NAIROBI EVANGELICAL GRADUATE
SCHOOL OF THEOLOGY

EXPLORING AN AFRICAN CHURCH'S STRATEGIES FOR FOSTERING HIV/AIDS AWARENESS, PREVENTION AND CARE

BY

NEGURA FELI KATHO

Thesis Submitted to the Graduate School in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Christian Education

JULY 2005

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July, 2005

Student's Declaration

EXPLORING AN AFRICAN CHURCH'S STRATEGIES FOR FOSTERING HIV/AIDS AWARENESS, PREVENTION AND CARE

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) _____

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July, 2005

ABSTRACT

The purpose of this study was to explore the strategies used in initiating HIV/AIDS awareness, prevention and care in Africa Inland Church of Kenya.

Data were collected through interviews conducted both with the denominational leaders of AIC-AIDS Division and participants working in local AIC-AIDS programs. Documents and archives related to AIC-AIDS program as well were analyzed.

The study revealed AIC of Kenya had various operational strategies in creating AIDS awareness and prevention among its members, some of which were initiated by individuals who ran AIDS programs within the AIC context before the AIC-AIDS Division was structured.

This awareness was created especially through education of both HIV negative and HIV positive people. Prevention among HIV negative people was accomplished through education in schools; application of the church's AIDS policy, and preventive policies applied in AIC health facilities.

People living with HIV and AIDS (PLWHA) received care in hospitals through the provision of free medication, inexpensive antiretroviral drugs and home-based care. The church also operated a feeding program for AIDS orphans.

To

My beloved husband Bungishabaku Katho

who believed in the abilities God has put in my life for His ministry

and supported me prayerfully during my training.

Our dear children: Furaha Sikanyani, Denise Linganaiso,

Rachel Makani and Winny Baleli-Kukwa.

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CHAPTER 1

INTRODUCTION

How long will the church keep silent about the HIV/AIDS scourge? When will we dare to talk about secret, immoral, sexual behavior from the pulpit? Is AIDS really a punishment from God on an immoral generation? These are the kinds of questions church leaders have been asking when facing the devastating impact of the AIDS plague among their members, relatives and friends (Medisch Coordinatie Secretariaat 1998). For a long time churches ignored AIDS. Today some progress has been made in spite of the cultural barrier, which made pastors and leaders hesitant to address the issue. People have come to realize that AIDS is not only a medical concern, but also a moral epidemic for which the church has a cure. This realization has led some churches to a compassionate ministry to the victims. Moreover, some churches are encouraging sexual practices that deter the spread of AIDS.

The Africa Inland Church (AIC) of Kenya is one of the churches having an elaborate HIV/AIDS program. However, AIC of Congo and other Congolese churches have done little. Some Congolese churches are still in the silence and denial phase. Their silence favors the spread of the HIV infection. There is great and urgent need to awaken and inform these churches so that they can move from denial to action. "Now is the time for Africa to act with total commitment against HIV/AIDS. Tomorrow may be too late" (Githinji and Nyagah 2003, 6).

Problem Statement

While the AIC of Kenya appears to have instituted workable HIV/AIDS awareness and prevention programs, churches like the Africa Inland Church (AIC) and the Emmanuel Church (EC) in the Democratic Republic of Congo (DRC) are not effectively dealing with the pandemic. These latter churches appear ignorant of effective HIV/AIDS intervention strategies. An understanding of strategies used in AIC of Kenya can help Congolese churches develop workable AIDS programs.

Purpose Statement

The purpose of this case study is to explore strategies used in creating HIV/AIDS awareness and prevention in the AIC of Kenya with a view toward their applicability to churches in DRC. Data were collected through interviews with participants in the church's AIDS programs and from the church's archival records. HIV/AIDS awareness here refers to activities organized to help people know more about HIV/AIDS and how they can be involved in preventing its spread (Shimuli 2002). AIC stands for the Africa Inland Church; an Evangelical denomination founded by the Africa Inland Mission in several African countries (e.g., Kenya, DRC, Sudan, and Tanzania). The AIC of Kenya is a national church with over 3000 local incorporated congregations. It was established in 1895 (Gration 1974).

Research Questions

This study was guided by the following questions:

Grant tour question:

What strategies were used at AIC of Kenya to create awareness and foster prevention among its members?

Sub-questions were as follows:

- What is the history of AIC-AIDS program?
- What factors motivated AIC of Kenya to start this program?
- How does AIC-AIDS program prevent and control AIDS spread?
- What role did the pastors play in the HIV/AIDS program?
- What challenges did the church encounter?

Delimitations

This case study is confined to analyzing AIC of Kenya's AIDS program archives and interviewing AIC participants. As my vision was to implement these strategies in evangelical churches in DRC (e.g. AIC of Congo and EC), I preferred to explore a sister evangelical church which shared the same doctrine and traditions. I limited my study to the AIC's headquarters and to two local AIC churches where the AIDS programs were implemented. The study on the ground helped me see and understand what members were doing and experiencing.

Limitations

In this qualitative study, the findings were not generalized to all churches in Kenya or elsewhere in Africa. Although it could be important to go beyond AIC and see what other denominations in Kenya were doing, financial and time restrictions did not allow me to do so.

Significance of the Study

This study, conducted in AIC of Kenya, will help the denomination strengthen its AIDS programs and review its strategies. More importantly, its findings will serve as a reference tool to guide Congolese churches, like CE and AIC of Congo, in formulating their strategies of HIV/AIDS awareness, prevention and control. Furthermore, an in-depth understanding of one denomination's strategies will allow researchers to compare and contrast its practices with those in other churches around the globe.

CHAPTER 2

SUBSTANTIVE LITERATURE REVIEW

According to Creswell (2003, 30), the literature review "provides a framework for establishing the importance of the study as well as a benchmark for comparing the results of a study with other findings." He also added, "In a case study," like this one, "literature will serve less to set the stage for the study" than to furnish a framework. Mugenda and Mugenda (1999, 30) stated that literature serves "to make the researcher familiar with previous studies and thus facilitate interpretation of the results of the study." These citations show the purpose of this literature review, which was to bring light to the phenomenon of the study. Through this literature review, I brought out issues that led to the need for this study.

