The impact of FAITH & RELIGION on HIV -related stigma, treatment adherence and service uptake among LGBTQ+ individuals in Uganda

Foreword

This report presents the findings of Universal Coalition of Affirming Africans Uganda (UCAA- UG) in collaboration with Friends of Canon Gideon Foundation (FOCAGIFO) from the study on the role of faith and religion in shaping HIV related stigma, treatment adherence, and service uptake among LGBTQ+ individuals in Uganda.

UCAAA-UG was the first faith-based organization established in 2017 to advocate for the inclusion of the most marginalized groups of people in Uganda using faith-based approaches. This was after the realization that marginalized groups are deprived of their human rights and treated unfairly in our communities, using religion as a justification.

Being that, diversity and Inclusion (D&I) seem to be subjectively understood by a reasonable number of the Ugandan citizenry. There is still a lack of a deeper understanding of the concept and its applicability in the day-to-day life. Ugandan society continues to be divided and eaten up by discrimination of people based on their differences. Different groups of people continue to be pushed to the margins. Consequently, this has cost our society balanced opinions, and views, and inspired creativity, and innovation that would have enabled a more positive and healthier human experience. It has also fueled economic crisis, human rights abuse and violations.

To address these realities, UCAA-UG adopted its 1st five-year Strategic Plan (2019 – 2023) titled 'Putting our world to rights: Deepening our struggles, consolidating our gains'. As an overall goal, UCAA-UG targeted to contribute to creating a safe environment in faith-based and wider communities where the rights of all persons are respected thereby fostering inclusion and acceptance. This five-year plan was based on the need for UCAA-UG to collectively deepen engagement with religious leaders, policymakers, communities and partners from a faith-based perspective. It is this very milestone that has contributed to the development of the second Strategic Plan for 2024-2028. Under this Strategic Plan the overall change UCAA-UG wants to achieve is "Empowered marginalized persons enjoying their human rights in an inclusive society." The ability of marginalized groups to fully enjoy their human rights is a function of their capacity to influence change in the mindsets of faith and religious leaders, duty bearers and the community towards protecting their rights and increasing their access to services.

It further depends on their financial capacity to meet the basic necessities of life, the capacity of UCAA-UG to provide evidence and direction on the use of faith-based strategies, the strength of an affirming faith movement to dismantle myths, and the capacity of UCAA-UG to support marginalized groups achieve these.

> UCAA-UG believes that ifthe attitudes of duty bearers and other stakeholders change positively towards marginalized personsand if marginalized persons and faith leaders have the capacity and urgency to demand their rights and have sustainable income sources, the society will be inclusive and they will be empowered to enjoy their rights.

Our Vision:

A transformed society where religion and faith are used to promote love and inclusion for all.

Our Mission:

To advocate for the -being and respect of human rights of marginalized communities through mindset change using religion and faith-based strategies.

Our values:

Inclusivity: We are responsive to all the people's need in their diversity and we shall do our best to genuinely include them and treat them fairly and equally. We shall be sure to be gender responsive in our programming and particularly look out for those issues that affect the most vulnerable in our community.

Accountability, Transparency and Integrity: We take responsibility for achieving our objectives. We do what we say we shall do. We do what is right, not merely what is expected. We act with openness, integrity and trust.

Commitment: We are determined to ensure that our objectives and promises are fulfilled. We are steadfast in what we do, resilient and dedicated to our cause.

Respect: We are courteous and compassionate to ourselves, partners and donors. We seek to build collaborations that are mutually reinforcing. We treasure our target communities and seek to constantly show them how important they are as individuals. We treat each other with respect regardless of our status or diversity.

Teamwork: We value and practice working together as a team to achieve our objectives. We build and support each other. We respect and treat each other fairly.

Institutional objectives

To conduct research in order to support advocacy and influence mindset change amongst all communities and policymakers.
To provide pastoral care and psychosocial support to address the mental health challenges for marginalized communities.

To strengthen the capacities of marginalized communities and other stakeholder using a holistic approach to effectively promote the rights of marginalized persons.

To build a strong and progressive network of affirming faith leaders and organizations to further advocate for an inclusive society.

To strengthen the capacity and system of UCAA-UG to deliver quality human rights programs in Uganda.

Our Beneficiaries

Women
Key populations People with disabilities
UCAA-UG is duly incorporated under the Companies Act.

Acknowledgement

This report is a publication of UCAA-UG in collaboration with FOCAGIFO. This initiative was supported by the United Nations Programme on HIV/AIDS (UNAIDS). We also acknowledge the support and partnerships of various stakeholders including healthcare providers, LGBTQ+ community, religious leaders, civil society organizations (CSOs) that work on HIV as well as those that provide legal services, for the support they provided that made it possible for us to produce this report.

Authors

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The other team members included: Mr. Marvin Lwanga, an advocate of the High Court of Uganda and a researcher. Miss Rose Atim, a lawyer, anthropologist and a researcher. Miss Atim has considerable experience of conducting evidence-based research. The fourth member of the team was Mr. Rashid Bunya, a lawyer and researcher with more than 10 years of experience of conducting human rights research and advocacy.

List of acronyms

AHA, 2014:	Anti-Homosexuality Act, 2014
AHA, 2023:	Anti-Homosexuality Act, 2023
AIDS:	Acquired Immunodeficiency Syndrome
CSO:	Civil Society Organization D&I: Diversity and Inclusion FBI: Faith Based Institution
FOCAGIFO:	Friends of Canon Gideon Foundation
HIV:	Human Immunodeficiency Virus
KII:	Key Informants Interviews
KPs:	Key populations
LGBTQ+:	Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning)+ represents other sexual identities, including intersex, asexual, pansexual, and Two-Spirit.
MP:	Member of Parliament
PEPFAR:	US President's Emergency Plan for AIDS Relief UCAA-UG: Universal Coalition of Affirming Africans Uganda UNAIDS: Joint United Nations Progamme on HIV/AIDS UPS: Uganda Prisons Service

Table of Contents

Foreword	iii
Acknowledgement	v
Authors	vi
List of Acronyms	vii
Table of Contents	viii
Executive Summary	1
1.0 Introduction	3
2.0 **Background:** Faith or Religion the Paradox of Integrating and Excluding Marginalized Communities	3
3.0 Methodology	4
3.1 Data Collection	5
3.2 Data Analysis	6
4.0 Findings	7
4.1 Literature Review	7
4.2 Key Informant Interviews	9
5.0 Interpretation of Findings	13
6.0 Recommendations and Future Actions	15

Executive Summary

HIV-related stigma and discrimination refer to any stigma or discrimination that impacts on the HIV response, including on the basis of sex, gender identity, sexual orientation, drug use, sex work or HIV status.1 HIV-related stigma includes a range of stigmatizing behaviors and actions, such as avoidance behaviors, gossip, verbal abuse and social rejection. Discrimination can include these stigmatizing behaviors where they affect the enjoyment of rights such as access to health or social services, employment or education opportunities, and it imposes restrictions on entry or residence, and leads to arrest. Discrimination can be enshrined in criminal laws, travel restrictions, mandatory testing and employment restrictions. This ill-treatment adversely affects the dignity of individuals. While Uganda has been hailed as a model in the fight against HIV, religious and faith attitudes have undermined progress in eradicating this epidemic. Faith plays an important role in influencing societal attitudes and practices to delivering services in Uganda. It also contributes to reducing and contributing to stigma and discrimination as well as in facilitating access to HIV services for key populations. In leveraging the interpretation and beliefs of these key populations as a method of sensitization, faith-based institutions (FBIs), their leaders, and followers may be effective in reducing stigma within places of worship, public spaces, and in health facilities. However, these attitudes remain largely unchallenged due to a lack of accessible and evidence-based information. HIV continues to be a critical public health challenge in Uganda, with young people aged 15-24 disproportionately affected by the epidemic. Related, little is known about the role of religion in addressing the stigma and discrimination faced by key populations.

