NAIROBI EVANGELICAL GRADUATE SCHOOL OF THEOLOGY

THE EXPERIENCESOF KAYOLE WOMEN WHO ARE INFECTED OR AFFECTFD BY HIV/AIDS: IMPLICATION FOR CHRISTIAN WITNESS

BY,
CROWN ABIOLA

A Thesis Submitted to the Graduate School in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Mission Studies

JULY 2005

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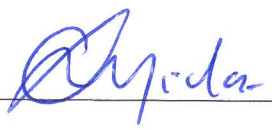
July, 2005

Student's Declaration

THE EXPERIENCES OF KAYOLE WOMEN WHO ARE INFECTED OR AFFECTED BY HIV/AIDS: IMPLICATIONS FOR CHRISTIAN WITNESS

I declare that this is my original work and has not been submitted to any other college or University for academic credit.

The views presented herein are not necessarily those of the Nairobi Evangelical Graduate School of Theology or the Examiners.

(Signed) 

Crown O.Abiola

July 2nd, 2005

ABSTRACT

This study explores the experiences of Kayole women who are infected or affected by HIV/AIDS and its implications for Christian witness.

A qualitative research designed employing phenomenology tradition was used for the study. Data was collected using face—to—face open—ended interviews that were recorded and transcribed. I used moderate participants' observation to build rapport with the informants.

Findings revealed that the general perception of, and approach to women who are infected or affected by HIV/AIDS is an underlying factor behind their unpalatable experiences.

Based on findings, women who are infected or affected by HIV/AIDS are in dire need of true and meaningful relationships. This provides platform for the evangelisation. The Church must engage in a holistic ministry in meeting their needs.

To

Every woman, who is living with HIV/AIDS. God cares and I care for you too.

ACKNOWLEDGEMENTS

My profound gratitude goes to the Almighty God for standing with me throughout this graduate study. Except the Lord had been on my side, I would have been consumed.

I will like to acknowledge and appreciate the influence and support of my husband Rev. Dr. Isaac Crown. Knowing him brings the greatest opportunity to bring out my hidden potential. Staying without him during the study was quite challenging I appreciate every support received. Our three sons, Joshua, Joseph and Emmanuel sacrificed a lot for me to go through this graduate School. Emmanuel was exceptionally supportive in fixing the computer, editing and sitting by me at night. God bless their dear hearts.

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Two days before we left for Nairobi, my son told me that God said He has prepared an angel before us to take care of us. I have a feeling that that angel puts on a human clothing and a female feature in the person of Aunty Diana who, although we never met her before, became a pillar of trust, friendship and support. Aunty Diana, a big God bless you.

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I am grateful to Rev and Mrs Adepoju. For all the support, the Lord bless you.

To every member of Women With Purpose. Thanks for all your support, prayers and remaining with the vision in my absence. God bless you all.

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List of Abbreviations

AIDS:	Acquired Immune Deficiency Syndrome.
HIV:	Human Immunodeficiency Virus
MAP:	Medical Assistance Program.
NGO:	Non Governmental Organization.
WWP:	Women With Purpose

TABLES

CHAPTER ONE

INTRODUCTION

The issue concerning AIDS that faces Christians today challenges the very core of their faith. Many questions are asked and no answers are apparent. The disease continues to spread like plague in Africa—statistics today is shocking. "Although HIV is a global phenomenon, sub—Saharan Africa accounts for the 71% of the 34.3 million men, women, and children estimated to be living with HIV at the start of the 21st century (Onyango Dorothy 2003, 1). Most people infected in Africa are parents with young children. As a result, Africa has experienced a catastrophic increase in the number of children living in Aids-affected households or struggling to survive after the death of one or both parents. The burden of caring for these orphans often falls upon the shoulders of aged grand parents, at a time when their own health, strength and economic well—being are starting to decline. As a result, hard won gains in life expectancy and child survival are being wiped out in many countries. In sub—Saharan Africa, the number of people newly infected with HIV in 1999 was 4 million, most of whom are expected to die of AIDS within the next ten years. AIDS is gripping Africa more than any other continent, yet in many African countries, the HIV epidemic has been surrounded with a wall of silence for the past two decades.

A decade ago, public health authorities and the public in general virtually equated AIDS transmission with male homosexual activity, yet they estimated that of the 18 million adults infected with HIV worldwide today, over 8 million were women. It was

estimated that by mid—1990s, as many adult women as men would have been infected by HIV globally (Edlin 1994, 332).

According to General Medical Journal (GMJ) news, the proportion of women and girls with HIV has increased in every region of the world since 2002. A new report from UNAIDS, the joint United Nations program on HIV and AIDS, shows (Raghav 2004). The report says that nearly half of the estimated 39.4 million people in the world infected with HIV today are female: the proportion in 1998 was 41%. The proportion is highest in sub Saharan—Africa, which has three quarters of all women infected with HIV in the world. 57% of adults with HIV in this region are women. Among people aged between 15 and 24 years in this region, there are on average, 36 HIV positive women for every 10 affected men.

The sharpest increases in the proportion of women to men with HIV, however, have been seen in Eastern Europe, Asia, and Latin America, says the report. In Russia, for example, the ratio increased from 24% in 2001 to 38% in 2003.The report indicates that women may be benefiting less from current efforts to prevent HIV infection than men. According to UNAIDS this may be because most HIV prevention strategies assume an idealized world and fail to acknowledge the discrimination many women still face.

In East Africa, Kenya has an estimated 2.5 million people living with HIV/Aids—about 15 % of the total population. Out of this population, 8.7 % Women, especially young women, are disproportionately affected compared to 4.6% men

Behind this wall of silence, the reality of AIDS has been concealed and denied. For many political leaders and government officials, development planner and policy makers, teachers and educators, religious leaders, employers, members of the armed

forces, local communities and families, AIDS has been a shameful secret, a disease "that dare not speak its name".

Description of Kayole

Kayole is a suburban district about 20 kilometres to the east of Nairobi the capital city of Kenya. Kayole is an area with widespread unemployment and over—crowdedness. There is scarcity of water and electricity supply. Kayole is characterized with deadly sickness including HIV/AIDS, poor sanitation, roaming gangs and house lootings. Infectious diseases such as tuberculosis, whooping cough and food poisoning are wide spread in this area. HIV/AIDS has a higher tendency of thriving in this environment due to poor medical services, poor hygiene and nutrition. Prostitution and promiscuous living have become the answer to poverty. However, many people are industrious; they do small scale trading and grassroot projects are mushrooming everywhere

In Nairobi, these slum dwellers only occupy 1% of Nairobi's living space with about three thousand people living in a space of a soccer pitch. If all Nairobi residents were crowded like the poor, the city would contain two hundred million residents instead of its four million people (Niemeyer 1991, 193).

According to Women Fighting against AIDS in Kenya (WOFAK), majority of the infected persons in Kayole are women. Young women aged 15 to 24 are more than twice as likely to be infected as men in the same age group (Dorothy 2003).

Problem Statement

Despite international, national and local efforts, the HIV/AIDS pandemic continues largely unabated—more so in Africa. AIDS is primarily a sexually transmitted disease, and the principal key to its prevention is behaviour change.

"Prevention, the mainstream strategy, relies on behaviour change" (Okaalet, 2004). In order to change behaviour, however, people need both information and support. Providing these is a task that cannot be left to the health services alone, but requires the active involvement of all available means of communication especially religious organizations most especially the Christians who profess the truth. The challenge therefore is; how does the Church carry out her "Mission and Pastoral Care" in a context infested, infected and affected by HIV/AIDS?

This study seeks to assess and describe the experiences of Kayole women who are infected or affected by HIV/AIDS and implication for Christian witness.

Goal

The aim of this study is to gain insight into the world of women who are affected or infected with HIV/AIDS with special reference to women in Kayole. Understanding their perspective will facilitate the Christian approach to them in Missions. This study will further help the Christians to determine the way to respond to these women who are affected and provide hope for them.

Purpose Statement

The intent of this phenomenological study is to understand the experiences of women in Kayole who are infected and affected by HIV/AIDS; to identify the felt needs of the women in Kayole who are affected by HIV/AIDS; and to determine the extent to which the experiences of these women can impact Christian witness.