I organized my review of literature under three subtopics to facilitate the readers' understanding: 1) general information about AIDS; 2) statistics, trends of AIDS spread, current state of HIV/AIDS; and 3) responses to the AIDS pandemic.

General Information about HIV/AIDS

Definitions

HIV stands for Human Immunodeficiency Virus, which destroys the body's immunity system rendering the body open to infection and attack by a wide range of diseases (Kenya Episcopal Conference 2000). AIDS stands for Acquired

Immune Deficiency Syndrome. It "is a group of diseases that occur when a person's immune system is damaged by HIV" (Granich and Mermin 1999, 6).

Mode of Transmission

HIV is found initially in the blood, semen and vaginal fluids of infected people. Transmission occurs when one of these infected fluids enters a new victim's bloodstream, for example, as the fluids enter into contact with an open wound as they are transmitted through the penis to the rectum or vaginal membranes especially during sex (Kiiti et al. 1996). "Over 80% of HIV infections in the sub-Sahara African tropical world are by heterosexual intercourse with an infected partner" (Kenya Episcopal Conference 2000, 39). Apart from sex, HIV can be transmitted through the exchange of blood (transfusions, unsterilized needles, syringes, knives, razor blades, etc). "In some cases, but not all, HIV-infected mothers pass HIV to their babies before the time of birth, at birth, or during breastfeeding" (Heidkamp, Dortzbach and Njoroge 2002, 36).

Signs and Symptoms of HIV/AIDS

Persons infected with HIV can live from two to ten years depending on their general state of health. At the first stage of the disease, no obvious symptoms are manifest. They may look healthy, but are susceptible to fevers, tiredness, aching muscles, cold or flu. They often do not realize they are HIV positive. At the second stage, they develop symptoms related to AIDS: loss of appetite, sores in the mouth, diarrhea, swollen lymph nodes, skin rashes, fever and night sweats. As these symptoms can result from other diseases as well, a test is required to confirm the presence of the HIV. At the third stage, infected persons develop AIDS. The immune system can no longer fight diseases. Infected persons are susceptible to all

kinds of sicknesses. In Africa they commonly develop tuberculosis, skin diseases such as Herpes Zoster, and disorders of the nervous system that cause confusion, loss of memory, and brain damage. This stage ends inevitably in death.

Test, Treatment and Prevention

To discover HIV, a blood test is performed to detect the presence of antibodies, which the body produces to counteract the invasion of the virus. Despite years of research, no cure for or vaccine against HIV has been discovered. Although people are talking of Anti-Retroviral Therapy, it does not cure the illness. It merely slows "the rate at which the HIV virus is able to multiply in the body of an infected person" (Heidkamp, Dortzbach and Njoroge 2002, 38). These drugs are expensive and not easily accessible to most Africans. For this reason, prevention appears the recommended option.

The cornerstone of prevention remains change in sexual behavior, including abstinence from sex before marriage and faithfulness in marriage (Clarke 1994). When a partner is infected, the use of condoms is recommended. Blood should only be given if anemia is life threatening. Health workers in all health care settings should practice consistent infection control. Unfortunately, this is not the case in most rural-based health facilities in poor African countries. For instance, there is lack of a national injection safety policy in Kenya and "Kenya has not put in place measures that lessen the risk of infection in case of clinical accidents.... Statistics from UNAIDS estimates that about 5 – 10% of global HIV infections in developing countries are directly related to infections that take place in the hospital" (East Africa Standard [Kenya], 14 July 2004).

Statistics, Trends of AIDS Spread and Current State of HIV/AIDS

"Until a few years ago the AIDS epidemic in Africa was more or less invisible.... But this is changing [so] rapidly that denial seems impossible" (Medisch Coordinatie Secretariaat 1998, 3). In *Front Lines,* vol. 40, No. 3 Anderson affirmed that AIDS is the leading cause of death in Africa and the leading cause of orphans in Sub-Sahara Africa. In 2003, 2.3 million people died of AIDS in Africa (Daily Nation/Kenya, 7 July 2004). Forty-two million are living with the virus, and about 29 million of them live in Africa (MAP International 2004). An estimated 80% of AIDS deaths worldwide occurs in sub-Sahara Africa.

The first AIDS case in Kenya was identified in 1984. Fifteen years later, HIV/AIDS was declared a "national disaster" because of the negative impact it had on the individual, family, community and the nation at large. By 2000 over two million people already were infected with the HIV virus in Kenya and approximately 600 people were dying every day. Many more people are infected daily. In 1999 alone, AIDS claimed about 200,000 lives in Kenya. According to the Ministry of Health (2001, 12), "The trend from 1990 to 2000 suggests that adult HIV prevalence in Kenya will increase to about 14% by the year 2005 and then stabilize at that level.... If HIV prevalence does increase to 14% by the year 2005, the number of infected people will increase from 2.2 million in 2000 to 2.6 million by 2005 and to 2.9 million by 2010."

The high rate of death among active adults has resulted in a large number of orphans in Kenya. A United Nations report in the Daily Nation of July 14, 2004

estimated the number of orphans in Kenya would rise to 1.9 million in the next six years.

Inevitably, these high rates of infection have an immense effect on the society. Hospitals in Kenya are filled with people dying of HIV/AIDS. For instance, 40% of beds at Longisa District Hospital are occupied by AIDS-related illnesses (Daily Nation/Kenya, 6 July 2004) while in government hospitals in Nairobi, like Kenyatta National and Mbagathi Hospital, 50% of hospital beds are occupied by AIDS patients (Gathoni 2001). Dr. Lillian K'ochola, the medical superintendent at Mbagathi District Hospital in Nairobi, reported, "the hospital daily attends to about 250 out-patients and 100 in-patients 60 percent of whom test positive to HIV" (East Africa Standard [Kenya], 14 July 2004).

