NAIROBI EVANGELICAL GRADUATE SCHOOL OF THEOLOGY

The Perception of Leadership Towards HIV/AIDS Prevention Campaigns of Map International in Embul Bul and Ngong Deliverance Churches

BY
GEORGE WILLIAM SEMPEBWA

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

JULY 2006

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July 2006

Student's Declaration

THE PERCEPTION OF LEADERSHIP TOWARDS HIV/AIDS PREVENTION CAMPAIGNS OF MAP INTERNATIONAL IN EMBUL BUL AND N'GONG DELIVERANCE CHURCHES

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) _____

George William Sempebwa

July 2006

ABSTRACT

The objective of this study was to evaluate the perception of leadership towards HIV/AIDS prevention campaigns of MAP International in Embul Bul and N'gong Deliverance Churches. In order to come up with a substantial study, a related literature review on HIV/AIDS epidemic was carried out. This dealt with the causes, spread, impact, the Church, prevention, achievements and MAP International.

Data collection was conducted from a sample of the target churches by means of open-ended questionnaire and semi-structured interview guide both in formal and non-formal way. The instrument was administered to forty; (40) Church leaders from both Churches who included Pastors and lay leaders. Frequency tables and Cross tabulation were generated in order to provide deep insights of the variables under study.

This study was based upon three significant research questions:

1. What are the perceptions of church leaders about HIV/AIDS prevention campaigns of MAP International?
2. What are the factors that affect their perceptions?
3. What are their suggestions pertaining to the improvement of the approaches used by MAP International?

The research findings indicated the following:

Concerning factors that led to development of HIV/AIDS prevention campaigns, a number of leaders from both churches admitted that HIV/AIDS is general concern that requires to be dealt with seriously. Some thought that the increasing problem of the epidemic needed to be given a focused attention to counter its impact on the community. Others said that the infected and affected are asking questions for which they could not have an answer. Therefore a need for HIV/AIDS prevention campaigns was a central concern for the general Church leadership. When Church leaders are educated, trained and equipped it is believed that they would in turn spread the message to other members of the Church and community. Participants urged MAP International and the general church leadership to organize frequent workshop, seminars on HIV/AIDS prevention campaigns.

From the findings it was evident that the leadership of both Churches had not come out to be mutually supportive in prevention campaigns of MAP International towards HIV/AIDS campaigns awareness. The Church leadership's perception towards HIV/AIDS prevention campaigns of MAP International needed to be intensified. Therefore the leadership of both Churches must commit themselves to work hand in hand with MAP International HIV/AIDS prevention campaigns. This conclusion paved way for recommendations that appeal to the need for MAP International and the leadership of both churches to come up with strategies that will foster the HIV/AIDS prevention campaigns among the leaders.

TO

My dear wife Martha Kaaya Sempebwa and my three children: Joshua Kaaya, Rebecca Kaaya and Joana Kaaya for the insurmountable support they gave to me in those moments when no one could be available. Also I dedicate it to those who are overwhelmed, perplexed, infected and affected by the HIV/AIDS epidemic.

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LIST OF ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome.

ART: Anti-retroviral Therapy

CBO: Community Based Organization

CHAK: Christian Health Association of Kenya

DC: Deliverance Church

FBO: Faith-Based Organization

GPA: Global Program on AIDS

HIV: Human Immunodeficiency Virus.

KNASP: Kenya National HIV/AIDS Strategic Planning

MAP: Medical Assistance Programme

NASCOP: National AIDS and STD Control Program

NCA: Norwegian Church Aid

NGOs: Non-Government Organizations.

UNAIDS: Joint United Nations Program on HIV/AIDS

STD: Sexually Transmitted Disease

WCC: World Council of Churches

WHO: World Health Organization

PLWHA: People Living With HIV/AIDS

CHAPTER 1

INTRODUCTION

A wall of silence has surrounded the Human Immunodefiency Virus (HIV) epidemic for the past two decades especially in most African countries. Behind this wall of silence, the reality of Acquired Immune Deficiency Syndrome (AIDS) has been concealed and denied. Many government officials, political leaders, religious leaders, community leaders, employers and families considered HIV/AIDS as a shameful thing that must be kept secret (Kaleeba 2002, 2). This was followed by denial and a tendency to blame others for introducing and spreading HIV. This paved ways for stigmatization, discrimination, prejudice, preconception and persecution directed against individuals or groups that were perceived as being victims of HIV/AIDS infection.

Kenya has a population of 28.8 million of which about 13% was declared infected with life expectation dropping from 64 to 51 years (MAP International 1996, 3). AIDS deaths in Kenya are having a profound and increasing societal and economic impact; the total death rate from all causes among adults 15-49 years has more than tripled since 1990. It is estimated that 1.7 million children under 18 are orphans, about half due to AIDS (KNASP 2005, 15). And some of the factors that have caused the widespread of the pandemic in the country were the failure of church in Africa to address the AIDS situation, to give a clear lead, challenge the behavior, model an alternative lifestyle, proclaim the Gospel of Jesus Christ (MAP International 1996, 3). The combinations of these factors have motivated Medical Assistance Program

International (MAP International) to intensify its work in Kenya and the Eastern Africa region at large. The study will focus on Ngong Deliverance Church located in slum area and Embul bul Deliverance Church situated in the urban center.

Problem Statement

This research undertakes to investigate the perception of Church leadership towards the contribution of MAP International in raising HIV/AIDS awareness. Therefore, their perceptions towards MAP international programs must be taken into account to ensure their willingness to share the knowledge acquired with the church and the wider community.

Purpose of Study

This study will be conducted in order to assess the perception of the church leaders towards HIV/AIDS prevention campaigns and to ensure that the grace of God and His forgiveness are expressed according to the context of the community without distorting the biblical message.

Significance of the Study

A study conducted by MAP International showed that while 95% knew AIDS was a problem in Kenya; only 39% were doing anything about it in their congregation. Nearly three-fourths of the leaders knew someone with AIDS, but only 17% were caring for them in any way (MAP 1998, 3). Nevertheless, little has been done to assess the causes of poor responsiveness of the church leaders to various HIV/AIDS prevention campaign especially in churches under study. It is expected that the results of this study will contribute positively to MAP International, and church leadership, to

focus on their areas of strength and to improve on their weaknesses. Also the results will shed light to theological institutions that train pastors and Christian workers to be equipped with knowledge of the epidemic.

Research Questions

The following research questions will be used in this study:

1. What are the perceptions of church leaders about HIV/AIDS prevention campaigns of MAP International?
2. What are the factors that affect their perceptions?
3. What are their suggestions pertaining to the improvement of the approaches used by MAP International?

Limitations and Delimitations

The study will cover the selected sites that are significantly involved with MAP International namely: Ngong Deliverance Church located in a slum area and Embul bul Deliverance Church situated in urban center. The research will not cover many Deliverance churches due to time and financial constraints. Therefore, the outcome of this investigation will only fit in the context of the selected churches and their leadership.

Definitions of Terms

MAP International: Founded in 1954 as the Medical Assistance Program, MAP International is a Christian global health organization with a Mission to support and promote health, healing and reconciliation ministries of the Church to transform Communities.

Virus: One of the smallest infectious organisms, which only live, and reproduce in live cells of other living things that they infect.

Awareness: A very basic cognitive level of understanding about the epidemic called HIV/AIDS.

Church leaders: This term refers to Pastors and Lay leaders in their team ministry.

Church Response: This refers to Church's reaction towards the members in terms of prevention the epidemic from spreading.

Affected: A term used for the friends, families, and other persons associated to someone living with HIV/AIDS.

Infected: This term is used for a person who has the HIV virus within his or her body.

Faith-Based Organizations: These are groups of individuals who have come together voluntarily around a stated spiritual or belief system that informs and guides their work together.

CHAPTER 2

REVIEW OF RELATED LITERATURE

This chapter reviews and discusses various literature related to HIV/AIDS and the relevance of MAP International to the leaders of deliverance churches. It deals with the historical dimension of HIV/AIDS in Africa, Kenya in particular, and tackles the issues of the attitude of the church leadership towards the HIV/AIDS scourge in relation to various prevention campaigns organized and conducted by MAP International to increase the church's capacity to respond to the challenge of the pandemic. The discussion focuses on the holistic and incarnational ministry that carries Jesus Christ at the core of people's worldviews in order to establish the living relationship that conveys the spiritual and the physical meanings to Christian missions.