This study relied on qualitative and quantitative methods to interrogate the impact of faith and religion on HIV -related stigma, treatment adherence and service uptake among LGBTQ+ individuals in Uganda. It relied on both non-numeric and numeric data. In essence, the study dealt with actual experiences of people through interviews and surveys (qualitative) with a goal of understanding the problem from multiple perspectives; as well as statistical data to come up with numbers in percentages (quantitative) to determine whether the generalizations of the problem are true.

This study aligns with our Strategic Direction 2024-2028 in as far as it informs Strategic Objective No.1: 'To generate knowledge and information on the faith-related realities of marginalized communities to inform advocacy for their rights and well-being', and Strategic

1 UNAIDS, "HIV and Stigma and Discrimination: Human Rights Facts Sheet", 2024.

Objective No .2 'To build the capacity of marginalized groups and faith-based leaders to use faith-based strategies to dismantle the bias created by the different faith denominations against marginalized groups'.

This study found that religion and faith play an important role in facilitating as well as hindering access to HIV services and reducing stigma, while they also influence stigma, discrimination, practice, and attitudes. Age, professions, and differences in faith or religious ideologies play a negligible role in influencing attitudes and practices to accessing HIV treatment adherence, and service uptake for LGBTQ+ Individuals. Faith and religion, culture, law, and policy, followed by personal beliefs in this specific order, are the main drivers of attitudes and practice to accessing HIV treatment, adherence, and service uptake for LGBTQ+ Individuals. Thus, to influence HIV treatment services for the LTGBTQ+ community, it is important to navigate challenges presented by religion and faith. In this regard programmatic activities should aim to influence attitudes and practices that flow from religion and faith.

LGBTQ+ individuals subscribe to religion and faith; however, they reject related teachings that marginalize them. There are also fundamental disagreements and contradictions regarding the religious and faith teachings as they relate to LGBTQ+ persons. While most of the participants were sympathetic to the plight of persons who live with HIV, the majority were intolerant of LGBTQ+ persons. Thus, it is important to direct efforts towards providing HIV services to LGBTQ+ persons.

HIV stigma towards LGBTQ+ persons is common among all religions, faith, age, and cultures. Faith and religion guide faith leaders in disclosing their sexual orientation and allegiances with the LGBTQ+ Community. This is largely because the broader Uganda community is largely shaped by religious

and faith ideologies, and as such healthcare services and loyalties are influenced by the same. In this context, because of faith and religion's rejection of the LGBTQ+ community, HIV treatment for this community is mainly provided in government facilities and private healthcare providers that are not faith-based. Related. LGBTQ+ individuals are reluctant to seek HIV services from healthcare providers that they perceive as faith and religion-based. In this context, government facilities are considered more inclusive.

Practice and attitudes of health service providers, including civil society organizations (CSOs) and other persons that engage in HIV service work, are also largely influenced by religion and faith, culture, and the law. The majority of these do not approve of providing HIV services to the LGBTQ+ community. Frontline HIV services workers provide these services because they are required to do so in the course of their work. However, CSOs that work in the legal sector largely take a different inclusive view, citing personal conviction to equality as the basis for this view. Inclusive faith leaders have established services in communities out of religious and faith compassion for minority groups with the aim to improve their lives through their targeted services. Government and private healthcare services have trained medical personnel to provide LGBTQ+ inclusive HIV services, although there are persistent challenges in some facilities. For instance, in some cases, LGBTQ+ individuals are asked to disclose their sexual orientation, and in others, when they are detected, they are turned away. However, disclosing sexual orientation does not always have an adverse impact in as far as it allows for the treatment to be tailored to the individual. LGBTQ+ persons who live with HIV only seek services from selected inclusive facilities that are not related to any faith or religion. While FBIs are credited with providing services in communities, including education, counselling, and HIV healthcare to marginalized groups, this study only found a few that provide HIV services that are accommodating of LGBTQ+ individuals. This is mainly because faith and religious ideologies condemn the LGBTQ+ community. FBIs that provide HIV healthcare are guided in this regard by the love of humanity regardless of sexual orientation, religion, or faith, and they contend that it is grounded in religious and faith teachings. Broadly, inclusive service providers work in an environment that is hostile to LGBTQ+ community. Thus, there is a need to create a safe environment allows LGBTQ+ community to access HIV services.

There is an alarming rate of HIV infections in prisons across the country. Faith and religion, culture and law influence attitudes to understanding sexual conduct among inmates. Thus, efforts to end the spread of HIV must include the prison population.

1.0 Introduction

Research concerning health has included significant contributions to the role of stigma in the lives of people living with HIV, including understanding the role of religious coping, religious beliefs and stigma regarding HIV, congregation-based prevention, intervention programs, and more. This study aims to contribute to new knowledge in Uganda's context, eight years after a comparable study was conducted. During this period, Uganda has experienced a lot of changes in attitudes, practices and policies related to HIV services uptake for the LGBTQ+ community. Although stigma is a major barrier to effective responses to the HIV epidemic, stigma reduction efforts are relegated to the bottom of HIV program priorities. The complexity of HIV related stigma is often cited as a primary reason for the limited response to this pervasive phenomenon.

This report details the research conducted by UCAA-UG in collaboration with FOCAGIFO, with the support of UNAIDS. This research seeks to assess the impact of faith and religion on HIV related stigma, treatment adherence, and service uptake among LGBTQ+ individuals in Uganda. It includes information collected during interviews with the LGBTQ+ community, religious leaders and people of faith, health care service providers, and persons who work closely on HIV, members of CSOs that provide legal and health services, as well as the general public. These broad groups are further broken down into subcategories. Informed consent was obtained from all the respondents. This study observed all ethical considerations that govern research. Respondents were assured of their anonymity. Consent was obtained from the respondents who agreed to audio recordings. For the LGBTQ+ community, this study sought to understand the communities' experience of faith and religion-based violence, exclusion, stigma, or discrimination related to accessing HIV services. This research further interrogated the impact of faith and religious-based stigma on LGBTQ+ individuals. In relation to faith leaders, people of faith, health services providers, persons who work closely on HIV, CSO workers and members of the general public, this research aimed to gauge these groups' perspectives towards the LGBTQ+ community. This research also explored if HIV service providers provided these services to the LGBTQ+ community, and if they did or did not, the factors that influence these decisions. It also sought to understand their attitudes and practices in service provision.

Bio data, including age, gender or sexual orientation faith and religion, was collected from all the respondents. Recommendations that would improve access to HIV health services for LGBTQ+ persons were enlisted from all respondents. Additionally, a desk review of publications, such as studies, commentaries, and reports on the impact of faith and religion on HIV related stigma, treatment adherence, and service uptake among LGBTQ+ individuals in Uganda and comparable contexts was conducted.

2.0 Background - Faith and Religion: The paradox of integrating and excluding marginalized communities.

This study is founded on the paradox of faith and religion in integrating and excluding marginalized communities. This research considers faith as a complete trust and confidence in something, and religion as a specific system of belief and/or worship that often follows a code of ethics and philosophy. While the specific frameworks within each religion and faith are distinctive, they commonly reject oppression, economic inequities, and disparities, and they seek to support disadvantaged or sidelined members of communities. LGBTO+ individuals in Uganda face these realities. It is therefore reasonable to provide a platform to LGBTQ+ persons to share how religion and faith influence and affect their lives. FBIs often provide a variety of social services to communities. These commonly include education, recreation activities such as sports, and medical services. They also receive donations from members of the public who believe that they will use such donations to support needy persons. FBIs seek to embrace as well as exclude members of society. They strive to shepherd individuals who stray.

Faith and religion are central to the human experience; they not only serve as mechanisms for understanding the world but also as powerful forces that influence indiv idual and collective behavior. They regulate social order, often through laws and policies. In the Ugandan society, faith and religion influence laws, policies, and relationships. Laws and policies reflect the religious and faith values of the community. Individuals and communities form, associate, and assimilate based on their common subscription to religion and faith. In this context, values are formed that scope lifestyles, emotional processes, beliefs, values, and rejection. These values are passed down from generation to generation, almost without questioning. To question these values is to defy the core foundations of faith and religion on which communities are formed, not to mention those who wield authority or influence and pass on these values, which is unacceptable.