Although anti-retroviral therapy exists, most of infected Kenyans die relatively quickly because they lack access to low-cost AIDS drugs (Shimuli 2002). Adults are dying and leaving behind orphans, which burdens families and society. Care of the sick person and the loss of income because of his/her inability to work are burdens to the family. Sometimes, instead of going to school, children are taking care of their sick parents or they do not have any money left for school fees because of medical care for the parents. These are just a few of the bad effects of AIDS. Considering this analysis, it is clear that each person, each community, and each church needs to wake up and act against HIV/AIDS.

Responses

Many books have been written about responses to the AIDS pandemic, internationally, nationally and locally. One can clearly see the effort people are making to address and fight the AIDS pandemic at different levels. I am examining various responses to the HIV pandemic under two groups: secular responses and church responses.

Secular Responses

The secular world was first to be alert to the attack of HIV. This is true at every level (international, national and local). As the trend of infection was increasing, the secular world took certain actions in order to fight AIDS. These actions included:

- Books: a countless number and series of books and curricula were produced in various languages in order to inform people about AIDS and how to deal with it. These books were used to inform and educate the masses.
- Campaigns: a wide mobilization campaign was and is still going on through newspaper and magazine advertisements, radio and television spots, posters, leaflets, dramas, videos, and songs [slogans] (Clarke 1994).
- Funds: a large amount of money has been invested yearly in AIDS programs, funding of the above two projects, researching about medicines and vaccines, treatments and care for sick persons, materials for prevention (condoms, gloves, syringes, etc.). Funding was given for

voluntary counseling and testing services, and to organizations ensuring safe blood and equipment at health facilities.

After such commitment and hard work, one might expect a positive result, but what are we experiencing on ground? Samson Radeny, Ag. Regional director of MAP Eastern Africa Office stated,

> Many local and international organizations are working to prevent further infections and reduce HIV/AIDS impact on individuals and families. Many programs are initiated to address various aspects of HIV/AIDS. However, these efforts are scratching the surface. The cry for more supports to orphans and people living with HIV/AIDS is a vivid indication of the unmet need.... Although reports from most African countries show increased level of awareness, it has not translated to actual change of behavior. (Githinji and Nyagah 2003, 6)

According to World Health Organization (December 2002, 16), "The annual number of new infections has remained steady, but it hides dynamic trends. In some countries, the epidemic is still growing, despite its severity. Others face a growing danger of explosive growth."

The Daily Nation of 14 July 2004 reported, "Ms. Machel said that plans for controlling AIDS among young women had not worked.... The infection rate among women aged between 15 and 24 years was rising, and accounted for 50% of all new infections."

These declarations are testifying clearly that there are still things to be done. People have not yet mastered the situation. If the secular world's objectives and purposes were well formulated, and its methods were various and creative, the only thing one can doubt is the content. What have they been preaching?

An AIDS radio spot on the Voice of Kenya, October and November 1988 declared, "Knowledge is the key to prevention," "Safe sex," "Limit your sexual

partners," "Be careful," "With AIDS, you are your own savior" (Clarke 1994). The list goes on. These are just half-truths and misleading statements that are not touching at the root cause of the spread of AIDS, that is sexual immorality. However, the language is changing. There is now the "ABC" slogan in which A stands for Abstinence, B stands for Be faithful and C stands for Condom.

The ministry of Health (2001) came up with the following strategies:

- ABC (Abstinence before marriage, Be faithful in marriage, Condom) intervention to prevent heterosexual transmission
- Reduction of sexual partners
- Voluntary counseling and testing services
- Controlling other sexually transmitted diseases
- Preventing infection in young people
- Intervention to prevent mother-to-child transmission
- Safe blood supply

The Ministry of Health plan's principal objectives were:

- Reducing HIV prevalence in Kenya by 20 to 30% among people aged 15 to 24 years by 2005
- Increasing access to care and support for people infected and affected by HIV/AIDS in Kenya
- Strengthening response capacity and coordination at all levels (National Aids Control Council, October 2000).

Church Responses

Churches took a long time to join the secular world in fighting AIDS. In fact, some churches are still reluctant to get involved. Yet, churches have the right message to give, and countries like Kenya have a large audience listening to the churches' message. (Seventy percent of Kenyans are said to be Christian.) There is a need for the church to feel the necessity and obligation to speak out and move into action against the HIV/AIDS pandemic (Grandia-Feddema and Samuel 2000). The world needs not only to benefit from the churches' action, but also to hear the message of salvation and hope. This mandate is exactly what the churches need to know and to understand.

Different churches respond differently to the challenge of AIDS. Peter Okaalet, M.D., summarized churches' responses as follows:

- Condemning apathy: AIDS is a punishment for sexually immoral people. Infected people need to deal with it themselves.
- Helpless resignation: church is ready to respond but cannot because of an apparent lack of skills, knowledge, resources and courage.
- Apprehensive involvement: church is ready and eager to respond but cannot because of fear of getting contaminated – lack of information.
- Whole-hearted involvement: church is running various AIDS intervention activities. It has policies, programs, educational materials and annual budget for HIV/AIDS work (MAP International 2004).

Each church falls under one of these categories. CE and AIC of Congo remain at the stage of "condemning apathy." Nevertheless, some churches and religious organizations are doing quite well. They have policies, a budget and

people in charge of programs. Among their actions one can cite the education of children and youth in schools as well as in churches, education of adults, taking care of sick people and support for their family members, taking care of the AIDS' orphaned children, and a pastoral counseling service. Yet, much needs to be done in some churches, communities and countries to help people.

On the basis of the above analysis, it is evident HIV/AIDS endangers everyone. Either you know or ignore HIV/AIDS, one day you will have to confront its effects or the virus individually. Therefore, the best strategy is to attack HIV/AIDS before it attacks you, bearing in mind that the church has the cure, which is to make a change in sexual behavior.

CHAPTER 3

METHODS AND PROCEDURES

Research Design

Strauss and Corbin (1998, 4) introduced qualitative design as "one way of gathering knowledge about the social world," which allows the researcher to interact with participants in order to better understand the phenomenon under study. Creswell (1998, 15) stated, "Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting."

These definitions justified the use of qualitative method to collect and analyze data with the intent of exploring HIV/AIDS awareness and prevention in the AIC of Kenya. I preferred to use qualitative research methods because of their basic characteristics as given by Creswell (2003), which fit the proposed exploration well.