Causes

AIDS is a sickness which weakness a person's body so that they no longer have the strength to fight off diseases. The term, AIDS, stand for: A – Acquired i.e. its caught from someone else who already has the virus that causes AIDS. I – Immune which relates to the body's defense system, had been known as the immune system. D – Deficiency that is, the immune system is weakened and therefore 'deficient'. S – Syndrome, implies that a variety of different symptoms and illness. The grouping of well recognized illness connected with AIDS makes AIDS a 'syndrome' (MAP 1996, 3).

An extremely tiny germ, a virus known as HIV, causes AIDS. The effects of the virus on the human body may not be seen for years to come after a person is infected. Most people who are infected with HIV are infecting others without even knowing they have the virus. HIV is a virus for Human only, I – Immunodeficiency, virus weaken the body's ability to fight other infections. This weakness leads to the group of illnesses we call AIDS. HIV can also attack the brain cells and nervous system directly causing mental and coordination problems (MAP and CHAK 1993, 4).

Historical Context

HIV/AIDS was identified about 20 years ago; it has caused economic, political and social crises in the world. In some countries, particularly Sub-Saharan African, AIDS has begun to reverse 20 years of hard won gains in economic and social developments (UNAIDS 2000, 3). AIDS was first recognized in industrialized countries where, the vast majority of the funding for research, prevention and care has been concentrated. Now in its second decade, the pandemic is expanding fastest in countries with poor economies, where all the economic political and social mechanisms that keep countries poor interact to produce a context in which AIDS thrives. Thus AIDS has become a development issue. The HIV/AIDS pandemic adds a heavy burden on health care systems. The cost of treatment is often disproportionate to the incomes of the affected families (Anderson 1999, 26). The HIV and AIDS pandemic profoundly impacts on the life of the nations and the church because it does not only affect the sick person but also affect the family and the community.

African Realities

In Africa AIDS from its inception has been transmitted mainly by heterosexually. Women in their child-bearing years are becoming infected with HIV,

more societies have to grapple with the medical and human tragedies of babies born with the virus most of whom will die before their second birth day (Dossier 1989, 6). By mid-1995, the World Health Organization's Global Programme on AIDS (WHO/GPA) estimated that there had been 20 million HIV infections in the world, including 18.5 million adults and 1.5 million children. In sub-Sahara Africa there had been a cumulative total of 11 million HIV-infected people, 8.5 million of whom were still alive (Forsythe and Rau 1996, 3-4).

Sub-Saharan Africa

Over two-thirds of all the people now living with HIV in the world live in Africa south of the Sahara desert, and 83% of the world's AIDS deaths have been in this region. An even higher proportion of the Children living with HIV in the world are in Africa-an estimated 87%. This is due to a number of factors: More women of childbearing age are HIV-infected in Africa than elsewhere. African women have more children on average than those in other countries, so one infected woman may pass the virus on to a higher than average number of children. Nearly all children in Africa are breast feed. Breastfeeding is thought to account for between a third and half of all HIV transmission from mother to child. Finally, new drugs that help reduce transmission from mother to child before and around childbirth are far less readily available in developing countries than in industrialized world (UNAIDS/WHO 1998, 10).

Kenya is one of the countries hardest hit by the epidemic. While the level of HIV infection is devastating from a national health perspective, the continued provision and delivery of effective health care is only a portion of the overall problem. Research carried out by AIDSCAP in Kenya, and other countries, as background for the AIDS sector business. Financial and human resource data provided by several

companies in Kenya was analyzed to assess the disruptions in productivity (absenteeism because of illness, care giving and funeral attendance, and training of new employees (Rau 1997, 12). It is estimated that in 2003 almost 65,000 adults and 25,000 children became infected with HIV in Kenya. Prevalence data suggests that the majority of non-paediatric infections occur among youth, especially young women aged 15-24 years, and young men under 30. The rate of AIDS deaths has risen dramatically in recent years; it is estimated that there are now about 150,000 AIDS deaths per year, double the rate in 1998. This increasing death rate, which now exceeds the rate of new infection, will tend to reduce overall prevalence as the epidemic in Kenya moves into the "death phase" (KNASP 2005, 15).

AIDS is a disease that is 100 percentage fatal. AIDS affects individuals during their most financial productive years, and at an age when they are most responsible for raising children. In addition to the impact on individuals and families, HIV/AIDS affects the productivity and profitability of business, with likely economic implications extending into the future. The progress made over the past three decades in economic and human development is already being compromised, with the brunt of the AIDS epidemic still in Kenya's future. AIDS creates unique demands at all levels of society (5). Most of them do not know that they are infected. About half of them are expected to develop AIDS within the next couple of years. The magnitude of the problem and the human-economic costs of its impact on every aspect of our existence grow at an alarming rate, the current and potential spread of the disease recognizing no geographical, socio-economic or political boundaries.

Spread

The AIDS epidemic has unfolded very differently in different parts of the world, and among different populations. Globally, it is certainly the poorer and less educated who are feeling the brunt of the HIV epidemic. Neighboring countries often have very different epidemics. And even within in a single nation, HIV can strike different populations or different geographic areas in dissimilar ways, ways that may change over the course of time (UNAIDS/WHO 1998, 20). There are several factors, which clearly influence the shape of the epidemic. People on the move escaping from the abuse, or even leaving their families in search of work are likely to be exposed to infection. People whose daily existence is stressful and dangerous may not care about the long-term risks posed by HIV. People in conflict and refugee situations may have little control over their exposure to HIV, indeed even to sex. The stigma that still attaches to HIV hinders people from protecting themselves and others from infection, or from seeking out care and support (Mobilizing Churches to collective Action against HIV/AIDS 27-30 April 1990, 11).

The HIV epidemic is mostly driven by individual behaviors, which put people at risk of infection. These behaviors may be driven in turn by poverty, by unequal relationships between men and women. It can between the old and the young people, or by cultural and religious norms that leave people with little control over their exposure to the virus (UNAIDS/WHO 1998, 23).

An analysis of the relationship between education and HIV illustrates that the pitfalls of drawing deceptively simple conclusion about the determinants of the epidemic. It is reasonable to assume that better-educated people are more likely to have better-jobs, and can afford the sorts of goods and services that allow them to act on their AIDS knowledge. Countries with high level of literacy have low levels of HIV

(UNAIDS/WHO 1998, 20). However, even the more educated are also likely to be HIV-infected. This is because social changes that accompany more schooling are also associated with behavior that increases the risk of HIV infection. This may be especially the case for women, who without education may have very much less social mobility and be exposed to a much narrower spectrum of social and sexual relationships (50).

A rich man is more able to afford a condom than a poor man; he is also more able to afford to invite a potential partner to a nightclub, to support a number of wives or to visit sex workers. Where men tend to have at least some partners of similar social and educational standing as themselves, higher HIV rates among educated men will translate into higher HIV prevalence among educated women (22).

Uganda, one of the first countries in Africa to be hard hit by HIV/AIDS has demonstrated some of the most effective ways of reversing the challenge. From the outset it was recognized that the issues were not just medical but societal and developmental. The response needed to be broad and multi-sectoral. Recent surveys have shown just now successful such an approach can be. Rates of infection are coming down, people are avoiding high-risk behavior and the dream of an AIDS-free generation is becoming a reality. These results can be attributed to a powerful combination of clear and sustained political leadership; empowering communities; mobilizing employers; addressing socio-economic issues and, above all, the full involvement of people living with AIDS (49).

Impact

The HIV/AIDS pandemic is not just a matter of statistics. Its effects are impoverishing people, breaking their hearts, causing violations of their human rights

and weakening havoc upon their bodies and spirits. Many who suffer do so in rejection and isolation. In a striking way HIV/AIDS has become a 'spotlight revealing many inquisitions conditions in our personal and community lives, revealing inhumanity to one another, our broken relationship and unjust structures. It reveals the tragic consequences of personal actions that directly harm others, or of negligence that opens people to additional risk. The pandemic exposes any silence and indifference of the churches, challenging them to be better informed, more active, and more challenging them to be better informed, more active, and more faithful witness to the gospel of reconciliation in their own lives and their communities. The impact of the HIV epidemic in developing countries must be understood in the context of the critical and economic problems already experienced by the countries: poverty, famine and food shortage, inadequate sanitation and health care, the subordination of women and adjustment policies that allocate insufficient resources to the social sector. These factors create a particular vulnerability to the devastating consequences of the epidemic.