Powerful social actors tend to reinforce oppressive structures that marginalize or prevent the integration of marginalized communities. Despite reports of decline in religious affiliation in Western Europe

since the 1970s,5 any framework for understanding the dynamics of exclusion or integration must reckon with the force of religion and faith in societies such as Uganda, where religion and faith increase to powerfully anchor forms of identity, meaning, community, and purpose6. This is particularly fateful for marginalized societies. Given that LGBTQ+ persons often belong to religious communities and thus adhere to faith and religious commitments, solutions to their exclusion can be found in interrogating the pivotal roles that faith and religion play in their broader integration and exclusion in the community.

As Ugandans increasingly realize that LGBTQ+ individuals exist in their communities, there is tension between encouraging inclusivity of the LGBTQ+ community and the religious as well as faith foundations on which communities were founded and exist. To this end, this study explores the impact of faith and religion on HIV -related stigma, treatment adherence, and service uptake among LGBTQ+ individuals. This study is significant in several ways. First, it generates robust context-specific data on the role of faith and religion in shaping HIV related stigma, treatment adherence, and service uptake among LGBTQ+ persons in Uganda. It also informs and influences inclusive faith-sensitive HIV programming and advocacy strategies that reduce stigma and improve health outcomes for LGBTQ+ Ugandans and thus addressing a research gap. Additionally, it provides new knowledge specific to Uganda, after the last similar study was conducted eight years ago.[7]

3.0 Methodology

The goal of this study is to assess the impact of faith and religion on HIV-related stigma, treatment adherence, and service uptake among LGBTQ+ Individuals in Uganda. This study has both long- and short-term objectives. In the short term, it seeks to generate robust, context-specific data on the role of faith and religion in shaping HIV related stigma, treatment adherence, and service uptake among LGBTQ+ individuals in Uganda. In relation to the former objective, the aim is to inform and influence inclusive, faith-sensitive HIV programming and advocacy strategies that reduce stigma and improve health outcomes for LGBTQ+ Ugandans.

This research employed qualitative and quantitative methods to understand the lived experiences of the key informants. This research involved 85 individuals from the targeted group of respondents. These respondents were interviewed on the telephone and in face-to-face meetings. The number of key informants was dictated by the resources available for this study. Key informants were recruited from across Uganda. They were identified on the basis of their membership of the target groups, diversity of opinion, high standing or influence in their communities, strong conviction or persuasion, and willingness to participate in this study. Key informants were identified through gatekeepers within local networks, including CSOs and FBIs, and among the LGBTQ+ community. They were selected using the purposive sampling strategy that provides the opportunity to select participants that best fits the characteristics /criteria required for this study. This was occasionally supported by the snowballing, especially in identifying members of the respondent groups that may have been excluded because of the nature of work or environment, status in society, etcetera. Saturation was arrived at especially among respondents with religious and faith-based convictions.

This research experienced several challenges. For example, fourteen of the recruited respondents declined to participate in the study, while others expressed views that they did not want to be put on record. They cited religious or faith or cultural or ethical or legal reasons for not participating or going on record.

To navigate some of these challenges, respondents were assured of their anonymity. The views contained in this study were collected through comprehensive key informant interviews (KII) with 71 individuals from the general LGBTQ+ community; LGBTQ+ persons who live with HIV, or have partners that live with HIV; faith leaders who are LGBTQI+ individuals, or live with HIV, or who have a partner that lives with HIV, or who are allies or affirm of LGBTQ+ individuals; the general community of faith leaders; and people of faith including those that live with HIV/AIDS. Other key informants included HIV health workers, workers of CSOs that provide legal or health advice, and any other persons who are closely related to HIV work. For these latter groups, the key informants were inclusive, non-inclusive, or not sure.

This study observed ethical considerations, including obtaining informed consent; respect for privacy and confidentiality; gender and sexual orientation equality and equity; as well as the security of key informants and data. Only the participants who provided consent were included in the study. To protect the identity of key informants, they were informed of their right to remain anonymous. To further ensure the safety of the respondents, interviews were conducted when they felt safe, for instance, at times and in places of their choice. The data collected was also labelled without disclosing the identity of the respondent, and it was stored in encrypted format on secure devices.

While the majority of the respondents spoke English, the study sought to simplify this language to ensure that we could easily communicate with them. In a few

cases, the interviews were conducted in Luganda as required by the respondents. Researcher bias was minimized through training of the research team. From the outset, members of the research team reflected on their biases and held candid conversations on how these may affect this study. To address the Hawthorne effect, rapport was built at the beginning of each interview by providing an explanation of the study and its purpose.

Different members of the research team interpreted the data collected to ensure a consistent understanding.
A desk review of 25 publications that were issued from 2008 up to 2025, on the impact of faith and religion on HIV related stigma, treatment adherence, and service uptake among LGBTQ+ individuals in Uganda and a comparable context, was conducted to supplement the interviews with the key informants. The number of publications was deemed sufficient to understand other perspectives related to this study from individuals who did not participate in this study.

This study integrates data from multiple sources, that is, KIIs and literature review, to gain a comprehensive understanding, engage in meaningful discussions, draw valid conclusions, and make relevant recommendations regarding the study. This way, this research sought to understand the impact of faith and religion on HIV-related stigma, treatment adherence, and service uptake among LGBTQ+ Individuals in Uganda.

3.1 Data collection

This research consulted publications in the last 17 years, including studies, commentaries, and reports on the impact of faith and religion on HIV related stigma, treatment adherence, and service uptake among LGBTQ+ individuals relevant to Uganda and comparable contexts during the desk review exercise.

KIIs followed a semi-structured guide of key topics that included:

- Experience of faith and religious -based violence, exclusion, stigma or discrimination faced by LGBTQ+ individuals;
- Impact of faith and religious-based stigma on HIV service uptake and adherence for LGBTQ+ individuals;
- Positive experience or inclusive treatment of HIV services uptake for LGBTQ+ individuals;
- Views towards LGBTQ+ community;
- Recommendation for religious and faith leaders, health care providers, law lawmakers that would improve access to HIV health care for LGBTQ+ persons.

Data was collected through telephone calls and during one-to-one interviews with the respondents. Interviews were conducted in English and Luganda as determined by the respondents. They lasted for an average of 15 minutes. Where the respondents agreed, KIIs were recorded. In cases where the respondents did not agree to being recorded, this research relied on the data collection tools to transcribe the interviews into English for data analysis. Two members of the team who use Luganda as their mother tongue, separately analyzed the data collected in Luganda to ensure it accuracy. The principal investigator reviewed all the data as well as the audio recordings as a quality control measure.

Table 1 below shows how data was collected among each group and the total number of participants, faith disaggregation age groups, as well as gender or sexual orientation of each group.

Table 1

Group	Method	Number of key informants	Faith disaggregation	Age groups	Gender /Sexual orientation
General LGBTQ+ individuals	KII	**7**	**Muslim (2)** **People of faith (1)** **Anglican (2)**	**18-25 (1)** **26-30 (2)** **31-35(3)** **41-45(1)**	**Lesbian (2)** **Intersex (2)** **Trans man (1)**
			People of no faith (2)		Bisexual (1) Other (did not disclose (1)
LGBTQ+ individuals that live with HIV or has a partner that lives with HIV	KII	6	People of faith (1) People of no faith (2) Muslim (1) Catholic (1) Other did not disclose (1)	18-25 (1) 26-30(2) 31-35(1) 41-45(1) 46-50(1)	Intersex (1) Bisexual (2) Trans man (1) Lesbian (1) Other did not disclose (1)