Research Questions

1. What are the experiences of Kayole women infected and affected by HIV/AIDS?

2. In what ways are the Kayole women who are infected and affected by HIV/AIDS trying to cope with the challenges of HIV/AIDS?
3. To what extent have the experiences of kayole women infected and affected by HIV/AIDS created a bridge gap between the Christian community and the Kayole women?

Significance of the Study

1. Through this study, I will gain significant insights into the lives of women who or affected and infected by HIV/Aids
2. The findings of this study will facilitate the work of those people who are interested in women ministry in their approach to women who are affected or infected by HIV/AIDS in Kenya and other parts of Africa where they have branches.
3. This study will contribute to the areas of missiological knowledge in responding to the challenges of HIV/AIDS and offer suggestions to the church in Africa in her endeavour to respond to the current problems affecting lives of people.

Assumptions

The outcome of the research will be influenced by assumptions and presumptions of the researcher. In this light, the researcher assumes the following;

1. Women who are affected or infected by HIV/AIDS are victims of circumstances (poverty, unemployment, sick husbands, unfaithful husbands, search for children) who need the love and care of the church.
2. In God's ultimate plan, everybody; affected or infected, needs to experience God's love. Rather than being object of God's judgement, they

are object of God's love. It is therefore the duty of the church to share the good news of God's love with them.

3. Most women who are affected or infected with HIV/AIDS need meaningful friendship and support.

Limitations

The data collection procedure covered only kayole women who were available to my fieldwork. As a foreigner, I used an accredited interpreter to interpret some of the statements my informants expressed in Kiswahili. Kayole is a far distance from the school hence doing the research was challenging in terms of finance and security.

Delimitation

Because of the diversity in kayole, I have sampled women from ohiayo areas as a representative of women infected and affected by HIV/AIDS in kayole area. The reason for this sample was based on the willingness of the women in ohiayo to share their struggles and experiences with HIV/AIDS.

Definition of Terms

Infected: Women who are infected with HIV/AIDS.

Affected: Women who are affected by HIV/AIDS widowed, separated, or divorced as a result of HIV/AIDS husbands.

Christian witness: Engaging in evangelism with respect to the realities of injustice, oppression, violence, and discrimination.

CHAPTER TWO

LITERATURE REVIEW

The role of the literature review in qualitative research is to compare and contrast the findings of a study with published literature. In this study, literature review on the subject of HIV/AIDS served as a basis for comparing and contrasting the findings. AIDS come from a virus called the human immunodeficiency virus, commonly called HIV. When someone is infected with the HIV virus, the person is said to be HIV positive. Some infected with HIV virus may not become sick right away. This virus can hide in the human body with no symptoms for several years. In developing countries, this can be between 5-7 years; in industrialized countries, 10-15 years. However, from the time a person is infected with HIV, they are able to spread it to others through their blood or bodily fluids shared thru sexual contact. It may also be passed from a mother to her child or through contaminated needles or blood.

HIV destroys special cells within the body which defend the body against other infections and diseases When these special cells are destroyed by HIV to the stage that the body can no longer fight off diseases and infection, the HIV positive condition changes into what is known as ACQUIRED IMMUNE DEFFICIENCY SYNDROME or AIDS. Sadly, HIV opens a way for other bacteria and cancers to freely invade the body. AIDS is rarely what actually kills a person; usually a secondary infection causes death.

According to the Centers for Disease Control and Prevention (CDC) surveillance report, Women are one of the fastest growing populations being infected with HIV, and the number of AIDS cases among women increases steadily each year. Women under 30 made up 22% of AIDS cases among women in 1996. Because the time from HIV infection to developing AIDS can be long, many of these women acquired HIV in their teens (1997).

While most researchers and writers are of the opinion that women are more affected with AIDS, Ashadeep feels it is a bit difficult and specious to conclude that women are increasingly affected by AIDS epidemic. Ashadeep argues for consideration of the accuracy of the margin error because sample groups can never be perfectly representative of a wider population, there will always be some degree of uncertainty attached to such figures (Ashadeep 2004).

Ashadeep substantiates his argument with the fact that HIV prevalence in developing countries is often difficult to measure–partly because much of the population does not have access to healthcare facilities and relies on traditional medicine. Therefore, HIV prevalence tends to be measured at whatever points the people does have contact with health staff. This is often at antenatal or STD treatment centers. "Obviously, this does not give a full picture of the spread of the epidemic in the country as a whole—the former will give an indication of the prevalence rate amongst sexually active women, the latter generally amongst presumably sexually non monogamous men (Ashadeep 2004).

He also observed that it is possible for HIV incidence to decrease at a time when HIV prevalence is increasing. For example, in a society where both education and treatment are adequately provided. Fewer new infections could occur, lowering HIV incidence, whilst people could live longer, increasing the number of

that world over, the numbers of women who have been and are being screened for HIV are far more than the men and children? (Ashadeep 2004).

Predisposing Factors for Getting Infected with HIV/AIDS

The GMJ news reported that not only were women biologically more vulnerable to HIV, but—driven by poverty and the desire for a better life—they commonly found themselves engaging in "transactional sex" in exchange for basic necessities such as money or accommodation, often with many and considerably older male partners.

The authors also say that society has to move away from the belief that long-term monogamous relationships are protective. Increasing numbers of infections within marriages reflected the fact that many men with previous or current other sexual partners transmitted the virus to their wives. Often women had no say in taking precautions against infection. As a recent study in Zambia shows, only 11% of women believed that they had the right to insist on condom use, even if they knew that their husband was HIV positive.

Abuse of any kind against women is strongly correlated with the risk of women contracting HIV infection, as various studies have confirmed. "Choosing to abstain or have safer sex is not an option for the millions of women around the world who endure rape and sexual violence", the report says.

Robert argues that HIV is not the cause of AIDS.

> For over 10 years I have rejected the HIV causes AIDS hypothesis because another hypothesis is far more explanatory and predictive; namely, that what is being measured in ELISA tests are non-specific antibodies activated in a variety of circumstances. Activation or increase in certain proteins, such as heat shock proteins, and genetic sequences, such as human endogenous retroviruses, also occur with

> many stressors, with overlap among these conditions, accounting for the sometimes absent sometimes present concordance between putative HIV antibody, HIV antigen, and HIV viral load tests (Robert 2004).

Substantiating his argument, he says that there are many ways to activate B cells to produce non-specific antibodies, some associated with serious illness (the titer of non--specific antibodies increases in many pre-terminal conditions), and some with usually trivial illnesses (such as the flu) and some with non-illnesses (e.g. pregnancy, flu shots). The orthodox literature demonstrates that at least 70 diseases (such as tuberculosis) cause "false positive" HIV antibody tests. The original group of 100 homosexual males who developed life-threatening opportunistic infections shared uniform histories of many years' use of psychoactive drugs, astounding (from an evolutionary perspective) amounts of interracial seminal fluid exposure, chronic polymicrobial enteric infections and long-term broad-spectrum antibiotic use.

> No doubt the interactive toxicities of these behaviors cannot be teased out easily, but they seem sufficient, without adding a virus, to account for morbidity and mortality. They also can account directly or indirectly for elevated levels of non-specific antibodies. Gallo demonstrated that very sick "AIDS patients" could accurately be distinguished from healthy "controls" (which were unmatched by disease or levels of hypergammaglobulinemia!) -- Not a great accomplishment since a granny could do the same with equal accuracy at a glance (Robert 2004).