Economic

It is now widely accepted that HIV/AIDS has major economic and social impact on individuals, families, communities and on society as a whole. In Kenya, as in other countries in sub-Suharan Africa, AIDS threatens personal and national wellbeing by negatively affecting health, lifespan, and productive capacity of the individual; and critically, by severely constraining the accumulation of human capital, and its transfer between generations. It is very clear that HIV/AIDS is the most serious impediment to economic growth and development. The impact of HIV/AIDS on economic growth and development, coupled with the direct impact of increased

mortality and morbidity on the lives of the poor, makes HIV/AIDS an uinquely corrosive threat to poverty reduction efforts in the country (KNASP 2005, 15).

We have economic need and dependency that lead to activities that magnify the risk of HIV transmission and this means that many people, particularly women, are powerless to protect themselves against infection. Inadequate standards of health and sanitation further exacerbate the spread of HIV and accelerate the progression from HIV infections to AIDS. The worldwide HIV epidemic is spreading at an even-increasing rate. Millions of children will be parent less. The tragedy of human suffering and the profound additional burden on health services are only the most apparent cost of these figures.

Socio-economic and cultural context are determining factors in the spread of HIV/AIDS. Because these circumstances differ in from place to place, countries, districts, and even villages may have quite different HIV/AIDS' stories and current profiles. But WHO currently estimates that nine out of ten people with HIV live in areas where poverty, the subordinate status of women and children, and discrimination are prevalent (Anderson 1999, 39).

HIV/AIDS could also have a severe economic impact on particular sectors within the wider economy. Each major sector is expected to produce less, and most households afflicted by AIDS are likely to be seriously impoverished. These effects are as serious for agriculture as they are for the formal business sector. They are as serious from the lowest income, rural farm households as they are for upper-income, urban households (Forsythe and Rau 1996, 11). The productivity of the agriculture sector, upon which the majority of Kenyans rely for their livelihood, is being undermined by negative impacts on the supply of labor, crop production, agricultural

extension services, loss of knowledge and skills, and a personal level the trauma associated with death (KNASP 2005, 15).

In addition to these direct effects on production and social services, there is a growing realization that HIV/AIDS may undermine the long-term revenue base of the economy, and so reduce Government's capacity to provide the infrastructure and social services essential for long-term economic growth. This suggests that the impact of HIV/AIDS on public finances in severely affected countries is large and growing (KNASP 2005, 16).

Financial

The impact of AIDS is extending far beyond the number of deaths and orphans associated with the epidemic. Estimates indicate that the total cost of treating a patient with AIDS related disease is Ksh 23,000-43,000 per month. In some parts of Kenya, persons with AIDS already fill more than half of the hospital beds. Other social services are likely to be affected by HIV/AIDS, as trained and skilled managers, technicians, teachers, machinists and others are lost from the workforce (Forsythe and Rau 1996,10).

Financial analyses of several Kenyan firms revealed that AIDS could increase labor costs (through increased absenteeism, labor turnover, health care costs, burial fees, recruitment costs, retraining cost, etc). Interviews with managers from Kenyan businesses revealed that almost all managers know of at least one of their employees who had died of AIDS and of others who are currently infected with HIV (12).

A person's social or economic position can affect his views about how HIV is spread.

It can also change his chance of infection and determine what kind of medical care he or she gets. For example, an educated person may have learned more about how to avoid HIV.

On the other hand, a person with a lot of money may be able to travel to large cities or other countries, which if he engages in risky behavior there, may increase his chances of getting HIV (Granich 1999, 101). In some countries, men with a lot of money are more easily able to have several sexual partners than men with little money; again this can increase the chances of getting HIV. On other hand, people with less money have more difficulty getting health care, information about HIV, and condoms. People with less money are often forced to travel long distances to find work. They may be in large cities away from their wives and families and community support. Sometimes they need to exchange sex for food, housing, money, or drugs. It is difficult to avoid HIV under these conditions (Granich, 101).

Communities

As HIV/AIDS epidemic progresses and people begin to die in significant numbers, the social and economic effects reverberate throughout communities. In many countries, funerals are community events in which every one must participate. Contributions to offset burial costs are mandatory, the deceased family needs help to dig the grave, and everyone provides comfort to the surviving family members during the mourning period. Traditional mourning periods often forbid planting and other agricultural work for anywhere from one to seven days (Donahue 1998, 7). HIV/AIDS stretches' resources decline, the assistance available from the community dwindles. The hired labor pool shrinks and become expensive, forcing communities to reduce their crop production. There may be fewer teachers and health workers to provide

services to the community, reducing access to education and health care (7). It is quite absurd that educational services are suffering as teachers are lost to AIDS, and children drop out of school as parents die and household incomes fall. At the same time, the health service is losing trained staff, and has to cope with the increasing burden of HIV related infections (KNASP 2005, 16). Also many families have been victims of HIV/AIDS epidemic.

Families

The pandemic is also having profound consequences for family and community life. In addition to causing the illness and death of members of the most productive age group, it severely restricts the opportunities of women and girls who care for persons suffering from the disease. In some societies the pain and the disruption HIV/AIDS brings to families and other basic social units weaken whole communities. Grand parents find themselves caring for their sick children or orphaned grand children, and children are therefore forced to become the bread -winners for others (Anderson 1999, 26). Extended family structures have in many countries been able to absorb some of the stress of increasing orphan-hood.

However, urbanization and migration of labor, often is eating away at those structures. As the number of orphans grows and the number of potential caregivers shrinks, traditional coping mechanisms stretch to breaking point. HIV has often caused huge increase in death rates among younger adults. This is the age when people are forming families and having children. This inevitably leads to an increase in orphans. In rural areas of East Africa, 4 of every 10 children who have lost one of their parents by the age 15 have been orphaned by HIV/AIDS (UNAIDS/WHO 1998, 9).

The disease again affects families so much, and their needs must be quickly identified and addressed in order to mitigate its impact. Because of the stigma attached to AIDS, some HIV-infected individuals and their families have sought to conceal and / or deny their illness. Denial, guilt, shame, anger and blame are common responses of both individuals and families to HIV. Despite the trauma of HIV infection, many people respond with courage and determination to live full lives. Some have even turned to serving others by publicly acknowledging their HIV status and becoming educators, counselors and advocates (Forsythe and Rau 1996, 8).

Due to HIV/AIDS epidemic, there will be incapacitating losses to families, communities, and business and to countries. These losses of the most valuable human resources, the parents and workers, will impoverish the economies and trade and even the social stability of many countries (Anderson 1999, 26).

HIV/AIDS affects people whose behavior has nothing to do with sexual risk. Current NASCP estimates there will be one million Kenya children under age 15 by the year 2005 who have lost their mothers to AIDS related diseases. Again the extended families are struggling to take care of these orphans, as well as other family members who may be HIV infected. Where the extended family structure is unable to cope, some Kenyan households are being led by children as young as 10 to 12 years old. In other families, the entire structure has fallen apart, leaving orphans homeless on the streets, themselves vulnerable to HIV infection (Forsythe & Rau 1996, 9).

Again AIDS impacts societies in many ways, challenging some traditional notions of the Social order. In some places, the pandemic is raising questions about the meaning and role of the family; elsewhere it has focused attention on those using drugs and their increased risk; still elsewhere it has raised questions about human sexuality and relationships. In the course of the pandemic the role of gay communities

in compassionate care and effective prevention has been recognized. This perspective has challenged the Church to rethink their relation to gay persons (Anderson 1999, 26).

It is difficult to visualize the devastating effect of the HIV epidemic within our lifetimes and beyond. This disease is different from other diseases. It continues to affect people who are responsible for the support and care of others, children, the elderly, and extended family members. Over 200 million dependants will have been affected, traumatized by the loss of their parents or children, left destitute, families scattered or children homeless (39). In the families, some women continue to experience a lot of hardships compared to the other gender.

Women

The imbalance in power between men and women and perceptions about the role of women in society are major contribution factors to their extreme vulnerability. Lack of education, low social status and economic dependence compound women's dependence on men and limit their ability to request or negotiate safer sexual practices (UNAIDS 1999, 58). Young women are worst affected. The peak age of infection is between 15 and 24, with a female –to-male ratio of two to one in that age group. And as infections arise, so do the infections in the infants born to them, with about a third of babies born to HIV-infected mothers becoming infected too (Paterson 1996, viiii).