- Qualitative research design is generally inductive. The researcher does not have hypotheses to prove, rather is willing to learn from participants.
- Qualitative research design gives the researcher the advantages of doing her research in a natural setting (at the site), enables her to develop a

substantial level of detail about the AIDS program and to be highly involved in actual experiences of the participants.

- This design is interactive and humanistic, seeking to build rapport and credibility with the informants, and involving their active participation in data collections.
- Qualitative research is emergent rather than tightly prefigured. As the research is going on, the research question or data collection approach might change as the researcher learns the best question to be asked or the best sites at which to learn about the central phenomenon of interest.
- Qualitative research is fundamentally personal interpretation. The researcher views social phenomena holistically.

Coming to the research design itself, Yin (2003, 21), quoting Nachmias and Nachmias, defined research design as a plan that "guides the investigator in the process of collecting, analyzing, and interpreting observations." Yin also underlined the main purpose of design as a work plan that "helps to avoid the situation in which the evidence does not address the initial research questions."

Thus, I chose to do a case study in order to explore a bounded case of the AIC of Kenya through detailed, in-depth data collection involving multiple sources of information including interview and analysis of documents (Creswell 1998).

Research Approach

The case study is one of several research traditions found within qualitative paradigm. Yin (2003, 13) defined it as, "An empirical inquiry that investigates a

contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident."

A common misconception about case studies is that they can be used only in preliminary research strategy and not in describing or testing propositions. This assumption is invalid because case studies can be explanatory or descriptive. For this present exploration, case study is an appropriate strategy because a "how" question has been asked and "the investigator has little control over events." Also "the focus is on a contemporary phenomenon within some real-life context" (Yin 2003,1).

Rhetorical Assumption

Creswell (1998, 77) stated, "Literary forms of writing such as the use of metaphors, the use of first-person 'I,' and a focus on stories pervade qualitative inquiries." This was the reason why I used "I," "me" and "my" throughout this study.

Research Participants

This study was conducted with two groups of participants from the AIC of Kenya: the leaders or the initiators of HIV/AIDS programs in the AIC, and church members who were implementing the programs.

I interviewed the team leaders, and church members who were implementing HIV/AIDS programs in two different local churches. Each interview took no more than one hour. I chose research participants by means of purposeful

sampling; that was, according to the informant's ability to advance the purposes of this study.

Data Collection Strategy

Data collection began with discovering the historical background and development of HIV/AIDS programs in the AIC of Kenya through documents and interviews. I examined archival documents from the church about this program. I also conducted interviews with two present leaders. From the church office I moved into two different AIC local churches to interview members who were directly involved in the AIDS program. The interviews were conducted in an informal, free flowing style, guided by leading questions that were open ended.

I took January and February 2005 to do these explorations in four different expeditions: two expeditions to the church's headquarters for document analysis and interviews, and two others to the local churches. Each session took approximately one hour. I audio-recorded the interviews while taking written notes. March and April were used for analysis of data and findings.

Data Analysis Strategies

"Data analysis is the process of bringing order, structure and meaning to the mass of information collected" (Mugenda and Mugenda 1999, 203). In this case, recorded interviews were transcribed. I analyzed both transcriptions and archival documents to arrive at useful conclusions and recommendations. As soon as the transcription was done, I coded (open coding) sentences or paragraphs and I wrote memos. Formation of categories followed (axial coding). These categories were

then reduced to a small, manageable set of themes (selective coding). A visual image of information was created (table or matrix) with text in cells instead of numbers to allow me to write the final report.

Validation And Verification Strategies

Validity and reliability in this study were assured firstly by triangulation, which refers to the use of various data collection methods to allow comparison while collecting, analyzing and interpreting data. After analyzing the documents and archives, the researcher interviewed the leaders and went on the ground to see and interview those who were applying the program. Secondly, I involved the participants in the process of verification (member checks) by giving them opportunity to interact with the findings for affirmation. Finally, I established an audit trail to allow an independent researcher to check the procedures used in this study.

CHAPTER 4
RESEARCH FINDINGS

The purpose of this case study was to explore strategies for creating HIV/AIDS awareness and prevention within AIC of Kenya. The central question guiding this research was: what strategies did the AIC of Kenya employ to create awareness among its members? During data collection, the researcher was able to analyze the AIC's archives and documents about HIV/AIDS programs, interview leaders in AIC-AIDS Division (headquarter), and interview those in charge of 1) AIDS education in schools, 2) a home-based care, 3) an orphanage, and 4) a hospital. The hospital provided free medication to the infected, counseling, and education to the general public. It also assisted mothers in preventing mother to child contamination.

This chapter summarizes answers to the central guiding question as well as to the sub-questions, which also directed the research. Data were analyzed using methods and procedures discussed in chapter three.

Before discussing the answer to the central question, it was important to analyze the AIC's archives in order to understand the history and current state of AIC-AIDS Division.

The History of AIC-AIDS Division

AIC of Kenya had over 3000 local congregations and was divided into 48 regions, each region being divided into a number of districts, each district into branches and each branch into local churches. AIC had over 20 Bible training

institutions ranging from university to lay leader training schools, as well as Bible education by extension. It had about 400 sponsored secondary and about 3000 linked primary schools, a school of nursing, 20 children's homes, 5 hospitals and about 50 rural dispensaries and clinics. It also had a printing press, radio station and recording studios (AIC Kenya 2004).

History of AIDS Work in AIC

Initially, the AIDS program was not included in AIC'S health Ministry Department. The denomination did not have a defined strategy for fighting AIDS. Today's strategies resulted from the initiative of some individuals and "unofficial" groups within the AIC of Kenya. In this way, several groups initiated diverse AIDS programs, running them individually. Among these groups was one from Moffat Bible School in Kijabe, which desired a far-reaching program associated with AIC as a denomination. However, because of AIC's administrative structure, it was necessary to obtain the bishop's permission before approaching other church leaders. The first attempt, in 1994, failed because the bishop refused. Nevertheless, the Moffat people worked with MAP International to produce a curriculum they used in their Bible school. The curriculum had two courses: one theoretical and the other practical. In the practical part, the students went into primary schools in class 7 and 8 to "teach and prepare teenagers to take responsibility for their life, to have a good self-image and self-esteem." The goal was to "teach them about family, friendship, peer-pressure, about their body, the reproductive organs, the transformations taking place in their bodies, their feelings, about AIDS and how to become an AIDS-free generation. We finish by Gospel teaching which can lead one

to salvation," one AIDS educator affirmed, "Our program is exclusively a behavior changing program as you can see."