Taking into account the observation that baseline non-specific antibody levels vary dramatically between races but not between the sexes, this hypothesis solves the dozens of paradoxes of the HIV hypothesis. Some examples: a) the 30 AIDS indicator diseases are not caused by an extremely versatile HIV; rather as people develop and progress through these diseases non-specific antibody levels rise, increasing the probability of testing positive to (among others) the HIV ELISA test, b) the male: female ratio of "HIV" positivist will simply reflect (for a given race) the male: female

female ratio of "HIV" positivist will simply reflect (for a given race) the male: female ratio of the disease in question, when matched for severity of illness, c) titers of "HIV antibody" will rise and fall based on the complex summation of factors which affect B-cell activation, d) those with black Africa in their genes have resting non-specific antibody levels much higher than whites. Oscillation in their gamma globulin levels is much more likely to reach the HIV positivist threshold; unfortunately, more trivial stimuli may get them there. Blacks are much more likely than whites to test positive to a variety of non-HIV antibody tests, also, such as Hepatitis C, indicating not infection but susceptibility to test positive to a lot of things which are not there, e) detecting a positive HIV test is an illness producing event: psychological trauma from the "diagnosis" and chemical trauma from the treatment artificially confirm the lethality of HIV, f) the fact that AIDS patients frequently test positive to a multitude of pathogens is not due to infection by all these different microbes; these are usually non-specific "false positives" just as the HIV antibody tests.

Male-to-female transmission is estimated to be eight times more likely than female-to-male; (Padian 1997,146) in 1997, 38% of women contracted HIV through heterosexual contact, as opposed to 7% of men. Reasons for this are twofold: there are more men than women in the US infected with HIV, which increases the likelihood that women would have an infected sex partner; and HIV is more easily transmitted from men to women due to the greater exposed surface area in the female genital tract (CDC 1998).

Different researchers and writers had also established that women can be affected or infected by HIV due to several factors: Sexually transmitted diseases (STDs) other than HIV can increase the risk of new HIV infections at least two to five

HIV to enter the body. (Wasserheit 1996). There are an estimated 12 million new cases of STDs every year, and populations at highest risk for HIV infection also have disproportionately high rates of other STDs. Treatment of STDs can be an effective HIV prevention strategy.

Injection and non-injection drug use puts women at increased risk for HIV infection and is strongly linked to unsafe sex. In one study, female IDUs reported sharing needles 32% of the time, and obtained used needles from their regular sex partner 71% of the time (Leonard 1996). Women who smoke crack cocaine, particularly women who have sex in exchange for money or drugs, are at high risk for HIV infection via sexual transmission (Edlin 1994,331)

> Sexual abuse and coercion places many women at risk. In one study, physical and sexual abuse were "disturbingly common" throughout life among women at high risk for HIV infection. Childhood sexual abuse (42%) and physical abuse (42%) was also common. Women who have been abused are more likely to use crack cocaine and have multiple sex partners. (Vlahov 1996).

Public health agencies need to raise public awareness about sexual abuse and coercion and help women and men develop the skills needed to prevent it (Murphy 2004).

Prevention from HIV/Aids

Global experience has demonstrated unmistakably that what people need in order to keep from being infected by HIV are a solid factual understanding of HIV and its transmission, access to relevant services and supplies, and the confidence and social power to initiate and sustain behavioural change.

Social power is a key element in this equation on two counts. The most marginalized members of a society may be hard put to gain access to the information, services and supplies of even well designed and funded aids designed programs.

services and supplies of even well designed and funded aids designed programs. "More limiting still is the kind of persuasive societal discrimination- the "sexual statuesque".

Renee is of the opinion that an important weapon against HIV is honesty. It is reflected that though much has been mobilized to stop HIV infection such as condoms and monogamy public health campaigns, we have done little to target or treat the pervasive inequalities that the world community has allowed to flourish to the detriment of free lives and personal choices for women.

> There has to be greater and more honest evaluation of human sexual behavior and the fact that monogamy is an incredibly subjective concept to the vast majority of human beings. We also need to understand that a significant proportion of the world population has no choice over who has intercourse with them be it through marriage, abuse, rape or prostitution (Renee 2004).

Udaih, on the other hand believes that the prevention of HIV is the sole responsibility of the men. It is concerting to note that women are sharing four times the burden of HIV as compared with men, but this is a definite reflection of women's lack of power of negotiation in relation to sex. Consensual sex need not only account for mutual agreement but also mutual responsibility of its consequence. Reproduction related consequence rested entirely with women for which women bore the contraceptive responsibility on them to protect themselves from the evils of excess reproduction. "Unlike contraception, prevention of HIV needs a greater realization by men as they become the transmitting agent of infection in the absence of power of sexual negotiation in women" (Udaih 2004). The ABC of HIV prevention focuses largely on men as whether it is abstinence, or to be faithful or using of condoms, they need men's participation in the end. Hence, any effort towards containing the spread of

HIV infection and reduce women's vulnerability to this infection calls for an awakening in men to become responsible sexual being.

Murphy agues that women are more likely to protect themselves from pregnancy using methods that do not depend on partner cooperation, such as oral contraceptives. "However, oral contraceptives like the pill do not protect against STDs and HIV. Female-controlled methods to prevent HIV transmissions are needed (Murphy 2004). Traditionally, abstinence, condoms and dental dams have been the main methods of protection. In 1993, Reality, a female condom, was introduced on the market but to date; results have been mixed as to its efficacy, affordability and interest in use.

Murphy Mary also revealed that Vaginal microbicides that would prevent STD transmission but allow for pregnancy have been developed and piloted in some prevention programs but in her own view, further efforts need to include large-scale efficacy trials and to increase scientific interest and support from pharmaceutical companies to develop microbicides that prevent HIV infection (Philips 1996).

Obstacles to Prevention of HIV/AIDS.

Different people have different factors that serve as obstacles to preventing HIV/AIDS on women;

Women do not wear the Condom.

For women to protect themselves from HIV infection, they must not only rely on their own skills, attitudes, and behaviours regarding condom use, but also on their ability to convince their partner to use a condom. "Gender, culture and power may be barriers to maintaining safer sex practices with a primary partner" (Murphy 2004). But

I feel that HIV prevention strategies must target both women and men in heterosexual couples and address gender norms in sexual decision-making (Gomez 1996, 33).

Women are disproportionately represented among the Poor.

Because of this, women are less likely to have health insurance and access to health care services" (Murphy 2004). It is an undisputable fact anyway that many minority women living in poverty are also disproportionately affected by HIV. For these women, the struggle for daily survival may take precedence over concerns about HIV infection, whose impact may not be seen for several years (Farmer 1996)

Like many People in Committed Relationships, Women may find Intimacy in their Relationship to be more important than Protection against HIV/AIDS

Unsafe sex may be linked to emotional and social (not necessarily financial) dependence on men. The ideal of monogamy, including assuming their partner's fidelity, may increase AIDS risk denial (Sobo 1995).

Achievements in Preventing HIV/AIDS.

Recruiting women as community leaders was the basis for an effective HIV prevention program among low-income urban women living in housing developments. Women opinion leaders were trained to lead risk reduction workshops, provide HIV educational materials and condoms, and conduct HIV education through community events. The women effectively mobilized their residential community through tailored preventation messages and activities. (Phillps 1996).

Because women at risk are not always visible as a specific population or community, programs must strive to be where women are. A program provided HIV prevention services for women visiting their incarcerated male partners at San Quentin State Prison. The program, based at the visitor's centre, trains women visitors as HIV educators, and the educators provide group and individual peer education. The program is low cost and has been well—accepted by visitors and by the prison (Coley 1997).

Interventions that promote HIV counseling and testing for both members of a couple should be considered. The California Partner Study provided couple counseling in combination with social support to serodiscordant heterosexual couples (Where one partner is HIV positive and the other HIV negative). As a result, condom use increased and no new HIV infections were reported among the couples (Padian 1993, 1043).

Most drug treatment programs are staffed by men and oriented towards male clients. Allowing pregnant women to enroll in drug treatment, and allowing women to bring children with them would be helpful. In San Francisco, CA, a women-only needle exchange program was well accepted and used by female drug users. The number of needles exchanged and number of visits was similar between women who attended the women-only exchange versus mixed gender exchanges. However, women who visited the women-only exchange were more likely to receive health care and to receive additional health promotion services such as food, vitamins, coupons and clothing (Lum 1998).

Medical Assistance Program (MAP)'s pastoral training workshops on HIV/AIDS continue to address the cultural issues that increase the risk and promote

the transmission of HIV/AIDS. MAP's activities include training on orphan support, home visitation, and community outreach.