More than half of all people now infected with HIV/AIDS in Kenya are women. There was a concern that women's vulnerability is greater than that of men, because often they have little control over the sexual behavior of their husbands/partners, are stigmatized if they insist on condom use by their partners, and they had biologic factors that increased their risk of HIV infection. Both women and

men informants identified the situation of women and their relation with men as a critical issue for Kenya's HIV/AIDS prevention efforts (Rau 1997, 11). It is also true that the degree to which women feared violence from their partners determined their ability to broach issues relating to risk reduction. Anecdotal and preliminary evidence suggests that fear of social stigma; alienation and a violent backlash are significant factors that prevent women from asserting their rights even when they are aware that their lives are at risk (UNAIDS 1998, 59). Apart from the women, the children follow in terms of HIV/AIDS epidemic impact.

Children

All over Africa, millions of children are left as orphans when a mother or father dies from AIDS related diseases. By 2010, 25 million young people in Africa under 15 years of age will have lost one or both to parents to AIDS. Twelve percent of all the children of Africa are orphans (Blyth and Garland 2003, 250). The dramatic increase in the number of AIDS orphans will create enormous social and economic problems for resource poor Africa Countries. Many of these orphans will fail to start or continue with education due to lack of school fees or due to the need to take care of their siblings (Kiarie and Muraah 2001, 123). In Rwanda in 2003, there are 63,000 child headed households (Blyth and Garland 2003, 259). The nutritional and health status of these orphans is expected to deteriorate. These orphans are likely to grow up lacking suitable guardians and mentors and this will hinder their development. Many of these difficulties will have a long-term impact on them and the community as a whole will have to cope with that later in life.

AIDS orphans will also further burden the meager budgets of their relatives, communities and governments (Kiarie and Muraah 2001, 123). The main hindrance to

the readiness of absorbing orphans in most households was identified to be lack of adequate resource. It was said that sometimes this resulted in the ill treatment of orphans. In such situations orphans are asked to do a lot of household chores, which is taken as a condition for their being assisted (UNAIDS 1998, 39). The direct cost and social problems associated with caring for increasing numbers of orphans, coupled with existing high poverty levels, are placing severe burdens on family and societal structures (KNASP 2005, 16). In some cases orphans are reduced to a level of house servants and are abused. In other cases, individuals will insist on taking orphans in order to benefit from the deceased estate or fro the support given by government, NGO's and churches (UNAIDS 1998, 39).

Children affected by HIV/AIDS are caught up in feelings, events that they do not understand and that threaten to destroy them. They face great emotional and psychological stress. Sometimes their grief may be overlooked as small and unimportant compared to the adults' grief. But bereaved children have many developmental and emotional needs because of trauma (Blyth and Garland 2003, 260).

One of the major problems host house holds face with orphans is the conflict of values, norms and ways living between them. Most families as well as orphans ma be unable to adjust to each others needs and expectations, because of their varied family conditions and social positions which may be very different from each other. Their differences usually end up in frustrations on both parties, which results in delinquent behavior, by girls and boys which eventually may result in them becoming commercial sex workers and criminals. This kind of delinquent behavior including alcohol, drug abuse, street children, predisposes orphans to HIV/AIDS infection, and resentment by host families (UNAIDS 1998, 39).

It has been observed that, many children whose parents have died of AIDS lack the basic necessities for survival and this include food, shelter and clothing. Most orphans do not have access to basic health care and will not complete their primary education. As a result, the recent achievements in reducing Kenya's child mortality and illiteracy rates are expected to be reversed in coming years by AIDS (Forsythe and Rau 1996, 9).

At the same time, orphans have a right to be heard and to be protected from abuse, neglect, maltreatment and exploitation. They have economic, social, educational, medical, emotional and spiritual needs like any other children with parents. Sexual exploitation is a serious risk for children, especially girls, orphaned or displaced because of HIV/AIDS. These girls are themselves likely to become infected (Blyth and Garland 2003, 262). The researcher agrees with Danahue who say that:

> Because the families of those stricken feel the burden of HIV/AIDS first, the first line of response should be to mitigate the impact on those households, in particular, by improving their income-earnings capacities. When a families are no longer able to cope, however they run to members of their community, and projects that strengthen communities' coping mechanism will become increasingly significant as an epidemic continues. Planners should therefore consider a two-pronged approach to mitigating the socioeconomic consequences of HIV/AIDS on affected communities: building the economic resources of households, primarily through micro credit programs, and supporting the creation of community safety nets (1998, 1)

The issues raised by the pandemic are far from purely medical or clinical. They touch on cultural norms and practices, socio-economic conditions, issues of gender, economic development, human responsibility, sexuality and morality (Anderson 1999, 39). In this regard, the church must respond to the challenge of the HIV/AIDS epidemic.

The Church

The HIV/AIDS epidemic provides the church with one of the greatest opportunities for ministry that it has ever seen. During times of natural calamity, the attention of unbelievers is more easily turned toward God (Clarke 1994, 171).

The Church has a massive, yet often untapped, potential to successfully reverse the course of the epidemic. Its core values of love, care, support and justice have produced the nurturing and development of strong Church-run care and support programs in many communities. At the same time, its promotion of abstinence before marriage and faithfulness in marriage, which can be strengthened, is an essential weapon to reduce HIV/AIDS prevalence and incidence in Africa (Garland and Blyth 2003, 277). But still the stigmatization and discrimination still abound within the Church, and seriously slow down, and sometimes reverse progress towards preventing and controlling HIV/AIDS (Ibid).

While Kenya could potentially be devastated by HIV/AIDS, the reality is that new HIV infections are preventable with appropriate changes in sexual behavior and in the situations which place people at risk. Kenya's churches have an important role to play in influencing sexual behavior. Many Churches have played an important role in providing care for people with AIDS and for their families. Their influence in addressing male and female sexual behavior and family life education, however, has been minimal (Forsythe and Rau 1996, 31). Clearly, HIV/AIDS is presenting religious groups with major dilemmas, not easily addressed or resolved. Numerous studies have found that most young people engage in sexual activity before age 18. However, many church leaders and parents fear that young people will become even more sexually active if sexuality is discussed or if condoms are promoted for disease prevention (14).

Kenya ranks third among all countries worldwide in the number of reported AIDS cases. The most affected ages for reported AIDS cases is between the ages of 20-40 years (MAP International 1996, appendix 30). The minister reiterated that the Government and the Church have to be mutually supportive in their endeavor to fight the AIDS Scourge. Bishops and Clergymen need to be instrumental in tailoring and diversifying the Curricula of educational institutions to include the HIV and AIDS Component.

The Church needs to transcend denominational differences, deal squarely with issues of human sexually especially in relation to women and children, and determine how to inculcate value systems that will generate behavioral change (MAP International 1996, 1). The Church as the body of Christ is expected to give both spiritual direction and moral guidance within its own communities and beyond. Such direction and guidance need to be given in caring love for the individual and in recognition of the value and dignity which human being has in the face of God. It is when the Church adequately responds to the suffering, sick, to people living with HIV/AIDS, when it ministers to and learns from them-that, the relationship between the Church and such persons will indeed make a difference, and thus become growth producing (Anderson 1999, 17). The effect of AIDS in the church is no longer a matter of guesswork.

The burden of prevention, care and support is fast falling on the church as most traditional forms of social support in Africa are weakened by social change and as AIDS takes heavy toll on the strong and active labor force. If there was a time the church needed to act with responsibility and commitment it is in this era of HIV and AIDS. The church may become irrelevant if it does not take its place in the fight against this global pandemic. The relevance of the churches will be determined by

their response. The crisis calls upon churches to re-examine the human conditions, which in fact promote the pandemic, and to sharpen their understanding and responses to reduce the pain AIDS is causing.

The Church, by its nature as the body of Christ, calls for its members to become healing communities. Despite the extent and complexity of the problems raised by HIV/AIDS, the Church can make an effective healing witness towards those affected. The experience of love, acceptance and Support within a Community where God's love is made manifest can be a powerful healing force. This means that the Church should not exclude, stigmatize and blame persons on the basis of behavior which many local congregations and Churches judge to be unacceptable (Anderson 1999, 36). The church is healing community; practicing healing in many different ways for example caring and support has a strong belief in hope for this life and the life to come. Families affected by HIV and AIDS need the hope and purpose for living that the church can offer. The church can play a more comprehensive role as a healing community to respond effectively to the HIV and AIDS epidemic and make a significant impact on HIV prevention as well.