Group	Method	Number of key informants	Faith disaggregation	Age groups	Gender /Sexual orientation
Faith leaders that are LGBTQ+	KII	5	Pentecostal (1) Other did not disclose (4)	31-35(1) 41-45(3) 46-50(1)	Intersex (1) Other did not disclose (4)
Faith leaders that live with HIV or have a partner that lives with HIV	KII	5	Other did not disclose (4) Anglican (1)	31-35(2) 41-45(3)	Other did not disclose (5)
Faith leaders that are allies or affirm of	KII	5	Other did not disclose (4) Anglican (1)	31-35(1) 41-45(3) 46-50(1)	Other did not disclose (5)
LGBTQ+ individuals					
General faith leaders	KII	7	Anglican (1) Catholic (1) Muslim (2) Pentecostal (1) Jehova's witness (1) Other did not disclose (1)	35-40(2) 41-45(2) 36-40(2) 46-50(1)	Cisgender Male (5) CisgenderFe male (2)
Persons of faith that live with HIV	KII	6	Other did not disclose (3) Muslim (1) Catholic (2)	25-30(2) 31-35 (2) 41-45(2)	CisgenderM ale (4) CisgenderFe male (2)
Persons of faith		7	Muslim (2) Anglican (4) Jehova's witness (1)	18-25(1) 31-35(4) 41-45(2)	Cisgender Female (4) CisgenderM ale (3)
Health care workers that provide HIV/AIDS services	KII	8	Anglican (2) Catholic (2) Muslim (2) Other did not disclose (1) Jehova's witness (1)	18-25(2) 31-35(4) 41-45(2)	Female (5) Male (3)
CSO workers that provide legal or health care services	KII	9	Other did not disclose (3) Anglican (4) Muslim (2)	18-25(2) 25-30(2) 31-35(2) 36-40(1) 46-50(2)	CisgenderFe male (4) CisgenderM ale (5)
Other persons related to HIV/ AIDS services	KII	6	Anglican (3) Catholic (1) Other did not disclose (2)	25-30(1) 26-30(2) 31-35(1) 46-50(2)	CisgenderFe male (4) CisgenderM ale (2)
Total number of respondents		71			

3.2 Data Analysis

The desk review exercise focused on analyzing literature on the impact of faith and religion on HIV related stigma, treatment adherence, and service uptake among LGBTQ+ individuals in Uganda and comparable contexts. This research also interrogated the state of HIV infections in Uganda as it relates to LGBTQ+ individuals. It further explored the influence of religion and faith on practices, attitudes, laws, and policies as they relate to LGBTQ+ and access to HIV-related services.

Data analysis of interviews was conducted by reviewing transcripts to identify themes. Following this, transcripts were analyzed to describe and compare the experiences across different key informants. Themes were grouped into categories and mapped into a conceptual model to explain the impact of faith and religion on HIV related Stigma, treatment adherence, and service uptake among LGBTQ+ Individuals in Uganda**.**

4.0 Findings

4.1 Literature Review

Drivers of HIV stigma towards the LGBTQ+ community

Contemporary attitudes in Uganda, including myths and stereotypes, perpetuate stigma, hate, alienation, and discrimination towards LGBTQ+ persons. They also project LGBTQ+ individuals as one of the causes for the country's problems. There is also a related common perception that homosexuality is a foreign imposition. These myths are often reinforced by influential persons, including religious, faith, and political actors, the media, and traditional leaders. While Uganda has been hailed as a model in the fight against HIV, these attitudes have undermined progress in eradicating this epidemic. Religion and faith play multiple roles in reducing and contributing to stigma and discrimination and in facilitating access to HIV-related services for key populations (KPs). HIV continues to be a critical public health challenge in Uganda, with young people aged 15-24 disproportionately affected by the epidemic. 8 While the United Nations has reported optimistic news about controlling the global epidemic of HIV, Uganda's infection rates are growing. Public health officials say that the trend is partially tied to stigma faced by at-risk groups like gay men and sex workers.9 According to a prominent activist:

"The situation of LGBTQ+ people in Uganda is difficult. It is simplistic to say that these difficulties are as the result of social attitudes or discriminatory laws. People's social attitudes towards LGBTQ+ people are affected by the law, but on the other hand the law is what it is because of people's religious views and the influence of religion over politics."

Influence of religion and faith on AHA 2014 and 2023

In 2009, the Family Life Network, led by Pastor Stephen Langa, and three American evangelists led by Scott Lively of Exodus International, held a three-day conference during which it was claimed that homosexuals had an agenda to take over the world and annihilate the family. Following a meeting between this group and the then Minister of Ethics and Integrity, Hon. James Nsaba Buturo, the Minister announced that a new and stronger law against homosexuality, than the Penal Code Act, was in the offing.11 Soon after the Minister's announcement, legislator David Bahati introduced the Anti-Homosexuality Bill, which was dubbed by the media as "the Gay Death Penalty Bill". He is reported to have claimed that:
"Homosexuality is against our values."

In February of 2014, President Museveni signed the Bill into law (AHA, 2014). The President claimed that he had received advice from medical professionals that there is no gene for homosexuality and that such relationships are deviant conduct. 13 In March 2014, the Court declared AHA, 2014, null and void because of the way it was passed, not because of its provisions. Parliament passed the law without the required quorum.

In February 2023, the Inter-Religious Council of Uganda vowed to do everything possible to return AHA, 2014, to Parliament as one of the measures proposed to tackle homosexuality in schools.14 When introducing the new Anti-Homosexuality Bill before Parliament on 9 March 2023, the Speaker, Hon. Anita Among, described the proposed legislation as concerning the morality of the people of Uganda and its children. She further insisted that to avoid the challenges that afflicted AHA, 2014, Members of Parliament (MPs) would be called by name to vote, which would also enable Parliament to identify homosexuals. She stated that:
"The overall objective of the Bill was to establish a comprehensive and enhanced legislation to protect the traditional family through prohibiting sexual relations between persons of the same sex, strengthening the nation's capacity to deal with emerging threats to the traditional family, protecting the cherished culture of Uganda, children, and the youth, who are vulnerable to sexual abuse."

The Anti Homosexuality Act, 2023 (AHA,2023) was passed with overwhelming support of Parliament and signed into law by the President. Following these events, the international community imposed sanctions against Uganda. The state minister for Sports, Hon. Peter Ogwang, urged MPs not to be intimidated by the Western World's withdrawal of aid that was meant to tackle HIV in the country. He disparaged:
"Have they been giving us that aid for purposes of promoting homosexuality in Uganda? Studies have shown that homosexuals are spreading AIDS. Friends, do not be shy. You were born to be in Uganda and we will remain Africans".

Impact of AHA,2023 on HIV and other services uptake among LGBTO+ persons

Before the law passed, HIV prevalence among gay men in Uganda's capital city was three times higher than other men.

Those who voted for the law, for instance, member of Parliament Dr. Michael Lulume Bayigga, said that gays and lesbians can still receive treatment like anyone else, because patients aren't required to disclose their sexuality.

Impact of religion-based stigma on HIV service uptake among the LGBTQ+ community

According to a study carried out by the Emory School of Public Health in Uganda and Kenya,16 FBIs work under strict adherence to religious doctrines and the policies of the "mother church." Catholic FBIs follow Catholic rules and doctrines, while others such as Anglican, Coptic, and Muslim adhere to guidelines established by their respective religious bodies. This adherence to established religious doctrine and church policy is credited with the attitude of FBIs towards LGBTQ+ communities. These structures are responsible for the emphasis on salvation as opposed to service LGBTQ+ individuals and such members of this community regularly complain of being preached to and condemned instead of being served without discrimination. However, religious authorities and doctrines are credited with inspiring the work that FBIs carry out in communities.

Effect of policy driven stigma on access to HIV-related services for the LGBTQ+ community

A study conducted by the Strategic Repose Team from September 2023 to May 2024 reported that LGBTQ+ individuals were terminated from employment and experienced exclusion from social services, to mention some of the effects of AHA,2023 on the LGBTQ+ community.17 For more than a decade, Uganda was a model of effective HIV education, treatment, and research. The country's HIV death rate was slashed by nearly 90% between 1990 and 2019, and Uganda set a goal of zero new HIV infections by 2030. 18 Experts from the Global Fund to fight HIV, tuberculosis and malaria, PEPFAR, and UNAIDS have said that AHA, 2023 threatens progress in the country's HIV response, which has been one of the most successful in the African region.19 The Gilead Sciences and the Gilead Compass Initiative track knowledge and attitudes around HIV and HIV stigma. In their 2024 report, they noted that there has been a significant decrease in the beliefs related to stigma and HIV over 5 years, from 89% in 2020 to 85%. However, the report observes that ending stigma and increasing public education about HIV remain urgent.20 Uganda Prisons Service (UPS) has reported that the prevalence of HIV and associated diseases is disproportionately high among prisoners relative to the general population21. This is attributed to several factors, including overcrowding, risk behavior, poor sanitation, inadequate nutrition, exposure to violence, and limited health services that contribute to disease transmission. This report further notes that approximately a third of prisoners (35.2% of men and 30% of women) reported it was possible to have sex with someone whilst in prison, and almost half of the prisoners (47.7% of men and 43.1% of women) thought they would not be able to avoid sex whilst in prison. The survey established that 30.3% of men and 29.4% of women feared they were likely to get infected while in prison, and 17.5% of men and 17.2% of women thought they were likely to infect others while in prison.