What needs to be Done?

"Strategies to address gender inequalities are urgently needed if we want a realistic chance at turning back the epidemic," said Dr Peter Piot, executive director of UNAIDS. "Concrete action is necessary to prevent violence against women, to ensure access to property and inheritance rights, and to enhance basic education and employment opportunities for women and girls."

Kathleen argues that because women are more likely to be infected by men, and AIDS cases due to heterosexual contact are increasing, programs that specifically target men (especially IDUS) will have a beneficial impact on women. Needle exchange and drug treatment are important strategies, since almost half of all infections in women are due to injection drug use. Encouraging women to seek STD diagnosis and treatment should also be a part of effective HIV prevention strategies.

Pamela, on the other hands, argues that more research needs to be done on modes of HIV transmission and risks for women, including woman-to-woman transmission. Innovative, women-specific interventions need to be evaluated. A comprehensive HIV prevention strategy uses many elements to protect as many people at risk for HIV as possible. Interventions that address sexuality, family, culture, empowerment, self-esteem and negotiating skills, as well as interventions located in varying community settings are especially important.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

Methodology

In an attempt to understand the challenges of women faced with HIV/AIDS, I carried out a qualitative research. The information in this paper were gathered through interviews; both structured and unstructured, observations, questionnaires, key informant; these include churches and organizations who had been involved with the women who are affected and infected by HIV/AIDS.

Qualitative research attempts to understand the meaning or nature of experiences of persons with problems and this involves getting into the field and finding out what people are doing and thinking (Strauss and Corbin 1998, 11). This means it involves an inquiry process of understanding, which is based on distinct methodological traditions of inquiry that explore a social or human problem. "The researcher builds complex, holistic picture, analyses words, reports detailed views of informants and conducts the study in natural setting"(Creswell 1998:15). The qualitative research method finds expression in several designs; for example, ethnographies, grounded theory, case studies and phenomenological research. For the purpose of doing this study, I utilized the phenomenological research tradition.

Phenomenology in research tradition has its origin in a philosophical movement founded by Edmund Husserl. He claims that knowledge begins with the self's experience of phenomena, which are the various sensations, perceptions, and

ideas that appear in consciousness when the self focuses attention on an object. This type of research studies the world as it appears to individuals when they place them selves in a state of consciousness that reflects an effort to be free of everyday biases and belief. (Gall and Borg 1996, 593).

Creswell states, "The phenomenological approach is primarily an attempt to understand empirical matters from the perspective of those being studied" (Creswell 1998, 275). Further in using this method, the researcher is intimately connected with the phenomenon being studied and comes to know himself within the experience of these phenomena. In a phenomenological study, a small number of subjects are studied through extensive and prolonged engagement to develop patterns and relationships of meaning. In this kind of research, the study of three to ten subjects will be appropriate (Creswell 1998,122).

Phenomenological research has some advantages as an approach to qualitative research. First, it can be used to study a wide range of phenomena. Second, the interview process used to collect data is wide–ranged: hence, it is capable of detecting many aspects of experience that may prove to be important variables in subsequent quantitative studies. In addition, the procedures are relatively straightforward, so it seems that less training would be required to do a phenomenological study than would be required to do a study using the method of a quantitative research tradition such as ethnography (Gall and Borg1996, 603).

My rationale for this design rests on the following factors:

- The nature of this research is such that it brings out the real practical experiences of women who are affected or infected by HIV/AIDS.

- It is my conviction that the experiences of women have not been adequately researched on this subject, especially within the researcher's context and hence, the research design.
- Since the procedure of the inquiry is relatively straight forward, it suits the research that I am dealing with as well as the time constrained in doing this work.
- Phenomenology deals with a smaller number of informants. In consideration of the accessibility to the informants and the sensitivity of this study, I had contact with fifteen women who are affected and infected with HIV/AIDS but six were my key informants.

Role of Literature in Phenomenology

In qualitative research, the literature should be used in a manner consistent with the assumptions of learning from the informants, and not prescribing the questions that need to be answered from viewpoint (Creswell 2003, 30). A qualitative research is an exploratory one therefore; I went out to gather information inductively from informants about the topic under study. I sought to listen to informants and built an understanding based on their experiences. In a phenomenological study, literature will serve less to set the stage for the study. The literature is presented at the end as a basis for comparing and contrasting findings of the qualitative study (31). I considered this approach suitable for this work because phenomenology involves an inductive process of qualitative research. The literature did not guide and direct the study but was an aide once patterns were identified.

The Role of the Researcher

In a phenomenological study, the researcher becomes the primary measuring instrument. This indicates that he/she carries out data collection and becomes personally involved in the phenomena under study. Hence, he/she interacts closely with field informants, attends social events in the field setting, and uses empathy and other psychological processes to grasp the meaning of the phenomena as it is experienced by individuals and groups in the setting(Gall and Borg1996,554). Therefore, I was physically present on the field to collect data using one- to one, in—person interview within a period of four months.

I have been working in Ministry for the past fourteen years with special interest in women ministry. In March 1993, I started the Women With Purpose International, a Christian, interdenominational Non-Governmental Organization in Bauchi, Nigeria. My special interest in reaching the women was one of the reasons for our Media program; "Today's Woman". The program is transmitted on Bauchi State Television and Bauchi Broadcasting Cooperation. I designed this program with the purpose of reaching the women, who will not enter the four walls of a church building to hear the gospel message, by addressing the challenges of today's woman. My interest and passion for women also led me to establish in year 2000, a Women School of Ministry (WOSOM) Where Women are trained as ministers and one of the courses in that Training school is the challenges of female ministers.

In year 2004, I started a branch of the same organization in Kayole. My observation, over the years, is that, women need a holistic gospel, which meets their needs spiritually, physically, economically and socially. A lot had been said about women who are infected and affected by HIV/AIDS as per cause, cure, and prevention; but not much had been said about how they feel and how we can minister

to them from the Christian view. This study had not only given me a deeper understanding of women who are affected and infected with HIV/AIDS in Kayole but had also assisted me in effectively ministering the gospel to them.

There were sensitive ethical issues that are associated with this study because of the nature of the research. In an attempt to protect the human rights of informants, the following necessary steps were taken:

- My role as a researcher as well as the research objective was made known to the informants
- The informants were asked whether their names should be used in reporting the data. Two permitted me to use their real names while others opted for pseudo names. However, in order to protect their dignity, I used pseudo names for all of them.

The interviews were conducted separately and in private. All my data devices such as the written notes and audiotapes were made available to them. My informants saw all my transcriptions, interpretations and reports. Before I started reporting the data, my informant's rights, interests and wishes were considered.

Entry

I gained entry into the research site through MAP international who introduced me to the Balm in Gilead, a Christian group who are working with people who are infected and affected with HIV/AIDS in Kayole. I also gained entry through the Jesus Disciples centre that has some women who are affected or infected by HIV/AIDS in their ministry.

Key Informants

The Key informants were six women selected by criterion sampling, which means I found individuals who are either infected or affected by HIV/AIDS.

Data Collection Procedure

Considering the nature of informants under study, the data was collected in multiple phases. The reason was to establish a rapport so that the informants would provide necessary data. I had been engaged in conducting seminars and various training with these women but I deliberately took some special interest in the ones I was interested in collecting data from.

Having established some common grounds, one-on one in- person, long open ended interviews were conducted for all the informants. The length of the interview lasted within an hour each. I took control of the interview to ensure that informants did not deviate from the focus. Interviews were conducted twice to ensure consistency. As I interview them I noted reactions and emotional expressions. Of Special significance were the informants' feelings regarding the experiences and what they appeared to have for them.

Two of the informants could not speak English hence I had to use an accredited Kiswahili interpreter. This is the lady pastor who interprets for me when I am preaching or conducting a seminar. Some of the informants were not intelligent in handling questions and self-expression. The data collected through tape recording was cumbersome, time consuming and challenging to transcribe but they were useful because it enabled me to go back to the interview as many times as possible for accuracy in analyzing data.