It is imperative that the church must know some deeper factors contributing to the epidemic such as the breakdown of family structures, unfaithfulness in marriage, sexual activity among youth, and lack of reverence for the value of life. The Church becomes an effective healing Community only if it is truly a sanctuary, that is, a safe space, a healing space. For healing, people need a place where they can be comfortable in sharing their pain. The Church needs to create an atmosphere of openness and acceptance (Anderson 1999, 41). Clergy and pastors have the necessary platform to explain to their community and influence their behavior for a change at home and abroad. As a community of compassion and care, "the church is called to sacrifice as

it addresses the AIDS crisis". The leadership of the Church is called upon to nurture the seeds of the *logos*, God's own word and God's energy among the people. By creating a proper atmosphere or disposition, that good moral action which is love will issue forth on the lives of the human community. Anderson gives a quotation from Basil,

> The advice of St. Basil the Great comes to all those in leadership positions within the Church, emphasizing their responsibility to create an environment-an ethos a disposition- in which the cultivation of love and goodness can prevail within the community and issue in that Good moral action that is love (1999, 44).

Church leaders should be fully equipped with accurate knowledge, appropriate skills and material resources to engage meaningfully in the fight against HIV and AIDS inspite of their perception towards the epidemic.

Perception of Religious Leadership

The church in Kenya is very diverse in its beliefs, practices, and structures, making it difficult to generalize about a single response to HIV/AIDS. The church has responded to the AIDS challenge in a number of ways, but two responses have been most characteristic. Some churches have responded with a *closed* fist. One man living with AIDS was asked if he received any help from his church. "No", he replied. "I do not want them to know that I have AIDS because if they knew they would not come near me. I have stopped going to church" (Forsythe and Rau 1996, 131). The tendency for religious leaders to prescribe abstinence and mutual monogamy in the face of overwhelming evidence that these behaviors are not always the norm has been seen almost all over (Green 2003, 4).

The sexual nature of HIV transmission has placed religious groups in a dilemma. Discussion of sexuality and pre- and extra-marital sexual relations raise

moral issues that run counter to established religious prescriptions. Many religious groups consider AIDS as outcome of individual immoral behavior and not a problem concerning religious community as a whole (Rau 1997, 6). Religious taboos on sexual education have been harassing AIDS prevention in third world countries. The confrontation between the condom and abstinence or fidelity has snapped closed any possibility for negotiating joint strategies. It has polarized political stances that clash public opinion and counterattack official efforts for AIDS prevention (Green 2003,4).

However, the growing number of illness and deaths resulting from the HIV infection and AIDS is creating social problems that religious groups are unable to ignore or dismiss as happening to others. For example it is recognized that many women become infected through their husbands who have had extra-marital sex with infected partners. Women are vulnerable, even when their behavior is prudent and morally acceptable. The changing perception has provided initial space for AIDS policy influencers to work quietly with the religious hierarchy and advocate policy and program changes that reflected the concerns of local communities (Ibid, 6). On the other hand some of these churches have sometimes responded with a *helping hand.* Support, both spiritual and physical, has been provided to the affected families. Youth have been challenged to avoid pre-marital sex, and husbands and wives encouraged to remain faithful to each other (Forsythe and Rau 1996, 131). The time for the church to fulfill her mission mandate of a holistic gospel is now.

The Mission

The HIV/AIDS pandemic focuses uniquely on the need for the world to repent and turn to the grace of God and to believe in the Good News of the gospel. The church's mission in AIDS is to extend God's grace—His forgiveness offered in our

relationship to our Creator and to each other (MAP International 1996, 2). Our mission cannot be confined to our church benches; our mission is both centripetal and centrifugal in its nature. The mission we are involved in is missio Dei (VanEngen 1996, 27). The church has a mandate to execute God's program of mission. Our master Jesus Christ has entrusted His church to be in partnership with Him so that every one will hear the gospel of Jesus that has power to save, heal and deliver. The church ought to reflect that mission ideology in both her living and her endeavors to the neighbors, AIDS victims, and the whole world. Our mission means responding to our world: feeling the pain, bearing the burden, risking life to save it, and identifying with those who are hurting and suffering. As the church is converted to sinners, sinners will be converted to God. The church's model is Jesus who walked thousands of miles/kilometers, held hundreds of hands crushed by calamity, ate with prostitutes and thieves, and marched into big churches to tell the religious leaders that the kingdom of God was upon them—out side in the community where the blind, cripple, sick, outcast, and lepers lay.

The church's mission is to understand HIV/AIDS, feel the pain and heartache; bind wounds, and share the sweetness of the fruit basket "gift" of forgiveness and life eternal (MAP International 1996, 3). Jesus loves all people regardless of their religious affiliations, ethnicity or cultural identity. As church leaders and Christians in general, it is our obligation to follow our master's footsteps. The gospel must be transforming and culturally relevant to the people concerned. The church should make a deliberate effort to conduct a holistic gospel that demonstrates not only the power but also the true love of the Lord Jesus Christ more in particular to meet the diversities of people's needs. In order to do great exploits in the Kingdom of God, the church need to be revitalized and be on fire than ever. The church's mission will involve sacrifice in the

AIDS crisis. Sacrifice means giving up our feelings of self-righteousness, our condemning judgments of others, our lack of concern, our denial of the problem, and our faulty doctrines that point to sin only and forgetting the grace of God (MAP International 1996, 4). The church's mission should include prevention of the HIV/AIDS epidemic. The Churches therefore, are particularly well-placed and well equipped to deal with the social and spiritual implications of the AIDS pandemic.

Prevention of HIV/AIDS

Since AIDS was discovered in Kenya in 1984, many efforts have been directed at the prevention of HIV/AIDS. These measures have been reinforced by the effort to bring an increasing awareness of the disease, its nature, its consequences and its modes of transmission. Although many misunderstandings and misconceptions still prevail in sections of the population, the general level of AIDS awareness in Kenya is high. This knowledge however, has not been translated into effective action for prevention. Knowledge has not been converted into behavior. Inspite of this, the importance of dissenminating correct and adequate information cannot be overemphasized (Shorter and Onyancha 1998, 47).

Experience shows that national leadership and open discussion about HIV/AIDS are key factors in attaining stable or declining national HIV seroprevalence rates. But it is also the involvement of religious leaders and FBOs in HIV prevention. In some countries Faith-based involvement may prove to be as necessary as condom social marketing, treatment for sexually transmitted infections, voluntary counseling and testing plus other state-of –the-art interventions in HIV prevention efforts (Green 2003, 17).

We have increasing momentum for preventing the spread of HIV/AIDS and the campaigns have managed to arrest or reverse HIV trends. The best prevention campaigns work simultaneously on many levels - increasing knowledge of HIV and how to avoid it; creating an environment where safer sexual or drug-taking behaviors can be discussed and acted upon; providing services such as HIV testing, treatment for other sexually transmitted diseases (which if left untreated greatly magnify the risk of HIV transmission) and access to cheap condoms and clean injection equipment; and helping people to acquire the skills they need to protect themselves and their partners. Structural changes can help by empowering people and reducing their vulnerability. Changes in laws, employment practices and even economic policy can create an environment in which people can more easily reduce or control their exposure to HIV (UNAIDS/WHO 1998, 26).

Again these comprehensive integrated should include: information and support for changes in sexual behavior, including reducing the number of sexual partners, the promotion, distribution, and use of condoms, and the proper diagnosis and treatment of sexually transmitted diseases (Forsythe and Rau 1996, 16). Strategies that promote individual behavior change will be most effective when supported by institutional changes. One man's decision to consistently use condoms will be easier choice for him if messages from respected religious, government and social authorities' support- not contradict- that decision. Institutional support can also come through business, which not only encourage HIV/AIDS prevention, but also provide the means for workers to change their sexual behavior (17). Programs to prevent the spread of HIV work best as a package with each initiative reinforcing the others. It is almost impossible therefore, to attribute changing behavior or low or falling rates of infection with HIV and other STDs to single element of a prevention campaigns. Careful

monitoring of both HIV prevalence and the behaviors that lead to its spread can, however, indicate whether such campaigns are having a collective impact (UNAIDS/WHO 1998, 26).