Good results started coming from this teaching and from the efforts of other groups. Some of these groups received funding from the same donors, who asked them to work together as one team. In 1996 the bishop finally agreed to introduce an AIDS program into the church. This program consisted mainly of seminars.

Considering the commitment of those few groups, the results of their work, and the demand of donors, the bishop agreed in 1998 to place the AIDS programs under the AIC's Health Ministry Department. In so doing, he merged all the individual groups doing AIDS education and AIDS-related activities. An effective structure emerged. AIC developed and expanded what these groups were doing and added some new programs.

Present Structure

AIC-AIDS Division operated under AIC's Health Ministry and had its central office within the church headquarters office. Seven people formed the leadership team: a director, a coordinator, an administrator and four facilitators. Apart from the leadership team, each local program had its own team of workers corresponding to the nature of the program (coordinators, facilitators, educators, counselors, chaplains, nurses, doctors, workers, supervisors). Each region that had gone through training seminars had a coordinator and a supervisor. Each trained local church had two educators who facilitated ongoing training. AIC-AIDS Division was represented in the annual committee of the church and reported each year to the committee.

In short, AIC-AIDS Division was formed by merging individual programs operating within AIC setting, which were expanded and developed to form the effective structure AIC has today. This brief background will lead us to the findings of the grand tour question: "What strategies were used at AIC of Kenya to create AIDS awareness among its members?"

AIDS Awareness Strategies within AIC of Kenya

Peter Okaalet, during a workshop conducted at NEGST on October 14, 2004, underscored three basic elements needed to fight HIV/AIDS: 1) an AIDS policy, 2) personnel specifically in charge of the program and 3) a budget. At the time of this study, AIC of Kenya had gathered these three elements and could be classified among HIV/AIDS fighters.

An analysis of the data manifested a variety of strategies implemented in AIC of Kenya to create AIDS awareness among its members. In all these strategies, AIC developed training materials, which enabled them to achieve their goals. I have grouped these strategies under church mobilization, education in schools, education of the masses (community), and testimonies of people living with HIV/AIDS (PLWHA).

Church Mobilization

In AIC of Kenya the mobilization of the church members was accomplished through seminars and training sessions for different persons at various levels. "Our first target was the church leaders of all levels, starting by the high hierarchy, so that they can catch the vision and get involved," said one of the participants. The first seminar was organized by AIC of Tanzania, at Mwanza, to which some

Kenyan regional leaders were invited. The leaders who participated in this seminar were so moved and motivated by the seriousness of the AIDS pandemic, they began inviting the AIDS division team to come and teach in their respective regions. In each region, the team gave two seminars. The first provided facts and general information about AIDS in order to help people to realize that AIDS was a reality, and that a great danger was among them. "Each church leader needs to see the real picture of AIDS standing beside him," reported one participant. Six months later, the team organized a follow-up seminar for those who participated in the first one. It allowed opportunity for feedback and provided greater detail about AIDS, self-protection, care of the PLWHA, and planning for a program addressing the needs people had seen in their local churches. Two five-day training sessions for AIDS educators followed, and finally the formation of a regional AIDS Task Force completed the mission in one particular region.

The challenge of church mobilization was evident. Some leaders of local churches were not receptive to the program. (One research participant attributed this lack of receptivity to their low educational level.) They simply rejected it and discouraged their members from pursuing the program. In order to overcome this obstacle, the AIDS Division appointed a program coordinator and a supervisor, who played the intermediary role between the central office and the local churches. They also planned activities and seminars in their districts, branches or local churches and invited the team for implementation.

In addition, the regional leaders usually came to the central office for the annual meeting of the church. On this occasion, the AIDS Division reported on what was happening in the regions and shared the community needs. From this

meeting, those who had not yet had seminars in their regions invited the team to conduct seminars. The process was downward, from central to local churches.

"Adults are more receptive than youth," reported one leader; "that is why we have turned our focus actually on the youth. We are training more youth who can make impact on their fellows' life. You know young people want to listen more to their peers than to adults." This statement justified the emphasis put on training youth, without neglecting adults.

Education in Schools

AIC, in collaboration with MAP International, developed curricula for its different schools. These curricula focused mainly on the prevention of AIDS. One group was taught to implement programs (Bible schools/colleges and nursing school); others were simply taught about sexual behavioral change.

1. Bible schools and colleges: AIC's Bible schools/colleges used *Choose Life* for courses lasting two terms. The first term focused on the theoretical part of the training, and the second on the practical, whereby students went into local churches and/or primary schools to apply what they had learned.
2. The AIC Nursing School: The nursing school also used the *Choose Life* to train students to provide pre- and post- HIV/AIDS counseling. Students also were taught to "enhance safe practices in respect to HIV/AIDS such as sterilization of equipment, disposal of sharp equipment, use of gloves, post exposure prophylaxis, management of S.T.I. and issuing of condoms to spouses." (AIC Kenya 2004, 5)
3. Primary and secondary schools: AIC of Kenya's 400 sponsored secondary schools and 3000 linked primary schools represented a very wide field to

cover, which required specific strategies. The first step in these strategies was to conduct seminars for the headmasters in order to convince them of the relevance of having HIV/AIDS teaching included in the school's curriculum. A second one was organized to train the teachers on how to use the AIDS curriculum, entitled *Why wait?* This program was implemented incrementally because of the large number of schools.

Meanwhile, there was a barrier to total implementation. Some headmasters rejected the program. In such cases, the church organized a training center or a club for youth outside the school to teach the young people.