UNAIDS has reported that 38% of people living with HIV who were surveyed in 25 countries in 2024 claimed that they had suffered internalized stigma in the past 12 months.22 In these countries, 26% of sex workers, 16% of gay men and other men who have sex with men (MSM) , 40% of people who inject drugs, and 49% of trans and gender diverse people reported experiencing stigma and discrimination during the same period. Stigma and discrimination are widely recognized as factors that fuel the HIV epidemic.

Uganda's success in combating HIV has been attributed to a number of factors, including political, religious, and societal engagement and openness of the actors that combat stigma and assist prevention efforts.

Regardless of strategy or vehicle responsible for Uganda's achievements, faith and religion play an important role in preventing new infections as well as in driving stigma towards LGBTQ+ persons in Uganda.

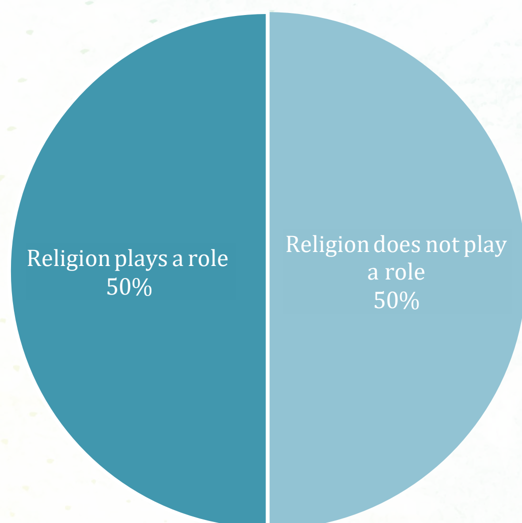
4.2 Key Informant Interviews

Experience of faith and religion-based stigma among LGBTQ+ individuals when accessing HIV services.

Role of religion and faith in the Lives of LGBTQ+ persons

LGBTQ + participants, including members of the general LGBTQ+ community, faith leaders, and people of faith who are LGBTQ+ or live with HIV or have a partner who lives with HIV, were divided on the role of religion in their lives. One-half or 50% of these participants stated that religion did not play a role in their life, while the other 50% claimed that it did. Persons who attended places of worship regularly, prayed, and continued to read holy texts noted that religious teachings are commonly employed to stigmatize their sexual orientation.

Figure 1: Role of religion and faith in the lives of LGBTQ+ persons

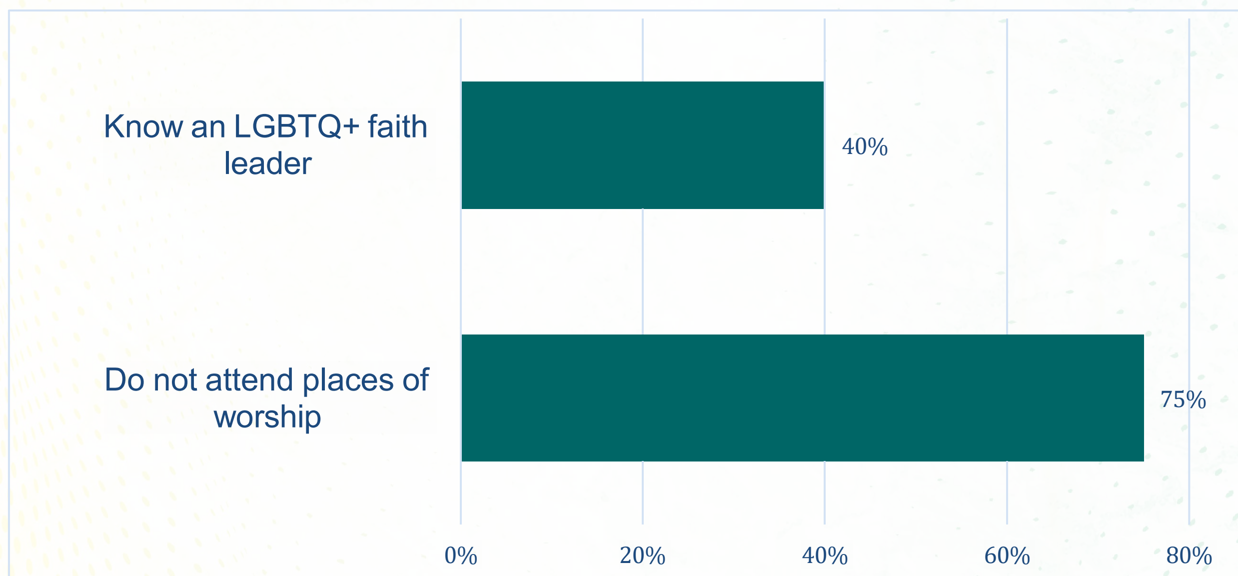


Save for two, LGBTQ+ faith leaders and faith leaders that are allies or affirming of LGBTQ+ individuals declined to state their denomination or branch of faith, while members of the general LGBTQ+ community, regardless of the role of religion in their lives, disclosed their branch of religion or reported that they are not people of faith. An LGBTQ+ faith leader R.B.5. described his double life. He exclaimed

"I was forced to marry because I am a man of God and I can't live without a woman. I am currently married, but we don't even sleep in the same bed."

75% of the respondents from this community stated that they do not attend places of worship because of the negative experiences they had experienced in such settings. At least two individuals reported to have been excommunicated from places of worship. However, 40% of this group of respondents claimed to know a faith leader who is an LGBTQ+ individual.

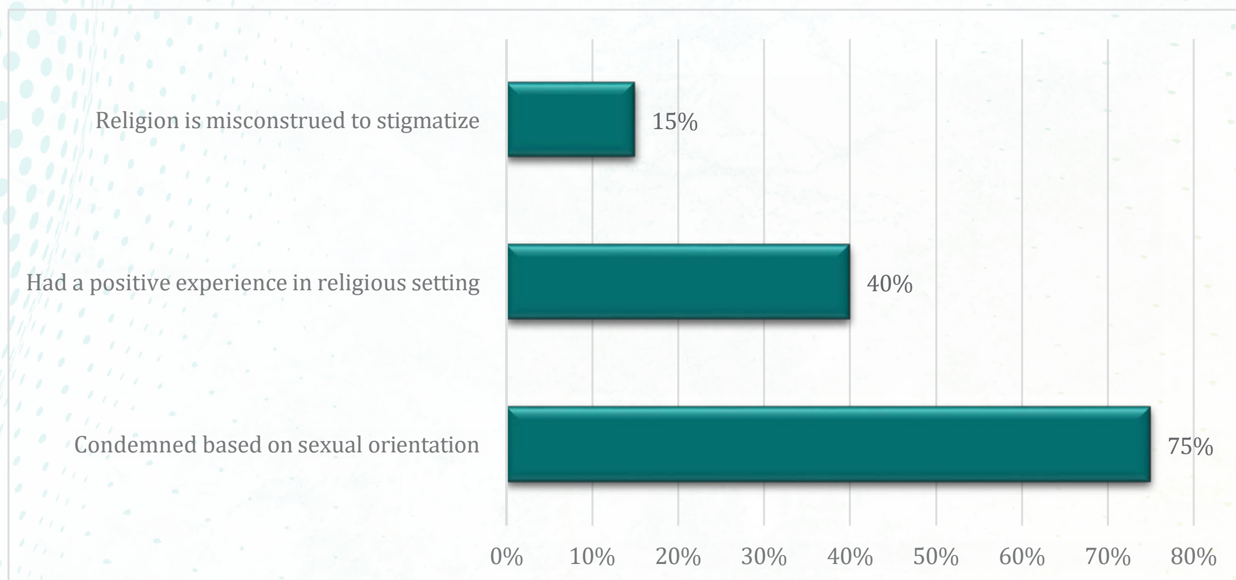
Figure 2: LGBTQ+ persons' experiences with places of worship