The church leader's statement, facilitated during a MAP International workshop in February 1996, and the on-going attention to all aspects of HIV/AIDS through the regional reviews of the Sessional Paper on AIDS and the provincial policy workshops held by the AIDS NGOs Consortium have contributed to a greater openness and sense of movement among AIDS activists and program staff. In some cases, the changes have been faster than had been initially imagined (Rau 1997, 15). Some denominations have already set up their own AIDS awareness programs to educate pastors, church leaders, women's fellowship groups and young people about AIDS (Blyth and Garland 2003, 288).

Similarly the Faith-Based Organizations have made a considerable contribution to HIV/AIDS mitigation, care, supported and organized a range of activities. Some of these activities include the following: Counseling support groups for people living with HIV/AIDS and their families, Support groups for educating local communities about HIV/AIDS, peer educator programs aimed at prevention of HIV and sexually transmitted infections, income-generation and vocational training programs for people living with HIV/AIDS and their dependents, Care and support programs for children orphaned by AIDS, voluntary counseling and testing services, alternative employment or income-generation opportunities for girls and women who are vulnerable to or trapped in the sex-trafficking trade, Hospice care, drama or music groups to raise awareness about HIV/AIDS, and to mitigate stigma (Green 2003, 5).

Likewise our theological colleges should have courses about HIV/AIDS on their training curriculum for pastors and theological students. Every Christian

Institutions need good training opportunities for its students to learn how to teach others about AIDS and how to mobilize congregations to respond to HIV/AIDS in their midst. This ought to include such issues as orphan, vulnerable children, stigma, discrimination of those infected, home-based care, and preparing for the death (Blyth and Garland 2003, 288). However, we have some achievable results in preventing the HIV/AIDS epidemic.

Achievements in Preventing HIV/AIDS

A number of Christian institutions and international agencies working in Kenya have responded positively to the HIV/AIDS challenge. The CHAK has numerous training workshops on AIDS awareness, home care, and counseling throughout Kenya, especially through church hospitals. NCA has developed the "Partnership in Community" approach for community education and training using the community itself to design AIDS programs (Ibid). World Vision Kenya has started an extensive AIDS program in the sprawling Korogocho slum in Nairobi. This program has grown to reach other slums in the city. World Vision also has effectively encouraged the use of traditional media such as song, dance, music, drama, and poetry to communicate HIV/AIDS messages.

The Kenya Catholic Secretariat (KCS), which coordinates health services for the Catholic Church in Kenya, has tried to tackle some of the problems that have come with the HIV/AIDS epidemic (Ibid). With its extensive programs focusing on educational material production and dissemination, home care for people with AIDS and counseling, the KCS has made an impact on many Catholics in Kenya. MAP International, a Christian health and development agency working through churches across Africa, is involved in enabling churches to respond to the AIDS epidemic

through networking, ethnographic research on home care and behavior change among Kenya's churched public, literature development and training of church leaders. Together, these agencies collaborate on a number of efforts, primarily through the Kenya AIDS NGOs Consortium (132).

In 1994, it was shown that giving an antiretroviral drug to women during pregnancy and delivery and to the infant after birth could cut HIV transmission from mother to child by as much as two-thirds (UNAIDS/WHO 1998, 49). The contribution of FBOs to promote positive behavior change like abstinence among others cannot be ignored in reduction of HIV and other sexually transmitted infection rates.

MAP International has sponsored an all-Africa HIV/AIDS Conference for Church leaders, facilitated two policy development workshops. MAP International has developed, produced, and published HIV/AIDS materials. They have established and supported the Kenya Christian AIDS Network. They have also established an essential medicines distribution and training program in 12 institutions in Kenya and conducted a presentation on "The Role of the Church in the Global Fight Against HIV/AIDS" before the US Senate in Washington DC in 2002 (MAP brochure).

Map International

MAP International was founded in 1954 as Medical Assistance Program, and is a Christian global health organization providing services and material to missions and churches in various parts of the world. MAP International provides training in community health development, donated medicines and supplies to mission hospitals, emergency medical relief for disaster victims, and unique internship experiences (MAP International 1996, 45). MAP International challenges and enables Churches, Church-based organizations and Christian's health Institutions to respond biblically to

the HIV/AIDS crisis. They do this through organizing consultations, developing AIDS materials, networking and training (MAP Annual Report 2003, 2). They have conducted training in various fields such as pastoral counseling; and supporting churches to undertake interventions on behalf of vulnerable groups such as widows, widowers, orphans and people living with HIV/AIDS (PLWHA).

MAP International believes that the Church is the only institution that can transcend national and ethnic boundaries to realize the wholeness of life, and bring healing for individuals, families, communities and nations in the region. The health and healing ministries of the Church will be effective when they are biblically based, culturally appropriate and in partnership with: health and development institutions and programs, the Church in and outside Africa, Church-based ministries, governments in the region and Christian communicators (MAP Annual Report 2003, 1). MAP International has enabled Churches, theological and bible schools and other faith organizations in East, Central and Southern Africa to develop effective programs that have responded to the needs of local communities and congregations.

The Church of Christ needs quality programs on HIV/AIDS to address the needs of poor communities. To curb this epidemic, MAP has designed and is applying its "Curriculum Training Program" in seven theological schools in six countries across Africa namely Uganda, Kenya, Zambia, South Africa, Zimbabwe, and Tanzania. MAP International believes that partnership with other organizations will become the driving force behind the agenda through the 21st century and beyond (MAP Annual Report 2003, 7). MAP International envisions a world in which individual, families and communities have the hope and capacity to build conditions that promote Total Health. While their Mission Statement says that, they promote the Total Health of people living in the world's poorest communities by partnering in the provision of

essential medicines, prevention and eradication of disease and promotion of community health development.

SUMMARY

In this chapter, the researcher has integrated with literature review that has been an eye opener in understanding the historical dimension of HIV/AIDS epidemic in Africa and Kenya in particular. The researcher looked into the issues of attitude of the church leaders towards the HIV/AIDS scourge. The researcher was more interested in the leadership of Deliverance Church in regard to prevention campaigns as conducted by MAP International in the local church. MAP International has responded to the HIV/AIDS pandemic by equipping and challenging faith-based institutions and individuals to identify and address the socio-cultural and economic factors that contribute to the pandemic's prevalence. The Church has a full potential to stop and eradicate the course of the epidemic. However, the stigmatization and discrimination still abound within the Church, and seriously slows down the progress towards preventing and controlling HIV/AIDS epidemic. The Church must come out and be mutually supportive in fighting against HIV/AIDS epidemic. It is time for the Church to act with responsibility and with commitment in this era of HIV/AIDS epidemic. The Church can play a more comprehensive role as a healing community to respond effectively to the HIV/AIDS epidemic and make a significant impact on HIV/AIDS prevention campaigns of awareness. Church leaders should be well equipped with accurate knowledge, appropriate skills and material resources to engage meaningfully in the fight against HIV/AIDS epidemic. Some Churches have responded with a *closed fist* while others have responded with a *helping hand.*

Many efforts have been directed at the prevention of HIV/AIDS through increasing awareness of the disease. However, this knowledge is still minimal and has not been translated into effective action for prevention. Therefore MAP International challenges and enables Churches to respond biblically to the HIV/AIDS crisis, by developing effective programs that do respond to the needs of communities and congregations.

From all the material resources analyzed, the researcher is optimistic that, Africa will eventually be HIV/AIDS epidemic free. The result obtained and data analyzed will be presented in qualitative and descriptive manner. The findings will be of great help to the theological institutions that train Pastors, Church leaders, Faith-based Organizations, NGOs, MAP International and Deliverance Church.

CHAPTER THREE

RESEARCH METHODOLOGY AND PROCEDURES

This chapter dealt with the qualitative research method that gave its suitability for this investigation. This section discussed the rationale for selecting qualitative research method and grounded theory. The chapter also covered the areas of selection of participants, data collection, strategies and procedures, data analysis, validation and verification that applied in the context of this study.

Method and Procedures

Qualitative approach is one in which the inquirer often makes knowledge claims based primarily on constructivist perspectives (i.e., the multiple meaning of individual experience, meanings socially and historically constructed, with an intent of developing a theory or pattern) or advocacy/participatory perspective (i.e., political, issue-oriented, collaborative, or change oriented) or both (Creswell 2000, 18). It also uses strategies of inquiry such as narratives, phenomenologies, ethnographies, grounded theory studies, or case studies. The researcher collects open-ended, emerging data with the primary intent of developing themes from the data (Ibid).