Treatment of Data

The raw data as recorded were transcribed verbatim and subjected for analysis for each informant. The latter's descriptions were read so as to acquire a feeling from them. Significant statements, which relate directly to the phenomenon under study were extracted. Statements, which contained the same or nearly the same meaning were cancelled. I formulated meanings by understanding the meaning of each statement without changing the original meaning as narrated by the informants. From the formulated meanings, five themes emerged. The statements, which were not relevant to the study were discarded.

For the purpose of verification, each theme was referred to the original descriptions. This revealed extra information in the original that was not accounted in cluster of themes. This called for my re-examination of data and theme clusters. It was discovered that some themes were not related to other ones; as well as a few other themes contrasted the rest. To achieve a final verification Step, I returned to the informants to ask if the description formulated validated the original experience. The informants confirmed the validity.

Data Analysis Procedure

Tape interviews of the six informants were transcribed, and the significant statements pulled from these transcriptions became raw data for analysis. As the significant statements were being extracted, it became apparent that it would be of value to make separate list for the four women who are infected with HIV/AIDS and the two who are affected by HIV/AIDS, These significant statements were put under various themes. This is because the statements differ in their emphasis. After

extracting all significant statements from all the transcriptions, duplicated and irrelevant statements were eliminated. From the significant statements, I formulated meanings. I arrived at these meanings by reading and reflecting upon the significant statements in the original transcriptions to get the meaning of the informants' statement in the original context.

I organized the formulated meanings into clusters of five themes. The themes were causes of HIV/AIDS, experiences of the women who are infected or affected by HIV/AIDS, coping with HIV/AIDS, effects on the Children, and the bridge gap between the Christian communities. I refer the themes to the original descriptions in order to validate them. Each description was examined to ascertain that each theme is a true representation of the original data.

CHAPTER FOUR

FINDINGS AND INTPRETATIONS

As mentioned in chapter three, five themes emerged from my analysis. They were: causes of HIV/AIDS, Experiences of women who are infected and affected by HIV/AIDS, effect on the children, coping with HIV/AIDS and the bridge gap between the Christian communities. A descriptive approach was employed in reporting my findings. Phenomenology uses a general description of the experience to present the findings of the research (Creswell 1998, 55). This chapter therefore describes the experiences of the women with regards to HIV/AIDS under the following themes:

Causes of HIV/AIDS

HIV/AIDS has motivated causes of misfortune and has eventually metamorphosed women's life into disaster. Findings reveal the following factors among others:

Table 1. Causes of HIV/AIDS

Factors	Frequency	Percentage (%)
Ignorance	5	83.3
Religion	2	33.3
Violence against women	4	66.7
Socio/Economic	5	83.3

Ignorance

Although there is a massive advocacy against HIV/AIDS, findings revealed a lack of knowledge of HIV among women in Kayole as a major cause of their infection (see Table 1). Five (83.3%)out of the key informants reported that access to information is often limited for those who do not have the means to travel to urban settings or trade centres. "If there is an HIV campaign at all then it did not reach people like us who lived in remote places."(Murphy 2004)

In some cases they simply do not understand the education messages that are conveyed. "There was a time some group came to hold a programme on HIV/AIDS, but I did not understand the whole thing, what it was all about and how it is transmitted. The whole program looked to me just like another medical programme and I felt that even if I get sick, I could be treated in the hospital"(Pretty 2005).

Religious Factors

The findings revealed that religious factor is not a strong factor in contacting HIV/AIDS (see table 1). Judith, a pastor's wife is one of my six key informants. She is of the opinion that one of the major causes of the rampant spread of HIV/AIDS is due to lack of respect for God's laws expressed by fornication, infidelity, loose living and the sex trade. She argues that God never wanted the disease of HIV/AIDS to ravage humanity.

> He pointed out a way of living that would have prevented this scourge from ever gaining a foothold. Yet, it is not too late to rediscover the power of God's commandments and God's promises. We, as individuals, as a nation, and as a world and community can beat the AIDS epidemic. We can beat it whether or not a vaccine or "magic cure drug" is ever developed.

> I believe we can stop HIV transmission dead in its tracks by returning to the Bible, the Bible's God, and His inspired rules for living (Judith 2005).

Patricia however, is of the opinion that Faith can be a risk. She sees absolute trust as a factor for contacting HIV/AIDS. She went on to explain what she meant. She sounds somehow bitter against the faith-based movement;

> Many women have been with only one man and have faith in and are faithful to their husband, and yet they contract HIV. Many women and men have faith in their pastor who tells them they are healed in the name of God. Confident in the words of their pastor, they then marry without seeking voluntary testing and counselling, and soon an infected child is born. Many other women are led by faith-based attitudes towards divorce and submission promoted by church groups to remain in marriages that endanger their health and lives. Churchwomen imagine they are happily married and safe. The church encourages them to be submissive to their husbands and not to question them. What does this mean to a woman whose husband has suddenly re-appeared after a long absence (Patricia 2005)?

Social and Economic Factor

Women in Kayole are subjected to a lower status in society: this attitude manifests into low levels of educational attainment, socio-economic dependence and in general, limited access to resources. Findings revealed that cumulatively, such factors hamper a Kayole woman's ability to protect herself from diseases such as HIV. Five (83.3%) of the six key informants had stories related to low level of educational attainment, socio economic dependency and limited access to resources establishing this factor as a major cause (see Table 1). Furthermore, these factors force increasing numbers of girls and young women to exchange sex for survival. Conflict makes women and girls disproportionately vulnerable to HIV infection: they are exposed to mass rape, sexual

abuse, including sexual slavery, at a time when there is little or no access to health care or protection.

Mary relates her experience as she sobs:

> I got into this mess because I was looking for a means of survival after my parents died I had no one to sponsor me so I engaged in petty trading. During this period, different men made love with me promising to help me. I cannot say exactly how and when I contacted the disease (Mary 2005).

Alice had a similar story to tell:

> My parents died when I was in standard 8 in 1998. All hope was gone at that point since they were all I depended upon. Although they were not very rich at least we managed to go to school. As a first child of the family with three other ones to cater for, life became difficult. I went to learn tailoring in a nearby shop with the promise that I would pay my apprenticeship fee when I finish. During the cause of this training skill, different men passed by with the promise that they will help me but each of them deserted me as soon as they had sex with me. Eventually I got a man that married me. I later tested positive in 2003 (Alice 2005).

Violence Against women

The study also revealed violence against women as a factor with high frequency in contacting HIV/AIDS in Kayole (See Table 1). Four (66.6%)of the informant reported that even when the women know about the infidelity of their husband, they are often unable to refuse sex or negotiate condom use, because to do so would indicate a lack of trust and undermine childbearing and could result in the men beating them up. " I knew that my husband was having multiple sex but I could not refuse him or use condom because we wanted children and more so he could, beat me up" (Patience 2005).

Patricia had this to say, "My husband was very oppressive even in bed. Whenever he wanted anything he had to get it. He never agreed to use condom when having sex with me and there was nothing I could do about it because he could do anything at that moment" (Patricia 2005). I tried to inquire what she meant by anything. She said " just anything, he could beat, he could force me and that made me more depressed, he could even attempt to tie me to bed" at this point she sobbed and even me as a researcher could not help myself. For that particular day, it was the end of my interview or interaction and for three weeks, I was depressed and aching because I knew I was just talking with one woman out many others who are going through such violence in silence with no help in site.

Experiences of the Women who are affected or Infected by HIV/AIDS

Table 2. Experiences of women who are affected and infected by HIV/AIDS.

Experience	Frequency	Percentage(%)
Social degradation and Stigmatization	6	100
Economic disadvantage	5	83.3
Lack of financial support	4	66.7
Spiritual uplifting	4	66.7
Emotional and Psychological depression	6	100
Guilt	2	33.3

The impact of HIV/AIDS on women is particularly acute. Findings revealed that Five (83%) out of the key informants; of women in Kayole are economically, culturally and socially disadvantaged. Four (66%) of the key informants lack equal access to financial support. Four (66%) of them are mistakenly perceived as the main transmitters of sexually transmitted diseases (STDs), HIV/AIDS—they are treated very differently from men. Men are likely to be 'excused' for their behaviour that resulted in their infection, whereas women are not. In some cases, the husbands who infected them may abandon women living with HIV/AIDS. Four of them were also rejected by wider family members. One (50%) out of the two women, whose husbands have died from AIDS-related infections, had been blamed for their deaths. "My mother-in-law tells everybody, 'Because of her, my son got this disease. My son is as simple as good as gold-but she brought him this disease" (Pretty 2005).