The second step in these strategies consisted of using students from Bible colleges to teach primary school' pupils. Normally they taught class seven and eight, one hour a week for ten weeks. This initiative had a tremendous success, reaching thousands of children. The rate of pregnancy among primary pupils went down. Some headmasters asked the team to return to their schools, while others asked them to start from class five instead of seven. Some pupils who received this teaching in primary school introduced both the team and the program to their secondary school authorities so that the same program could take place in their new schools.

Community Education

AIC reached out to the non-AIC community through a weekly AIDS educational program via "Biblia Husema," an AIC radio station. In addition, wherever church leaders had seminars about AIDS, they invited community leaders. Finally, AIC hospitals contributed an important part of community

education. They provided training for both sick people (HIV positive) and those who were well (HIV negative).

- Education for HIV positive people: AIC hospitals provided pastoral counseling (VCT), free treatment for PLWHA and provision of cheap antiretroviral treatment. With this offer, many PLWHA frequented its hospitals. Furthermore as its facilitators, workers and educators were working in the community, they encouraged sick people to come to the hospitals. One facilitator affirmed, "You know, most of the time those people are desperate, they are sick so often that they cannot neglect a chance of free medication. They do come." As PLWHA were visiting hospitals, the AIDS team working in hospitals taught them how to take care of themselves, how to live with their family members without contaminating them, what to do at home when they were sick and when to come back to hospital.
- Education for the whole community: AIDS teams working in hospitals taught people about cleanliness and diseases, including AIDS, and how to take care of sick people without being infected. The same teams trained people to become community workers in order to take care of PLWHA at home, especially those who were terminally ill. These community workers formed the team of the home-based care program.

Testimonies of People Living with HIV/AIDS (PLWHA)

AIC-AIDS Division had a coordinator for the PLWHA network. Mainly, the AIDS Division team helped PLWHA to overcome the stigma of AIDS and empowered them to testify in churches or seminars. As the team went around

giving seminars, the coordinator arranged with one or two PLWHA to accompany them at each occasion if possible, so that they could testify. "Through those people we can teach so powerfully," affirmed a coordinator, "such people are found even in the church. As they testify, leaders are now realizing that AIDS is among them. We want them to know this reality that their members can be positive as well as their children." In other words, PLWHA represented a powerful tool in creating awareness both in community and in church, especially among leaders who were neglecting or overlooking the issue.

In summary, AIC merged strategies from individual groups, which were functioning independently. To these strategies it also added new elements to make what I summarized under church mobilization, education in schools, education of the masses (community), and testimonies of people living with HIV/AIDS (PLWHA). The next question to analyze was, "What factors motivated AIC of Kenya to start this program?"

Motivating Factors

The motivating factors for the AIC at large were not identical to those of the individuals who made the initial efforts to confront the pandemic. However, the efforts of those individuals, the success of their efforts and the intervention of donors helped mobilize the church as a whole. Hence, the key motivators of AIC-AIDS program were individuals who started various independent programs. I was able to interview some of them and came up with the following understanding of factors that motivated them to start the AIDS program:

- The disaster of the AIDS pandemic in the community: Many people had experienced the death of close friends, a spouse, a family members, or useful person in the community. "You know, my elder and only brother died of AIDS, I couldn't take it anymore," said one facilitator. It was no longer possible to ignore the reality of AIDS and individual people decided to act despite the rejection of church leaders. One leader of an educational program related, "as HIV has a large effect on the society, we wanted to do something more large which will have a large effect, we wanted to include the entire denomination. That's why we sought bishop's permission."
- Compassion: Other people were moved by compassion for sick people, seeing the way they were rejected, stigmatized and helpless. "I just felt that there was a need of someone else, out of their (PLWHA) circle, to stand for them, to speak for them, to act for them. And I thought I could be one of those people who could be of help for the helpless," reported one participant.
- Need for meaningful work: One participant related, "I was jobless. You know all my children are grown up, most of the times I had nothing to do. So, I wanted to do something for the community but I did not know how to start. I was then directed by a friend to visit Korogocho home-based care organized by Catholic nuns. I volunteered myself to work with them for eight months, and I liked what they were doing. I went through seminars and started a home-based care in my church first, then in my community." Another participant, who went through Bible College and followed the *Choose life* curriculum, reported, "Before I graduated in 2001, our leaders

saw my zeal and commitment for the work, my performance both in school and in the ministry where we were going. Furthermore, I didn't have any specific job to do after the accomplishment of my studies being a lady in AIC, whereby women don't have a considerable place in the ministry, my teachers and leaders in this program considered me to help them in the program after finishing my studies."

As I analyzed these explanations I came to understand that various factors motivated people from AIC to start an AIDS program. Although churches' motives might appear a bit different from individuals' motives, the bottom line was the devastating effects of AIDS among people. The "motivators" possessed zeal, commitment and devotion, resulting in a desire to work together, all bringing their contributions, ideas and abilities to fight AIDS. The important element was having the same vision, goals and objectives, regardless of diversity of procedures.

After analyzing motivating factors and strategies used in creating AIDS awareness, I found it important to know exactly what AIC was doing to prevent and control AIDS spread among its members and community.

AIC's AIDS Prevention and Control Program

The following AIDS prevention and control activities emerged from an analysis of the AIC-HIV/AIDS policy statements, archives, observations and interviews:

Educational Programs

Educational programs were AIC's primary tool in AIDS prevention. The denomination developed materials to enable its team to educate people at various

levels and in various contexts. There were two dimensions to that education. First, they sought to teach everyone. By means of instruction, people gained understanding and knowledge about HIV/AIDS and what they needed to do for themselves. In AIC, the teaching took place in church through seminars and pastoral counseling, in schools (primary, secondary), in hospitals (community education) and through AIC radio studio (Biblia Husema).

Second, they trained specific individuals to minister in several capacities. Using various curricula, the AIDS team provided training in Bible schools/colleges and nursing school, in hospitals (training of community workers) and in churches through seminars for pastors/leaders, teachers and chaplains. So, AIC of Kenya educated people through teaching, training and counseling by means of seminars, meetings and class sessions.