Bogdan and Taylor distinguished qualitative methods of research from quantitative methods purely by the descriptive nature of data qualitative studies produce as opposed to quantitative data (Bogdan and Taylor 1975, 4).

Rationale for Choice of Research Paradigm

According to Strauss and Corbin, the preference of one method over the other is determined by a number of factors. The researcher may be much more comfortable with one approach than the other (1998, 33). Creswell identifies three research paradigms: qualitative, quantitative and mixed methods. The first has been available to the social and human scientist for years. The second has emerged primarily during the last three or four decades, and lastly is the new and still developing in form and substance (2003, 18).

For the purpose of this study, the researcher opted to use qualitative research paradigm. The rationale for such a method was based on the following reasons:

- Qualitative approaches in research are increasingly being used to address social and economic problems.
- Qualitative researcher is very effectives in addressing social issues that do affect individuals and families.
- By applying qualitative method, the researcher is able to collect data and explain phenomena more deeply and exhaustively
- The researcher prefers qualitative research method because it gives a room to the researcher to have an extra mile beyond the statistical outcome usually reported in quantitative research (Mugenda and Mugenda 1999, 155,197).
- It is usually an exploratory activity
- Data is usually collected in a real-life, natural setting and is therefore often rich, descriptive and extensive.
- The design of a study emerges or evolves "as you go along-sometimes leading to a broadening or blurring of focus, at other times leading to a narrowing or sharpening focus.

- The typical methods used are observation, interview, collection of documents and sometimes photography or video recording (Wellington 2000, 133).

The qualitative research method refers to any scientific endeavor that attempts to construct theory based on interpretation of data (Strauss and Corbin 1990, 23). It includes various approaches such as ethnographies, grounded theory, case studies, phenomenological research and narrative research. The proposed study was focused on grounded theory. Qualitative research stresses the importance of the people's perception and their interpretation of the reality around.

The Grounded Theory

In the grounded Theory approach, the reseacher is the key instrument, situated in the world being studied (Wellington 2000, 18). The researcher attempts to derive a general, abstract theory of a process, action, or interaction grounded in the views of participants in a study (Creswell 2003, 14; Creswell 1998, 12). Hence Grounded theory will be applied to provide clarifications about the perceptions of the church leaders towards HIV/AIDS prevention campaigns of MAP International in their churches.

Entry

A letter of introduction was given to the researcher from the Deputy Vice Chancellor for Academic Affair's office (DVCAA) at Nairobi Evangelical Graduate School of Theology (NEGST). A second letter was obtained from MAP International head quarters to Deliverance Church Secretariat. These letters enabled the researcher to be introduced to the Pastors, Lay leaders and the officers of HIV/AIDS implementers in the churches concerned namely Embul Bul and N'gong Deliverance

respectively (see appendix). Therefore the researcher clarified the intention of his intended study to church leaders of the two churches. All these two churches are also being pastored with my former and current classmates who are part of the pastoral team. This constituted an added advantage for introduction and explaining the objectives of the study.

Data Collection Strategy and Procedures

The idea behind qualitative research is to purposefully select participants or sites that will best help the researcher understand the problem and the research questions. This does not necessarily suggest random sampling or selection of a large number of participants and sites, as typically found in quantitative research (Creswell 2003, 185).

Two Deliverance Churches were selected for my data collection. One was located in slum area and another in urban center. The data collection was based on the readiness of the church leaders to participate in data collection exercise for better management of time and financial resources (Strauss and Corbin 1990, 43). Observation was used in order to glean data that the participants might have overlooked during the exercise.

Population

The term "population" is used to denote all those who fall into the category of concern (Oppenheim 1992, 38). Mugenda and Mugenda also define population as an entire group of individuals, events, or objects having a common observable characteristic. This population is the aggregate of all that conforms to a given specification (1999, 9). The population under study included Pastors, and Lay leaders from Ngong deliverance Church and Embul bul deliverance Church.

One of the site locations for the researcher is Embul bul Deliverance Church in urban area is pastured by Rev. Musa Mweti Musau and the church has been in existent for over seven years. While the second site location is Ngong Deliverance in a slum area and Rev. Peter M. Wange'ra is the Pastor of the church. The church has been in existing for 15 years. Rev. Wange'ra has managed to open other 13 sister churches. The two-named Deliverance Churches are frontiers of HIV/AIDS awareness.

Sampling

The appropriateness of any sampling frame is evaluated in terms of the particular needs of the study at hand. There should be an exact correspondence between sample characteristic and population attributes (Oppenheim 1992, 39). Again the term "Sampling" may refer to the process of selecting a number of individuals for a study in such a way that the individuals selected represent the large group from which they were selected (Mugenda and Mugenda 1999, 10). In this study a sample of 40 participants was drawn from a population of Pastors, and lay leaders. The sample was split into groups of Church designations from both churches.

Types of Data Collection

Qualitative interviews was conducted and complemented by observation for in depth analysis. The questionnaire consisted of open-ended questions so that information and perceptions could be freely obtained. The open-ended questions gave respondents' clarification, flexible and more probing that gave the researcher more information needed. Seidman has suggested that, truly effective questions flows an interview's concentrated listening engaged interest in what is being said and purpose in moving forward. Effective questioning is so context-bound, such a reflection of the relationship that has developed between the interviewer and the participant (1998, 63-

65, 78). Data collection was collected in an informal setting that included semi-structured interviews that was one to one with 40 participants, and well as active observation.

Qualitative Interview

The researcher conducted face-to-face interviews with the leaders. The interviews involved unstructured and open-ended questions (Creswell 2003, 188). A face- to-face interview was used because of its effectiveness in developing information (Weiss 1992, 3). Ethnographic interviews and engagement in participant observation was also used (Spradley 1980, 175). Again ethnographic was used because it was a friendly conversation into which the researcher slowly introduced new elements to assist informants to respond as informants. The researcher used ethnographic elements because of its explicit purpose, explanation, and questions (Spradley 1979, 58).

Participant Observations

Participate observations is a good strategy for both listening to the people and watching them in natural settings (Spradley 1979, 32). Therefore the researcher attended the site churches and participated in their services in different turns. This helped the researcher to interact with church leadership and other HIV/AIDS activists who played a big role in data gathering.

Data Analysis Procedure

The use of a survey was often associated with the collection of quantitative data. The analysis of such data was often straightforward, given the design of a clear and unambiguous question. However, questionnaires can be also of value in collecting

qualitative data through open-ended questions (Wellington 2000, 106). In qualitative studies, researchers' try to establish patterns, trends and relationships from the information gathered (Mugenda and Mugenda 1999, 117).

Validity and Reliability

Creswell argues that validity is seen as strength of qualitative research and it is used to determine whether the findings are accurate from the standpoint of the researcher, or the reader of the account (2003, 194). Mugenda and Mugenda say that validity is the accuracy and meaningfulness of inferences, which are based on the research results. Therefore validity has to do with how accurately the data obtained in the study represents the variables of the study (1999, 101). Validity on the other hand, tells us whether the question, item or score measures what it is supposed to measure (Oppenheim 1966, 144). Wellington looks at validity as the degree to which a method, a test or a research tool actually measures what it is supposed to measure (2000,30). Mugenda and Mugenda continue to say that, "internal validity of a study depends on the degree to which extraneous variables have been controlled for in the study" (1999, 103).

While reliability refers to the measure of the degree to which a research instrument yields consistent results or data after repeated trials. Reliability in research is influenced by random error (Mugenda and Mugenda 1999, 95). According to Wellington, the term "reliability" refers to the extent to which a test, a method or a tool gives consistent results across a range of settings, and if used by a range of researchers (2000, 31). Oppenheim refers to reliability as the purity and consistency of a measure, to repeatability, to the probability of obtaining the same results again if the measure were to be duplicated (1992, 144).

The researcher therefore, used the following strategies in ensuring the validity and reliability of the study:

- Triangulation approach was used in compare and contrasts the different data collected while at the same time analyzing and interpreting data.
- The researcher ascertained the reliability using the internal checks. Participants who became a gauge mark of their accuracy checked specific descriptions or reports.
- Participates are involved in the process of validity with a chance to interact with the findings for affirmation.
- Expertises are to be involved as external checks and these include MAP International and NEGST department leaders.
- Verification for the ground theory research depends on the researcher and can be done at different stages in conducting research. The participants were asked several questions and their answers will provide fertile ground for verification purposes. The literature review also offered valuable insights that pertained to verifications.