Another informant related her experience;

> My mother-in-law has kept everything separate for me-my glass, my plate, they never discriminated like this with their son. They used to eat together with him. For me, it's, don't do this or don't touch that. Even if I use a bucket to bathe, they yell—'wash it, wash it'. They really harass me. I wish nobody comes to be in my situation and I wish nobody does this to anybody. But what can I do? My parents and brother also do not want me back (Alice 2005)

Social Experiences

Findings revealed that everyone who is living with HIV/AIDS experience social degradation and stigmatization. Six (100%) of the six key informants voiced out the issue of social degradation and stigmatization (see Table 2). "People look down on us and many avoid having a contact with us" (Pretty 2005). Even those of them who are

not HIV positive are being treated the same way because people who know about the death of their husband just assume that they must be positive. And because many people are not adequately informed about HIV/AIDS, they think it can be contacted even through handshake. For this reason, some people do not even want to shake hands with them.

> By the grace of God I am not positive although my husband died of HIV/AIDS. I don't know how it happened that I am not but the bad thing is that those who know the reason for husband's death assume that I am positive and treat as one. Even where I had attempted to explain, they could not believe that I am not positive.(Judith 2005)

Economic Experiences

Response to their economic experiences revealed hardships and pains with no obvious solution in sight. Five (83%) of the key informants said they lost everything; they are uncertain whether they would make it through or survive. Due to difficulty in finding jobs, economic empowerment to take care of basic necessities such as feeding, paying hospital bills, house rent and the likes becomes a challenge. For these women, it is hard to catch up with life let alone enjoying it.

> I was very much affected because even for that year, my son left school, stayed at home. It was very hard to catch up with life when my husband died. This is because I didn't have a job and had two kids to feed, house rent to pay and as at then we had incurred so many debts when he was sick. The church did not do much because they felt he was suffering for his sin of adultery. My daughter also was sickly and most of the time I used to take her to hospital. Many times she got sick at night and I didn't have a single cent. So I will just cry, I feel helpless, but I thank God. It brought me closer to God because I knew that at that time He was the only refuge (Judith 2005).

Emotional and Psychological Experiences

Findings revealed that everyone living with HIV/AIDS is emotionally and psychologically depressed (seeTable2.) For all (100%) of the key informants, the pain they went through left all of them with wounds very difficult to heal. The emotional and psychological consequences that followed their ordeals cannot be overemphasized. I observed that each time the women, (every one of them), recounted their experiences, there were emotional expressions of anger, sighing, tendencies to cry, a brief silence with deep breathing and then their stories continued. This shows, to a large extent, their states of minds.

They all have general resentment for male folks. This negativism towards men is an offshoot of their experiences. Alice vows she will never forgive him. I feel such a self—vow as made by Alice is a way of getting out of personal pain. Psychologically, the wounded women tend to give a self –vow, such as, "I will never forgive him" Sometimes I can't hug my son because he is a man.

A good number (67%) of them also feel sexually vulnerable due to their emotional state of loneliness and dependability. Mary says "since I was tested positive, my husband never related with me sexually and that creates a big vacuum in my life" Although Alice contacted the disease through her promiscuous husband; she had developed a state of bitterness toward him that does not allow her to have sexual relationship any longer. "It has affected my sex life tremendously. I haven't had sex since I was diagnosed"(Alice 2005).

There is also the issue of insecurity. Anxiety and worry prevail in their lives. Apprehension and uncertainty have made them loose their self worth. Their ability to

trust fellow human beings especially men, has been badly eroded. Their self confidence has been shattered leaving them in the valley of rejection and quagmire of pain. They wished they can close this chapter of their lives and lose the memory of what happened. Due to the rejection they suffer, some (50%) of them were forced to self—pity. There is also the feeling of betrayal and sometimes guilt. 67% are yet to come around for the shock of what happened to them; they wallow in confusion and anger, which they take out on others areas of life and on people around them.

> I don't talk much about the negative stuff: perpetual grief, loss of partner, 99% of the past 5 years I've been in the grief process. It's affected me in a big way, not letting people get close to me. I feel like I'm living in a fucking war zone. I'm constantly in it - I live in a building with lots of people who are HIV-positive. I want to withdraw from the world and that's not like me. I've always been pretty positive in attitude but it's pretty tough. (Patricia 2005)

The study also revealed the extent to which people are stigmatised and discriminated against by health care systems. 50% of the women reported that they go through the reality of withheld treatment, non-attendance of hospital staff to patients, lack of confidentiality and denial of hospital facilities and medicines. One factor, fuelling stigma among doctors and nurses is the fear of exposure to HIV as a result of lack of protective equipment. John, a medical officer in one of the hospitals gives a probable reason for the evident denial marginalization.

> There is an almost hysterical kind of fear at all levels, starting from the humblest, the sweeper or the ward boy, up to the heads of departments, which makes them pathologically scared of having to deal with an HIV-positive patient. Wherever they have an HIV patient, the responses are shameful (John, 2005).

Spiritual Experience

The spiritual experiences are different from one informant to the other. Four (67%) of the informants had been drawn closer to God, as they see him as the only last hope they have hence they want to serve God for the remaining part of their lives which according to some of them may be short. "My present situation keeps me closer to God. Although others reject me I have found hope through my pastor who keeps encouraging me and I also vow to serve him if there is any way I can while I am still alive although I don't know when I will die"(Alice 2005).

Below is a detailed but pathetic story of one of the informants

> We were married less than a month when we discovered that he was HIV positive. What a shock that was to me! He told me that he had no idea that he was infected but that he was a reformed drug addict. However he was still using drugs without my knowledge since I worked nights, I'd come home and go to bed thinking that he was sleepy sometimes because he worked nights also. I did not think of being tested until one afternoon he told me that his DR. said that I should be tested. OK I thought I know that I couldn't possibly be infected since I didn't use drugs and not gay (Stupid me). I got the test, and I was positive also. It really blew my mind, I couldn't think straight or anything, this must be a mistake, I went to work, I was sitting at my desk and I just started screaming no! No! No! No! Tears were streaming down my face. I went home later and I remember saying to my husband, how could you do this horrible thing to me don't you know I have a child to raise? I wanted to kill him, but I didn't. We broke up for a few months and after listening to my Dr and praying we got back together so that we could support each other since we didn't know of anyone living with this disease. Well it's been fourteen years now, he has developed congestive heart disease, end stage renal failure, and several other problems, and he has lost a lot of weight. As for myself I've had two minor strokes but I'm fine gained a few pounds, but Glory be unto God, I'm doing well. On the other hand he has begun to drink, smoke cursing staying all night and literally stopped going to church. I'm a minister and will never stop attending church and praising my God for He's been too good to me and He continues to bless me daily even though I don't deserve it. My husband left home last week and stayed out for two nights and came home and told me that he'd been drinking and thinking, and he had decided we should

> part because he wasn't doing me any good, wasting money couldn't work no sex in our life. I was injured at work. I have no income at all everything is going wrong I've been evicted from the apartment etc. but he says I love you. I'm trying to hang in here and be supportive to him but it's hard. Since he's walked out on me he's somewhere in town, but I have not seen or heard from him since Monday morning, I'm in a pickle and don't know how to deal with it since I've never been without a job or money to provide for myself. I really would like to hate him and move on but God will not allow me to do so. All I'm asking you to do is pray for me. It is very difficult. (Patricia)

An alarming 40% of the key informants retain a feeling of resentment and bitterness, as they could not understand why God who is good should allow them to pass through this stage. "I feel bitter against God I don't know why He should allow me to suffer for the sin I did not commit although I've been told that God loves me I find it difficult to comprehend His love in this situation" (Pretty, 2005)

Guilt

Few (33%) of the informants express a sense of guilt. They blame themselves for the illness with the feeling that it is punishment. This guilt is worsened by society's prejudice and ignorance about HIV and AIDS. "I feel guilty and also feel I am just being punished for my offence against God because those days when I was really looking for survival I cared less about my conscience, any offer was just right even when my conscience told me it was not"(Mary 2005)

Coping with HIV/AIDS

Table 3. Coping with HIV/AIDS

Coping	Frequency	Percentage(%)
Positively managing	3	50
Helpless, frustrated	3	50

Findings revealed that half of the women who are infected by HIV/AIDS may be able to find a positive way of facing life while half of them are helpless and frustrated into doing just anything to make ends meet. The mental and emotional trauma that followed HIV/AIDS has been accompanied by stigmatization of the women by their community members. Hence many women who might have gotten infected chose to suffer in silence. Some of these women are widowed, separated from their spouses, or had become displaced from their homes and productive resources. In order to survive, they have to fend for themselves and their children. Two (33.3%) of the key informants had formed various types of sexual relationships with men in exchange for economic and social protection. One of them does not do anything; her health is in a bad state as at the time of this research. She lives at the mercy of friends and caring neighbours.