AIC provided education for both HIV positive and HIV negative people. The facilitators taught PLWHA to 1) accept their status, 2) know how to live positively with AIDS without contaminating people around them and 3) take care of themselves. Meanwhile they taught HIV negative people to live a life free of HIV/AIDS.

With regard to preventing the spread of AIDS, the first enemy AIC attacked was **immorality**. The church sought to promote behavioral change, focusing both on single, young people and married couples that were still HIV negative. For singles, AIC preached abstinence until marriage. No other option was entertained. During pre-marital counseling, counselors encouraged the couple-to-be to take a voluntary HIV test.

For couples, AIC promoted purity and faithfulness in marriage. "The church discourages couples living apart for extended periods of time. However, in unavoidable circumstances, both partners must exercise abstinence and faithfulness.... AIC advocates for monogamy, however there is pardon for those who become Christians after a polygamous marriage.... Divorce is allowed in cases of adultery.... On the issue of condom use, the church will allow it for prevention of STI's and HIV/AIDS especially in cases where one partner is infected.... Anything that promotes a couple to be unfaithful in marriage will be discouraged" (AIC Kenya 2004, 7-8).

Widows were free to remarry, but encouraged to resist family or community pressure involving wife inheritance. An HIV test was strongly recommended if the cause of the death of a marriage partner was not certain, especially when the remaining spouse was considering remarriage. AIC prohibited local practices, rites, rituals and ceremonies that might cause the spread of HIV, including wife sharing, wife inheritance, sexual cleansing, and cutting of skin with an unsterilized instrument.

The above elements formed the contents of education about prevention and spread of AIDS. It incorporated self-protection as well as ministry to others. AIC promoted yet another method of prevention that focused on the protection of others (as opposed to self-protection).

General Protection Program

Although it was necessary for each person to take care of him or her self, it was also important to encourage measures to prevent inadvertent infection. These measures particularly concerned hospitals and health centers because of the

likelihood of infection in these environments. AIC of Kenya aimed at training at least "50 % of nurses and laboratory technicians in order to enhance safe practices in respect to HIV/AIDS such as sterilization of equipment, disposal of sharp equipment, use of gloves, post exposure prophylaxis, management of S.T.I. and issuing of condoms to spouses... screening of donated blood" (AIC Kenya 2004, 5). AIC facilities also promoted prevention of mother to child transmission (PMCT).

AIC not only prevented the spread of AIDS but also took care of infected and affected people. Hospitals implemented programs for infected people, providing free treatment to PLWHA, cheap antiretroviral treatment and voluntary counseling and testing. Through this program for PLWHA, AIC was of great help and support for infected people. Moreover, hospitals trained community workers to care for and support PLWHA within the community.

Regarding affected people, AIC focused particularly on orphans. First, AIC helped those dying to prepare a will and decide how children were to be cared for. "The church will ensure that these wishes are adhered to, and that orphans are not exploited or abused. The church will seek to help any extended family or older sibling to care for the remaining orphans as well" (AIC Kenya 2004, 10). Second, AIC ministered to orphans. One facilitator reported, "we start giving money for children who were in need. As we go to schools we identify the most needy, the orphans. We take food to them... It is more of feeding program."

Thus, AIC-AIDS programs prevented the spread of HIV through education and general protection program in its health facilities. AIC-AIDS programs also

attended to PLWHA through providing medications and home-based care. Further, they facilitated the care of orphans.

The context of this study was a denomination whose key leaders are pastors. Hence, it is important to examine pastors' involvement in the AIDS program. What role did they play?

Pastors' Role

In a church setting, pastors are shepherds and members are sheep. Normally sheep follow the direction taken by the shepherd and hear his voice. Hence, those desiring to influence the sheep need to be in agreement with the shepherd. I think this was the principle used in AIC from the time the church incorporated AIDS into its health ministry. (Prior to that time, individual members were the "prime movers.") Mobilization was from the top downward, leaders and pastors first (starting with the bishop), then members. In this way, pastors were exposed to the reality of AIDS before most of the members. They got the vision and some of them were immediately involved in the program. Furthermore, AIC introduced the *Choose Life* curriculum in its Bible schools and colleges where pastors were trained. Hence all new pastors came in contact with the AIDS issue during their training. Some were employed immediately in an AIDS program upon completion of their studies. For this reason pastors' presence in AIC-AIDS program was prominent.

Before ending the analysis of these findings, I found it necessary to highlight some difficulties AIC experiences in its AIDS program.

Challenges

Findings on church mobilization and education in schools already revealed some challenges AIC faced in trying to mobilize its members. I also discussed how these difficulties were surmounted. However, the resistance of some local church leaders and headmasters was not the only difficulty confronted by AIC.

Various Approaches to Fighting HIV/AIDS

Many people, churches, organizations and institutions were engaged in the fight against AIDS, governmental as well as non-governmental. Each group had its own principles and methods, some of them contradictory. Similar disagreements were present even among various churches, resulting in certain conflicts. Hence, the same instructional material could not be used in all settings. One leader explained, "People are trying to fight AIDS transmission leaving in place the root cause, which are the immorality, drug addiction and some other unacceptable behaviors. Their messages sound, as if immorality is not the matter, as long as you don't get AIDS; drug addiction is not a big deal unless you have enough syringe and needle for each person… Church needs to point out where the root problems are, and fight them." In order to overcome this difficulty, AIC articulated its own policies and developed its own materials.

Stigma

AIC confronted a lot of ignorance in the church, which went hand in hand with discrimination and judgmental attitudes that resulted in stigmatization. "AIDS is known as dirty thing to be talked about, judgment from God, sickness of sinners; in this situation, who can say that he/she is positive? Yet, as long as people are

keeping quiet there is no way of having any help," explained a facilitator. "The hard task we have now is to help people to overcome the stigma and show up."