General LGBTQ+ individuals overwhelmingly (75%) reported that faith and religion perceive their sexual orientation as a curse or condemn it. They also stated that religion and faith play a major role in forming negative public perceptions about their sexual orientation. Related, the LGBTQ+ community claimed that religious teachings have been used by influencers and politicians to vilify them and deny them their rights. 5% described a positive experience in religious settings where the clergy was aware of their sexual orientation. However, this group stated they had not disclosed that they live with HIV or have partners who live with HIV. Minority (15%) from this community felt that religion has been misconstrued to stigmatize them, in the words of M.L.2,

"I am a person of faith, and I know Allah granted unto us love and free will as the greatest gift to humanity. Unfortunately, some people have failed to acknowledge that love is gender free and that no one ought to control another's choice or freewill".

Figure 3: Faith or religious setting perceptions and experience of LGBTQ+ persons



Impact of religion and faith-based stigma on HIV services uptake among LGBTQ+ persons

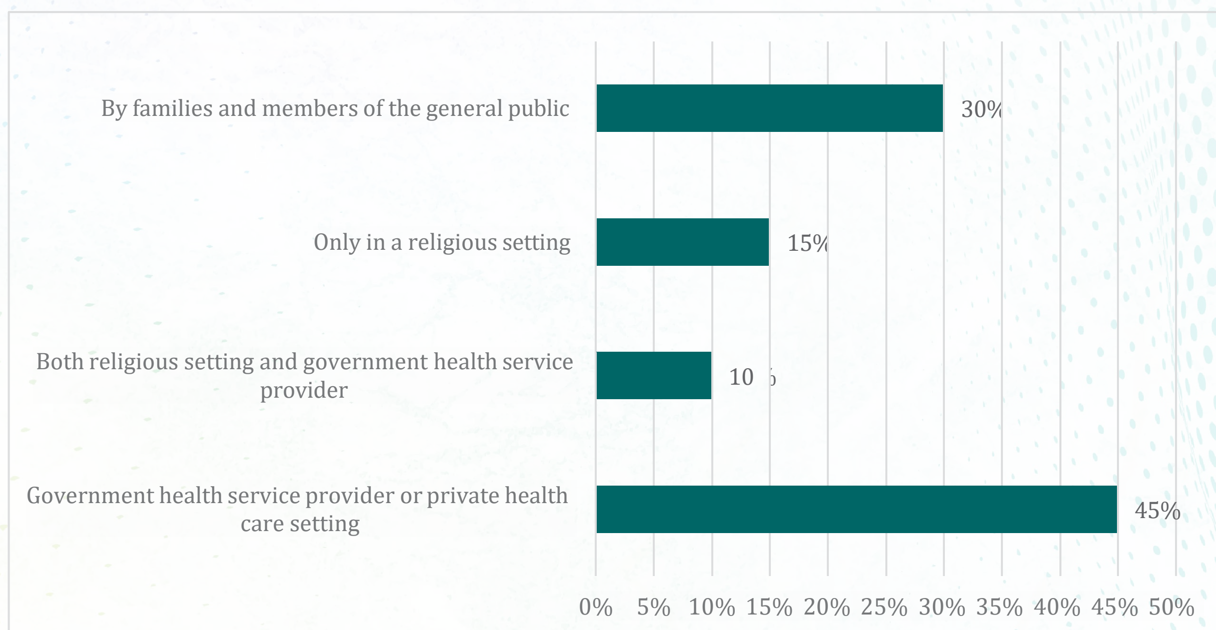
When asked if they or any LGBTQ+ person they know had experienced violence, exclusion, stigma, or discrimination based on faith and religious belief, all members of the LGBTQ+ community responded to this question in affirmative. 45% of the respondents stated that they had faced this experience at a government health service provider or in a private health care setting, while 10 % stated that they had suffered such treatment in both religious settings and at a government health service provider. Families and members of the general community were cited by 30% of the respondents as perpetrators of this treatment in health settings. The former group (60%) was also defiant to the stigma, they claimed that they will disclose their sexual orientation, continue to access health services, and will not be deterred by the ill treatment. Some participants (15%) reported that they had experienced this treatment in a religious setting. 25% percent of these respondents described a positive experience at selected government and private medical health facilities. Another respondent from this group commended the attitude and practice of the HIV key populations (KPs) focal person at an inclusive HIV/AIDS health facility and described their ability to either empathize or sympathize with members of the LGBTQ+ population. This enables LGBTQ+ persons to feel that they are welcome and safe to receive health services at the facility.
M.L.3 stated

"At the government facility where I would acquire HIV services from, there were medical personnel trained to handle LGBTQ+ people situations. The medical personnel had been sensitized about our issues."

One individual described that while as a couple they were seeking healthcare at religious-based health facility, the other partner called out 'hubby' from a consulting room. On entering this room, the doctor saw the tattoo of the face of the partner on this respondent's arm, and he asked them to leave the facility immediately.
M.L.4 described that

"Yes, people randomly ask about my sexuality at the government health facility where I usually go for HIV treatment, the nurses often loudly label me a homosexual, shaming us in public".

Figure 4: Settings where LGBTQ+ persons experienced violence, exclusion, stigma or discrimination



All the LGBTQ+ participants described that HIV/AIDS services are offered to all without considering if the individual is a Muslim, Anglican or any other faith.

90% of LGBTQ+ individuals who live with HIV or who have a partner that lives with HIV stated that they and their partners will not disclose their sexuality while seeking medical services, however only 40% claimed that they had been asked to disclose their sexuality when seeking medical services. The latter group also reported that they will only seek medical services from selected healthcare providers that have been trained in working with KPs. In such a setting, they would disclose their sexuality. None of the LGBTQ+ respondents who live with HIV or who have a partner who lives with HIV reported that they had received healthcare services from a faith-based facility.

Two LGBTQ+ individuals who live with HIV decried the shortage of HIV services in rural communities.

Religious and faith attitudes and practice to providing HIV services to LGBTQ+ persons

Faith leaders, including people of faith, discussed their attitudes and practices towards the LGBTQ+ community as it relates to HIV service provision. Same for those that are allies or that affirm this community, but including those that live with HIV that are not members of the community, 70% condemned the LGBTQ+ community, describing them as unacceptable in their religion as well as their culture. They disparaged homosexuality as a foreign behavior and a chosen lifestyle that is responsible for spreading HIV. This group also cited their communities, laws, and practices as disapproving of LGBTQ+ individuals. M.L.7 expounded

"Leviticus 18:22 says that no man should have sex with a fellow man, it is a sin. I was raised by staunch Baganda parents who always advised me against homosexuality and even refused to take me to a single sex school in fear that I might become a homosexual. The Anti-homosexuality law in this country prohibits homosexuality and it is punishable by death".

