also hard to rule out under-reporting of testing promotion if the participants perceived that they are supposed to uphold religious values and not seek testing. This may not be the same in every participant, but it is difficult to rule out this possibility. To minimize bias, we used a skilled interviewer and focus group facilitator with qualitative research experience to collect the data. They provide participants with clear information on the study purpose and employed interview strategies to reduce potential embarrassment, secure trust, and ensure confidentiality. Also, our study instruments were pilot tested and careful worded to be cultural appropriate for this population. Despite these limitations, we feel that this study provides novel and important data that help us to understand how Pentecostal churches influence their adherents' decisions about HIV testing.

CONCLUSION

The qualitative nature of this study provided rich data on how Pentecostal religious leaders influence church members' decisions about HIV testing. Pentecostalism is rapidly expanding in sub-Saharan Africa. We have shown that many Pentecostal congregation members would like their religious leaders to provide more HIV advocacy, including promotion of HIV testing in churches. Harnessing the positive influence of Pentecostal religious leaders to address the barriers that exist in promoting

HIV testing in churches could have substantial benefits in terms of HIV prevention and treatment in the region.

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