Ministry Focus and Human Resources

Among the individuals who initiated AIDS activities within AIC was a lady who had a vision for training people for home-based care of PLWHA. She presented the idea to the pastors so that they could mobilize believers to participate in a training seminar. "First of all the church was not ready to get involved into the project. The sensibilization [*sic*] was not enough, thus three people only showed up for seminar. I was discouraged and canceled it." She added, "Immediately with pastor's wife we started visiting sick people. As they were many we went the next day.... I deviated from my goal of training people so that they can take care of the sick. I started the work itself: caring for the sick." Soon, she had trained a few people who were coming with her. They were no longer just from the church but anyone from the community. Together they visited, helped and fed the sick. The team was built of "people of various background and belief, they knew that they are not working for a church but for a project, they expected to be paid. As I didn't have any salary to give them, most of them abandoned the project." As a result, she found herself in trouble. She did not have enough trained workers to carry on the work. As she was struggling to keep running the project, she encountered many needs in the field that she was no longer able to meet as an individual. She concluded in saying, "my advice to you is to have church involved in whatever AIDS project you are starting, as individual it is not easy. Don't take it as a personal business, share the vision with others in the church, train church members, and make sure you do what you planned to do."

Conclusion

AIC of Kenya is in the forefront of churches responding effectively to the AIDS crisis. It has developed specific programs for reaching everyone in the community and it has translated its materials into Kiswahili, making them easily understood by many communities in Kenya. The denomination has trained about 1006 teachers from both primary and secondary schools and 855 AIDS educators in 33 ecclesiastical regions. Each trained region has its own AIDS regional task force. Nevertheless, many people in AIC's target group still need to the reached.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

As the AIDS pandemic became a reality for some churches, they involved themselves wholeheartedly in fighting the spread of HIV. At the same time, other churches were still ignoring this reality. AIC of Kenya is among churches fighting HIV/AIDS, while numerous churches in DRC, including AIC of Congo, remain ineffective. Therefore, this study aimed at understanding the strategies used in AIC of Kenya in creating HIV/AIDS awareness and prevention that they might be applied to churches in DRC. The central question guiding the study was "what strategies were used in AIC of Kenya to create awareness among its members?"

Summary of Findings

I chose the case study approach above other approaches in order to discover inductively from participants strategies used in AIC of Kenya through interview and archives and documents analysis. The analysis of data collected led me to the finding summarized below.

- AIC of Kenya did not have a structured strategy to fight HIV/AIDS until it merged individual groups that were functioning independently within AIC settings to form AIC-AIDS Division. This merger resulted in an effective structure and strong, operational strategies.
- In order to create awareness among its members, AIC formulated various educational programs, targeting: 1) church leaders and church goers (church

mobilization) through seminars and pastoral counseling; 2) pupils and students (education in schools) through teaching; 3) community in general (community education) through radio and ministry in its hospitals and health facilities. PLWHA who had overcome the AIDS stigma also were used to create awareness among its members.

- Various factors motivated people from AIC to start AIDS programs, from individual factors to church's factors. Yet the bottom line was the devastating effects of the AIDS pandemic, which mobilized people of zeal, commitment and devotion.
- AIC prevented HIV/AIDS spread through education of both infected and non-infected people, and general protection program in health facilities.
- AIC not only prevented HIV/AIDS spread but also took care of PLWHA by providing treatment, home-based care, and intervention on behalf of orphans.
- Pastors played a prominent role in AIC-AIDS program.
- Although AIC faced challenges in the implementation of its programs (various views in fighting HIV/AIDS, stigma, overwhelming demands), it found ways to overcome these difficulties.

Conclusion

The HIV/AIDS pandemic threatens to destroy Africa. Churches need to know that they have an important role to play in fighting this plague. Indeed, they have the audience and the true message, which can defeat HIV/AIDS. Every church on the continent must wake up and take action now. Some churches, like AIC of

Kenya, are doing their part. Others, who are still watching from a distance, need to follow in their footsteps and get involved.

Recommendations for Communaute Emmanuel and Africa Inland Church of DRC (CECA-20)

I have come up with the following recommendations for churches in DRC based on the findings and conclusion of this study:

- In order to have an effective HIV/AIDS program, these churches need three basic elements: 1) an AIDS policy, 2) people in charge of the program and 3) a budget.
- The team in place needs to consider training a large number of people in order to increase their number instead of them doing the work alone. Furthermore, the AIDS team needs to choose carefully the people to be trained. Their motivation for AIDS work is of paramount importance.
- Pastors and church leaders need to be highly motivated if members are to be reached to help carry out the vision.
- Churches should incorporate those already exercising AIDS ministries outside the churches.
- As AIDS teams plan for seminars, they need ongoing teaching and training, and regular feedback on the effectiveness of their efforts.
- It is important to complete a mission with a given group or local church before heading to another one in helping them to come up with a program according to their needs.

- As people are trained, it is important to give them an opportunity of applying immediately what they have learned.
- The AIDS program needs also to involve the denominations' health facility, not only its churches.
- AIDS teams need to help PLWHA overcome stigma so that they can be useful in the mobilization of the church members.

Recommendations for AIC of Kenya

First of all, I would like to commend AIC of Kenya for allowing individual initiatives to operate within its context even before denomination got involved in fighting AIDS. Other denominations might not be ready to engage in AIDS activities, yet they should not hinder their members from getting involved or operating within their "borders." I also commend AIC of Kenya for its effort in fighting AIDS.

In view of the findings above I advanced the following recommendations for AIC of Kenya:

- The orphans' program needed to be developed alongside other orphanages. Even if the children live with their relatives, other help is needed in addition to feeding. AIC also should consider school fees, clothing and health care.
- AIC-AIDS Division should consider how to incorporate programs that started in the church and moved out into the community. Merging these initiatives with the church's programs could strengthen the efforts of both.

Recommendation for Further Study

I have explored AIC-Kenya's strategies for creating HIV/AIDS awareness among its members. Further evaluation of these programs in the future would help determinate their overall effectiveness. Furthermore, a comparative study of AIC strategies and other church strategies could reveal the most effective strategies.

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APPENDIX

Interview Questions Guide

1. Please tell me about yourself and what is your position in the program?
2. What motivated you to start HIV/AIDS programs?
3. What did you do to create awareness among your members?
4. How did you start and implement your programs?
5. What are you doing to prevent and control AIDS spread?
6. What challenges are you facing in the implementation of the AIDS programs?

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