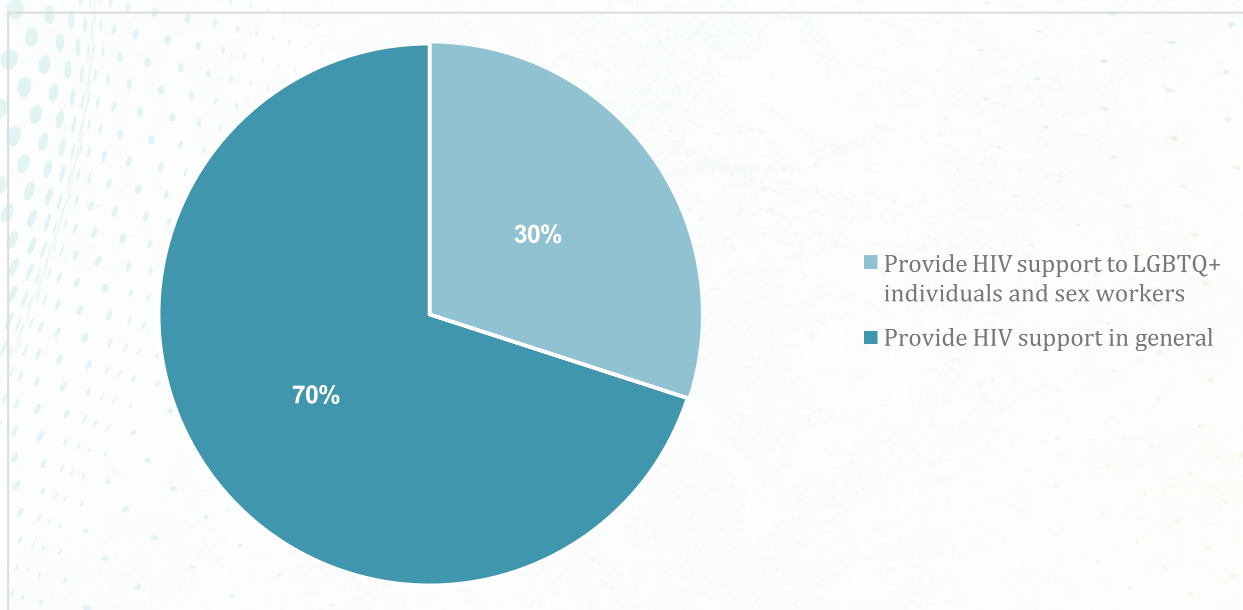
25% of LGBTQ+ faith leaders and faith leaders who are allies to the LGBTQ+ community commonly take a contrary view. They do not believe that there is a contradiction between their sexuality or their allegiances to the LGBTQ+ with their faith and religion. They expressed that individuals should be able to make choices about their lives. This group also stated that some FBIs established services in communities out of compassion for minority groups with the aim to improve their lives through their targeted services. To further this mission and reach a large portion of these groups FBIs do not charge for services. According to M.L.20

"God is for us all; there is no one below that. I have seen some religious leaders advancing hate speech through preaching. That is ungodly, for God demands us to love one another in every way. Roman 15:7 says accept one another just as Christ accepted you in order to bring praise to God."

LGBTQ+ faith leaders and faith leaders who are allies or affirming of the LGBTQ+ community criticized the law that criminalizes same sex relationships describing it as an instrument of hate that is used by some politicians, people of faith and the public to isolate people who make different choices and to deny them their rights and services, including access to HIV treatment. 95% of the faith leaders stated that their FBIs provide services including health care, mentorship, prayer groups, and education in the communities. 70%claimed that they provide HIV support, but only 30% stated that they provide HIV support services to LGBTQ+ individuals and sex workers. Both groups cited their religious or faith values and common decency as the basis for providing these services. A member of this latter group R.B.1. exclaimed

"The church should be a place of worship and acceptance for all people without discriminating against them, but accepting them the way they are. The world is full of people with different beliefs, and the way they see things is different but God does not punish them."

Figure 5: Attitudes towards provision of HIV support to LGBTQ+ persons



Attitudes and practice of healthcare and legal services providers towards LGTBQ+ persons and MSM that live with HIV

HIV/AIDS health service providers, CSOs that provide health or legal services, people who work in the HIV/AIDS sector, and members of the general public also described their experiences, including attitudes and practices related to the impact of faith and religion on HIV -related stigma, treatment adherence, and service uptake for LGBTQ+ Individuals. A prison officer, while admitting that HIV infection rates in prison are higher than in the general community, reported that:

"We do not have key populations in our prison setting. We treat each prisoner according to their natural birth. In terms of treatment, it is equal treatment without discrimination. We have on-entry screening for every prisoner. Anyone found with HIV, TB or any other communicable disease is treated. Each prison has a medical staff, and each prisoner is attached to a medical facility. This allows all prisoners to take their medication. Our facilities are designed for males and females only."

An employee of a CSO that works in the health sector stated that she was not comfortable with discussing LGBTQ+ issues because her organization does not work with this group. She did not disclose why they do not work with LGBTQ+ individuals; however, she explained that her faith does not encourage acceptance of this community. Another CSO health sector work M.L.35. expressed that homosexuality is a chosen lifestyle according to her religious subscription. She declared that

"The Bible talks about how Sodom and Gomorrah were destroyed due to unacceptable sexual behavior. Because the Bible that serves as our reference document is against it. The practice is also against African culture."

A health care service provider of strong religious conviction, M.L.33. dismissed the narrative that LGBTQ+ persons are born homosexuals. She expressed her support for AHA, 2023, stating that it is aimed at preventing a wrong from being done. She further expounded that

"I am a nun and I can tell you that God himself or herself, because we don't know his or her sex, does not love homosexuals and the religious teachings are in line with the will of God." She stated that her FBI provides HIV/AIDS services, but she and her colleagues are not aware of any LGBTQ+ individuals who access these services. She further stated that:

"Personally, I would not refuse to treat an HIV positive person because they are homosexual. That would be against my professional standards, although it would affect my conscience. I would also advise my colleagues to do the same regardless of how it makes them feel."

While expressing their strong conviction in faith as well as in embracing all humans, several members (30%) of CSOs that work in the legal and health sector, as well as HIV health care, disparaged the stigmatization of the LGBTQ+ community. One of them, R.B.7. reported that his CSO provides legal services to LGTBQ+ individuals. This group broadly (60%) expressed acceptance for the LGBTQ+ community, and they empathize with the struggle and stigma that the community encounters in seeking health care services. Some respondents from this group also referenced their commitment to the Hippocratic Oath to serve all in need. According to R.B.3. a HIV health services provider:

"They (LGBTQ+ Persons) are like us, and we need to welcome them. According to my faith, we do not distance ourselves. I am supposed to get to them and support them from that kind of behavior and get them to what God wants them to be."

A health care worker in the HIV/AIDS sector who self-described as an ally to the LGBTQ+ community, M.L.35, stated that

"The law against homosexuality is a detective. It affects various sections of the LGBTQ+ people, such as those living with HIV, in that some fear to access medical care."

M.L.34, a health sector CSO employee, urged health care providers to provide services indiscriminately. While she expressed support for AHA, 2023, she called for the law to be revised to stop fear among LGBTQ+ individuals from accessing HIV-related services.

A legal services provider R.A.1 stated that:

"The Bible says that love your neighbor as yourself and do for others what is done to you. My interpretation of Biblical teachings is that it brings contradictions. The Bible is consistent on homosexuality; it condemns the act not the person."

Two inclusive HIV/AIDS healthcare service providers reported that they and their colleagues had experienced criticism and condemnation from religious leaders and politicians because of their work. Despite their strong religious conviction, they continue to work unperturbed. 65%of CSO workers in the legal and health care sectors reported not providing any form of services to LGBTQ+ individuals. This is because these individuals are unacceptable in their faith, culture, and under the law. This group claimed to provide a variety of services, including HIV/realted services, sexual health and reproductive rights as well as gender-based violence advocacy and legal assistance. However, 45% of all CSO workers claimed to be people of passive faith.

5.0 Interpretation of Findings

Religion, faith, culture, law, and personal convictions: the hierarchy that influences attitudes and practices towards LGBTQ+ individuals who live with HIV.

The data reveals that the practice and attitudes to HIV treatment and service uptake for LGBTQ+ are mainly influenced by faith and religion, culture, law, and personal convictions in this order. There are fundamental disagreements and contradictions regarding the religious and faith teachings as they relate to LGBTQ+ persons. LGBTQ+ persons who live with HIV face risks due to limited inclusive services. Fueled by deeply felt responses including fear of infection, moral, faith, and religious outrage, and shame, those living with HIV are shunned, denied care and support, or avoid life-saving medical care out of rejection.