Three (50%) of them were lucky, they found some low paying jobs in the formal sector, or alternatively joined the informal sector.

> When I discovered that I was positive, at first I attempted to work things; so many fights. So many tears. It became apparent it was not going to work. I was scared. I felt dirty felt ugly felt like I wanted to die. 24 hours a day 7 days a week it was on my mind. I couldn't clear my mind of it, it drove me crazy so I started drinking and taking drugs. STOP I wanted control of my mind. I wanted to get healthy but I was so scared of living. Then, one day I woke up, the sun was out. The breeze was soft. It was the most beautiful morning. I stood and looked at myself in the mirror, I wasn't sick!! I was just lost for a moment I lost the faith I had had in me. I lost direction and joined a group I wasn't scared anymore. I knew I would get over this. Today, I have a very successful business (she sells second new clothes). I am still not on medicine my body is amazing and my mind is so strong. I never thought I would find love in the way I had found it. You must

never loose yourself and the strength within you. I will like to say to any one who is this position, fight on. Never give up (Patience).

It is hard enough to live with HIV knowing that any day you'll going to become ill and have to leave your love ones behind maybe sooner than anticipated (especially your grandchildren), but we certainly don't have to be stressed out by the man that claimed he loved you and leaves you with this demon (Alice).

Although there were a few organizations that are working with people living with HIV/AIDS in Kayole, none of the key informants mentioned any support received from them. Only one of the informants said her church had been supportive but not because they have a structure that provides support for people living with HIV/AIDS.

Interpretation

As I explore the world of women who are affected or infected by HIV/AIDS in Kayole, I realize that they are going through trauma and grief. This grief is expressed in various forms as bitterness, anger, and withdrawal. For the first time I was also able to empathize with them as I see the challenges they go through. From these, it is evident that these women are lonely, neglected and need to be supported rather than being condemned as we have been doing.

From the findings in the research, it is also evident that people living with HIV/AIDS can work with their own hands, they don't get sick immediately. They can still live for years if they receive adequate support. In response to the evident need above the recommendations in the following chapters are made.

CHAPTER FIVE

MISSIOLOGICAL IMPLICATION /RECOMMENDATIONS AND CONCLUSION

As the Church considers its mission and ministry especially to the women who are affected or infected by HIV/AIDS, it must view itself as the communicator of Hope. Through its special rites, sacraments, spoken words, acts of love, and witness, the Christian community can more effectively bring God's holistic gospel to the women where they are most needed.

Missiological Implications

The findings both from literature review and ethnographic study have missiological implications for the church. "Anthropological study is a human tool that enables us to start where God wants us to start. We thus gain freedom from our own cultural biases to be the kind of cross—cultural witnesses that God desires" (Kraft 1996, 4). How can we best communicate hope to those the world had condemned? The commandment of God to be his witness demands the church to re-evaluate its position on mission to those who are infected or affected by HIV/AIDS especially the women who are glaringly neglected. Bridges can be built to these women in spite of the recurring neglect, abuse, and violence in the society. For long the church had taken a judgmental position against people who are infected or affected with HIV/AIDS. The church condemns them and rejects them leaving them without hope and without God. It is high time the church brought to remembrance that

God does not want anyone to perish. God hates sins but loves the sinners. Blessings and hope are strategic concept that must be basic to any built bridge-theological, missiological and liturgical—that the church attempt to build to women who are affected or infected by HIV/AIDS. The implementation of hope will mean that the church must reorient its strategy so that it can become concerned with all aspects of it life and messages; priestly, prophetic, diaconal and missionary. The incorporation of hope into the ministry, outreach and theology of the church in Africa will enhance its witness. Its emphasis will increase the African receptivity to the gospel because it emphasizes the solidarity and totality of God's relationship to man, especially, at point of transition and crisis.

It is particularly essential that the church recognizes the strategic centrality of women in the society. For its witness to be effective, the church must develop and implement creative and personal programs that readily communicate the gospel of hope. These could include:

- Life embracing program designed to provide HIV-positive women with education and emotional support in their efforts to cope with life in the midst of an evident crisis. This type of program will equip them with personal and interpersonal skills to enhance their health, quality of life, and relationships.
- Physiotherapy and photographic counselling where experts uses Photography and/or Phototherapy to assist women to improve their self image directly through being photographed (along with, or apart from, direct counselling).
- Couples' program that offers couples a place to celebrate, honor, and nurture their relationship and stay together to support one another in trouble or trying times.

The future of the women, who are affected with HIV/AIDS in the

community and in Africa at large, is at stake. The dynamic potential of holistic gospel stands readily to help bring this large, growing community into life-giving sheepfold of the good shepherd.

Recommendations

This research has achieved its purpose in that it has described the phenomenon of HIV/AIDS. The position of women who are affected or infected by HIV/AIDS is a marginalized and stigmatized one which leaves them in an entirely depressed state.

These findings offer some recommendation first for Church and Para church organizations; and to MAP international through whom I picked my deep interest in ministering to people with HIV/AIDS. Every church and Para church organizations should;

- Educate the members about HIV/AIDS. This knowledge will help the church members to sort out facts from false speculations about the causes of HIV/AIDS.
- Provide practical help to those who are infected and are sick. This will go a long way in lifting their spirit.
- Allocate special fund in the budget to support those who are affected or infected by HIV/AIDS because of the social economic effect of HIV/AIDS.
- Empathize and find a way of enhancing their self worth. Instead of addressing these women as "AIDS Victims", they can be addressed as persons living with AIDS. This will also go a long way in addressing the problem of rejection.
- Incorporate Sex education in the programme of the church. This will reduce further chances of infection.
- Provide faith-based voluntary counseling and testing

My experience as a missionary in the northern Nigeria shows that although there are a few government organizations fighting against HIV/AIDS in the north, we do not have any Christian body that provides hope and support for people who are infected and affected by HIV/AIDS in Bauchi State of Nigeria. I am therefore recommending that MAP international should open an office in Nigeria and unlike many other organizations whose services rarely get to the north because they are based in Lagos, MAP international should be established in Bauchi Sate of Nigeria.

Conclusion

Each and every day, the cries of the people who suffer from HIV/AIDS grow louder. The cries for help are heard in every part of Africa and they come from every child, man and woman. Across the African continent and throughout the Diaspora the disease is devastating communities and decimating lives. The statistics are both terrible and familiar: Africa claims a disturbing 80 percent of the world's AIDS cases. In Africa it is estimated that a staggering 5,000 adults and 1,000 children die daily from HIV/AIDS related illnesses. The epidemic is depopulating Africa faster than any catastrophe since the slave trade. Death rates are on the increase, life expectancy is in decline, livelihoods are being destroyed and, for many, hope is in short supply. The lives of women and the young are especially endangered. The faith community has always been the resource that Africa's people turn to in a time of crisis. I believe that the church in Africa is strategically positioned to play a major role in the fight against HIV/AIDS.

The Church must be committed to make a difference in the war against HIV/AIDS. The moral and theological stakes, as well as the social and political stakes,

are high. There is no single formula or easy process that will result in the eradication of HIV/AIDS from every country or region. The Church must work to create moral and social networks based on their belief in the sacred worth of every human being and recognition of the HIV/AIDS epidemic. The common challenge is one of decisive action through HIV/AIDS ministries, HIV prevention, education and service. Otherwise, the loss of life and hope throughout all of Africa will be immeasurable. In this time of crisis, there is a clarion call on the body of Christ to be a source of compassion, acceptance and understanding. All of us are called in this moment to convey hope and responsible, transformative love to all persons who are infected with, and affected by, HIV/AIDS. We must overcome stigmatization and discrimination within our own religious ranks, while being a voice of moral resolve in the broader community, society, nation, continent, and world. Discrimination is sinful. Stigmatizing any person is contrary to the will of God.

However, changes in attitude toward those who suffer from the disease itself do not always translate into more effective forms of intervention, prevention, and care. It is important to have a theological vision and practice that is proactive and visible, and that is prepared to meet the most pressing needs of the people. With this we can change the destiny of our dear land—Africa.

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APPENDIX A

INTERVIEW QUESTIONS GUIDE I

Date_____

Name_____

Age_____

1. When did you discover you were HIV/ADIS positive
2. Do you know how you contacted the HIV/AIDS?
3. How did you feel when you got the first news that you are HIV/AIDS positive?
4. What was your husband's first reaction?
5. What are your experiences since then?
6. What are the major challenges with being infected?
7. Do you have any children?
8. What is the effect of this situation on your children?
9. What is the impact of the situation on your work/business?
10. What is your relationship or opinion about God as at present?
11. How are you coping with this present situation?

APPENDIX B

INTERVIEW QUESTIONS GUIDE II

1. When did you discover your husband was HIV/positive?
2. What was your first reaction towards the news?
3. what is your reaction towards him/
4. What are your experiences since then?
5. How are you coping with the situation?
6. Do you have any children/
7. what are the effects on the children
8. What is your impression about God as at now?

APPENDIX C

HIV/AIDS STATISTICS FOR AFRICA.

An estimated 25 million adults and children were living with HIV in sub-Saharan Africa at the end of 2003, and an estimated twelve million children have been orphaned by AIDS.

In 2003, 2.2 million people died from AIDS in sub-Saharan Africa.

The statistics for adults and children living with HIV/AIDS, the statistics of the estimated number of deaths from AIDS, and the number of orphans in individual countries in Sub-Saharan Africa at the end of 2003 are shown below.

Country	Adults	Adult Rate %	Women	Children	AIDS Deaths Among Adults & Children	Orphans due to AIDS
Angola	220,000	3.9	130,000	23,000	21,000	110,000
Benin	62,000	1.9	35,000	5,700	5.800	34,000
Botswana	330,000	37.3	190,000	25,000	33,000	120,000
Burkina Faso	270,000	4.2	150,000	31,000	29,000	260,000
Burundi	220,000	6.0	130,000	27,000	25,000	200,000
Cameroon	520,000	6.9	290,000	43,000	49,000	240,000
Central African Republic	240,000	13.5	130,000	21,000	23,000	110,000
Chad	180,000	4.8	100,000	18,000	18,000	96,000
Congo	80,000	4.9	45,000	10,000	9,700	97,000
Cote d'Ivoire	530,000	7.0	300,000	40,000	47,000	310000
Dem. Republic of Congo	1,000,000	4.2	570,000	110,000	100,000	770000
Djibouti	8,400	2.9	4,700	680	690	5,000
Eritrea	55,000	2.7	31,000	5,600	6,300	39,000
Ethiopia	1,400,000	4.4	770,000	120,000	120,000	720,000
Gabon	45,000	8.1	26,000	2,500	3,000	14,000
Gambia	6,300	1.2	3,600	500	600	2,000
Ghana	320,000	3.1	180,000	24,000	30,000	170,000
Guinea	130,000	3.2	72,000	9,200	9,000	35,000

Kenya	1,100,000	6.7	720,000	100,000	150,000	650,000
Lesotho	300,000	28.9	170,000	22,000	29,000	100,000
Liberia	96,000	5.9	54,000	8,000	7,200	36,000
Madagascar	130,000	1.7	76,000	8,600	7,500	30,000
Malawi	810,000	14.2	460,000	83,000	84,000	500,000
Mali	120,000	1.9	71,000	13,000	12,000	75,000
Mauritania	8,900	0.6	5,100		500	2,000
Mozambique	1,200,000	12.2	670,000	99,000	110,000	470,000
Namibia	200,000	21.3	110,000	15,000	16,000	57,000
Niger	64,000	1.2	36,000	5,900	4,800	24,000
Nigeria	3,300,000	5.4	1,900,000	290,000	310,000	1,800,000
Rwanda	230,000	5.1	130,000	22,000	22,000	160,000
Senegal	4,000	0.8	23,000	3,100	3,500	17,000
South Africa	5,100,000	21.5	2,900,000	230,000	370,000	1,100,000
Swaziland	200,000	38.8	110,000	16,000	17,000	65,000
Togo	96,000	4.1	54,000	9,300	10,000	54,000
Uganda	450,000	4.1	270,000	84,000	78,000	940,000
United Rep. Of Tanzania	1,500,000	8.8	840,000	140,000	160,000	980,000
Zambia	830,000	16.5	470,000	85,000	89,000	630,000
Zimbabwe	1,600,000	24.6	930,000	120,000	170,000	980,000
Total Sub-Saharan Africa	23,100,000	7.5	13,100,000	1,900,000	2.2 million	12,100,000

Notes

These statistics are estimates at the end of 2003 published by UNAIDS in their 'Report on the Global HIV/AIDS Epidemic, July 2004'. The estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 2003. If a country is not included in the table it is because there are no reliable statistics for the country.

Adults in this report are defined as men and women aged 15-49. This age range captures those in their most sexually active years. While the risk of HIV infection continues beyond the age of 50, the vast majority of people with substantial risk behaviour are likely to have become infected by this age. Since population structures

differ greatly from one country to another, especially for children and the upper adult ages, the restriction of 'adults' to 15-49 has the advantage of making different populations more comparable.

Children in this report are defined as under the age of 15 at the end of 2003, whilst orphans are children aged under 17 who have lost one or both parents to AIDS.

Source;http://www.avert.org/subaadults.htm.

CURRICULUM VITAE

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MARRITAL STATUS	Married
SPOUSE	Isaac Crown
CHILDREN	Emmanuel, Joshua, and Joseph.

EDUCATIONAL BACKGROUND

2003-2005	Nairobi Evangelical Graduate School of Theology	Master of Arts (Missions)
1998	Haggai Institute Singapore	
1991	Ahmadu Bello University, Zaria.	Bachelor of Education (Maths)
1983	Advanced Teachers' college, Zaria	NCE (Chemistry/Maths).
1980	Ilorin Teacher's College	GradeII Teacher's Certificate
1979	Offa Grammar School	West African School leaving certificate

CHRISTIAN SERVICE

1983- 1984	Associate Traveling Secretary Fellowship of Christian Student, Niger State
1991-1998	Director New Anointing Bible Institute, Bauchi
1992- 1996	Senior Pastor Peculiar people's Church Yelwa Branch
1995 to date	President, Women With purpose International Bauchi
1998 to date	Matron, Nigerian Christian Corpers Fellowship Bauchi State.
1998 to date	Editor, Total Woman.
1997-2003	Producer/Presenter, Today's Woman.
2001to date	Principal Women School of ministry, Bauchi.

PROFESSIONAL EXPERIENCE

1984-1986	Mathematics Teacher Government Day Secondary School, Igbonna.
1987-1991	Mathematics teacher, Government Secondary School, Gadau, Bauchi.
1989- 1991	Mathematics teacher, Government day secondary School, Bauchi.

Author

1. Battered but not Scattered
2. Make Your Life Count.
3. Living by Loving
4. Making Profit in Life
5. Marriage: The Master Builder's Plan