LGTGQ+ individuals subscribe to religion and faith, however they reject related teachings that marginalize them

The majority of the participants in this study professed to be religious or people of faith, with a handful claiming not to subscribe to any of these or choosing not to disclose their faith. LGBTQ+ persons are divided on the role of faith and religion in their lives; half of this group claimed that it

plays a minor role. They however overwhelmingly rejected religious teachings that stigmatize them. The dominant religions among the respondents were Islam, Catholicism, and Anglicanism. This is representative of Uganda's society, according to the national population and housing census 2024. HIV stigma towards LGBTQ+ persons is common among all religions or faiths, ages, professions, and cultures. Places of worship are reported to excommunicate LGBTQ+ persons, although a few are known to embrace this community. In some cases, LGBTQ+ individuals have

opted not to disclose their sexual orientation or that they live with HIV in order to be included in religious, faith, government, and private health care settings. Others had turned to atheism to escape the endless scrutiny and condemnation from religions or faith, while some are defiant in their beliefs dismissing the stigma as a misconstrued interpretation of faith and religious teachings.

Healthcare service providers embrace persons that live with HIV, except for members of the LGBTQ+ community

Whereas the broader community of participants were respective to caring for and embracing persons that live with HIV, the majority rejected the LGBTQ+ community including individuals from this community that live with HIV. This position is largely influenced by religious and cultural beliefs.

Religious and faith leaders that are LGBTQ+ individuals are reluctant to disclose their faith

LGBTQ+ faith leaders and people of faith, including those who live with HIV or who have a partner who lives with HIV, are reluctant to disclose their faith or religion in fear of going public against faith and religious teachings, albeit some privately criticize such ideologies. This is also true for religious leaders who are allies or affirming of the LGBTQ+ community.

Religion, faith, culture and law driven stigma adversely affects HIV services uptake among LGBTQ+ persons

There are reported experiences of stigma and discrimination in the daily lives of LGBTQ+ persons who live with HIV, including in religious, family, general community, and health care settings. Lived experiences of LGBTQ+ individuals depict a hostile environment driven by deeply entrenched religious, faith, cultural, and legal stigma. This has adversely affected their access to HIV treatment, adherence and service uptake and arguably undermined efforts to curb infections. None of the LGBTQ+ persons interviewed worked as an HIV focal person for KPs.

Faith and religion are major influencers of negative and positive attitudes as well as practices towards providing HIV-related services to the LGBTQ+ community

The relationship of religion and faith with the broader society is a key driver of attitudes and practices to HIV treatment adherence and Service uptake for LGBTQ+. A minority of FBIs that provide HIV services reference religion and faith as the basis for providing these services. They established these services in communities out of compassion for minority groups with the aim of improving their lives through targeted services. To further this mission and reach a large portion of these groups, they do not charge for the services.

Inclusive healthcare providers work in an environment that is hostile to LGBTQ+ persons.

Inclusive HIV service providers face challenges to providing such services to LGBTQ+ persons in an environment that is hostile to this community; consequently, these services are accessed through discreet frameworks or government facilities. Social support is an important protective factor for a number of health outcomes, including curbing infections and treating persons from the LGBTQ+ community who live with HIV. Inclusive HIV health care providers provide services via social networks, social interaction, and support. Frequenting religious services for many LGBTQ+ adherents provides these individuals with regular social interaction, as well as a sense of community and mutual support. There are few formal social institutions that provide people with similar access to social resources. Such support, if accessible to LGBTQ+ individuals who live with HIV, could have beneficial effects on health outcomes.

Faith, religion, culture, and law influence attitudes to understanding sexual conduct among inmates

Prison authorities are dismissive of sexual behaviors of inmates, explaining these as related to other challenges, including overcrowding and antisocial behavior, despite the alarming rates of HIV infection. This failure to recognize different sexual orientations

is founded in religion or faith as well as culture. It undermines attempts to curb HIV infections. AHA, 2023 has impeded LGBTQ+ rights activists from engaging in constructive dialogue with policy makers and implementers, as well as HIV healthcare service providers. The fear is that such engagements amount to "promoting homosexuality" which is prohibited by AHA,2023. When describing factors that motivated their work with members of the LGBTQ+ community, participants mentioned religious and ethical values. Respondents gave generic recommendations that reflected their attitudes and practices. For instance, participants from the inclusive camp called for embracing LGBTQ+ persons and for providing inclusive HIV services to KPs, while exclusionists condemned inclusive HIV/AIDS services as encouraging immoral behavior that is anti-religion and faith and culture and against the law. There is a relationship between the AHA, 2023, and attitudes as well as practice in providing LGBTQ+ persons with HIV services. Some of the respondents, albeit a minority, think it is against the law to provide such services to the LGBTQ+ community. LGBTQ+ individuals called on stakeholders to expand HIV services to rural communities. Efforts in addressing barriers to access to HIV services for the LGBTQ+ must not be limited to understanding and addressing barriers such as stigma, cultural norms, but must also address economic empowerment, limited access to information that increases HIV vulnerability.

Partnerships between stakeholders such as FBIs, health services providers, donors, civil society, and the private sector are essential for creating a coordinated and sustainable response to HIV.

6.0 Recommendations and Future Actions Rights/ Healthcare Activists

Programmatic

Evidence based advocacy

1. Rights activists should conduct evidence-based advocacy with the view to sensitize policy actors and implementers, the donor community, as well as HIV service providers, about the adverse impact of religion, faith, culture and policy on efforts to combat the spread of HIV. Such engagements should navigate policy, religious, faith and cultural challenges related to the AHA, 2023. They must also be founded in evidence-based research.
2. Development agencies should conduct future studies to interrogate the role of culture driven stigma in influencing practice and attitudes towards providing HIV services to LGBTQ+ persons.
3. Development agencies should aim to focus on the leadership of faiths and religions in order to enlist official positions regarding the LGBTQ+ community.

Practice and policy reforms:

4. Advocates for health care should engage in campaigns that decriminalize LGBTQ+ persons and promote non-discriminatory HIV service provision
5. Advocates for health rights should seek to influence practice and attitudes towards providing HIV services to the LGBTQ+ community.

Capacity building

6. Rights activists should capacitate members of the LGBTQ+ community to work as HIV focal persons for KPs.
7. Advocates for healthcare should target LGBTQ+ individuals in key hot spots where they are known to frequent through peer outreach and provide them with services and information on preventing and treating HIV.

All stakeholders

8. Stakeholders should aim to ensure that HIV information is disseminated in various local languages and braille.
9. Stakeholders should engage in advocacy aimed at ensuring that all HIV/AIDS health care service providers have a focal person for KPs.
10. Stakeholders should aim to include the inmate population in programmatic interventions aimed at combating HIV.
11. Stakeholders should adopt an inclusive code of conduct or practice for accessing HIV services that health service providers can voluntarily subscribe to with benefits, for instance, funding. The Patients Charter issued by the Ministry of Health maybe revised if it is not sufficient in this regard.
12. Stake holders should aim to influence attitudes and practice towards providing HIV treatment to LGBTQ+ persons in their programing activities

Ministry of Health

13. Government facilities should train focal personnel for KPs, who should also intern in such facilities to adopt best practices.
14. To facilitate inclusive access to HIV services, duty bearers should provide a safe environment that is free from hostile communities for LGBTQ+ that live with HIV
15. Health service providers should expand HIV services provision to rural areas.

Faith-based Institutions

16. Faith leaders must demonstrate active leadership in HIV response by integrating stigma reduction, inclusive messaging, and service promotion into their ministry and outreach. This means preaching compassion, hosting HIV education sessions, and visibly supporting access to care for all including LGBTQ+ individuals.
17. Leadership of faith-based institutions must publicly affirm their commitment to non-discriminatory HIV service provision by issuing inclusive policy statements and ensuring LGBTQ+ persons are not excluded from care**.** This includes reviewing internal policies, training staff, and creating safe, stigma-free pathways to HIV services.

Health Services Providers

18. Encourage focal persons for KPs to prioritize offering mental health services such counseling, especially for LGBTQ+ individuals that liv with HIV.
19. Train HIV focal persons for KPs and offer them safe, rewarding and secure employment in order to retain them.