CHAPTER FOUR

FINDINGS

Introduction

This chapter presents the findings of the study on the perception of leadership towards HIV/AIDS prevention campaigns of MAP International. The study was conducted at Embul Bul and Ngong deliverance Churches, Nairobi District.

The findings presented here are derived from an analysis of the findings of the study in response to the three research questions (page 3). Frequency Tables presented the findings of this study (Appendix B). Also Cross-tabulation was applied here to assess the perception of the Church leaders of both Churches. The findings helped the researcher to make recommendations that will enhance both the Church leadership and MAP International to improve on their areas of weakness and strength.

Again discussion of the findings from the interviews and observations were from Church leaders in the Deliverance Church N'gong and Embul Bul. The Questionnaire was administered to 40 Church leaders of the two Churches in order to assess their perception towards HIV/AIDS prevention campaigns of MAP International. The participants included Pastors, Elders, Deacons, Youth leaders, Women leaders, Prayer leaders, Worship leaders, Sunday school leaders, Development leaders, Welfare leaders and Consultant leaders. This population sample helped to get the data that was used for comparison purposes.

The researcher's findings are presented in line with three research questions that were used to guide in data collections and these included the following:

1. What are the perceptions of church leaders about HIV/AIDS prevention campaigns of MAP International?
2. What are the factors that affect their perceptions?
3. What are their suggestions pertaining to the improvement of the approaches used by MAP International?

In view of the above questions, the data collection from the field was edited, classified and coded, to generate frequencies and to cross tabulate the variables understudy.

According to the results from table one (see appendix B), it was indicated that, out of 40 participates from both Churches, 25 were male which is equivalent to 62.5% and 15 were female equivalent to 37.5% of the gender. However, from the cross tabulation, Ngong deliverance church has more men compared to Embul bul that has more women (figure 1).

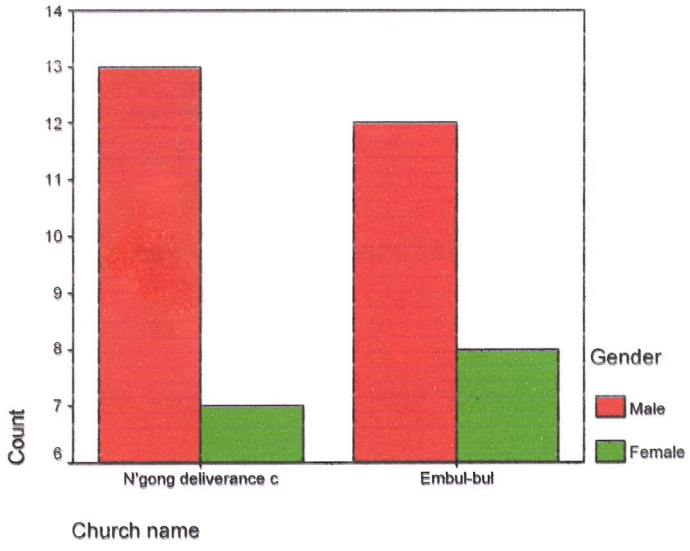

Figure 1. Showing gender of the two participant Churches

All the analysis was based on the responses given by the Participants. The interviews with the 40 Church leaders, and the researcher's personal observation supplemented the findings.

Marital Status

From table 2 (see appendix B), 13 singles that make up 32.5% did participate in the interviews while the married were 27, which is 67.5% of the total population required. From the marital status Cross tabulation, Ngong deliverance Church had three singles and 17 married participated while from Embul bul deliverance Church had 10 singles and 10 married participated (figure 2).

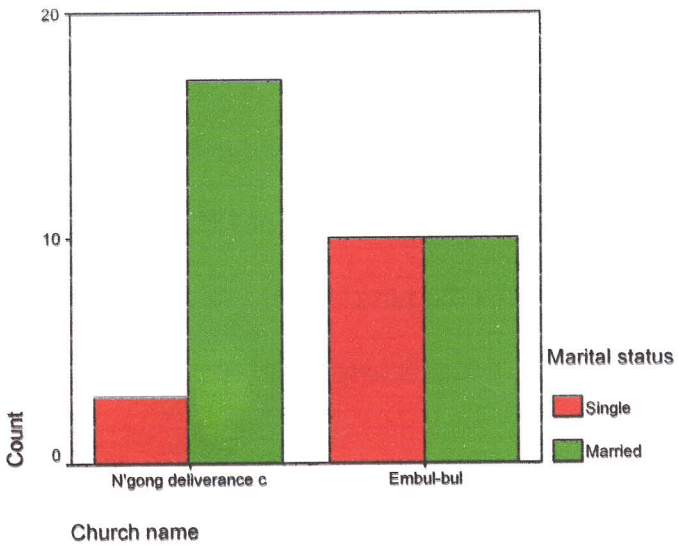

Figure 2. Indicating the marital status of members of the two participant Churches

The results from above show that Ngong deliverance church has more married people in leadership than Embul bul.

Participants' Church Designation

According table 3 (see appendix B), 12.5% were Pastors; 17.5% were Choir/Worship leaders; 17.5% were women leaders; 12.5% were Elders; 2.5% were welfare leaders; 5% were prayer leaders; 2.5% were consultant leaders; 22.5% were

youth leaders; 2.5% were deacons; 2.5% were development leaders; and 5% were Sunday school leaders.

From the Cross tabulation of the two Churches, Ngong deliverance church had three women leaders compared to four from Embul bul. Embul bul did not have any welfare leader but Ngong had one participant. Embul bul had two prayer leaders but Ngong deliverance church had none.

Ngong deliverance church had one consultant leader while Embul bul had none. Ngong church had three Pastors and Embul bul had two. Embul bul had four youth leaders while Ngong had five youth leaders. Embul bul had four choir / worship leaders compared to Ngong with three. Ngong had two deacons while Embul did not have any. Embul bul had two Elders and Ngong had four. Embul had no development leader but Ngong had two. Ngong did not have a Sunday school leader but Embul bul had two. All the above indicated that, the data collection was more reliable (figure 3).

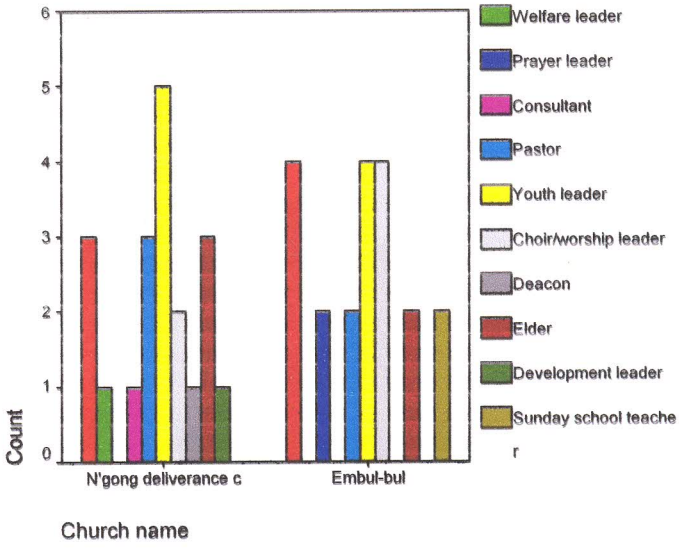

Figure 3. Highlights the Church leadership designations

Age of the Participants

From table 5 (see appendix B), 13 people were in average age between 21-30years that made 32.5%; 12 people were in average age of 31-40 that is 30.0%; 15 people were in a range of 41-55 years that makes up 37.5%.

Participation from each church was as follows: Ngong deliverance church had three people average 21-30 years; six people were in range of 31-40; and eleven people ranged in 41-55 years. While Embul bul deliverance 10 people ranging between 21-30; six people were between 31-40; and four people in average 41-55 years.

These findings show the reliability of the population targeted in giving information about the perception of leadership towards HIV/AIDS prevention campaigns of MAP International. These are the leaders of church departments and are considered to be the most active in church ministry and major decision makers and implementers of the church programs. However from the two churches, average age in leadership is quite opposite to one another though they have the same average age between 21-30 years of people (figure 4).

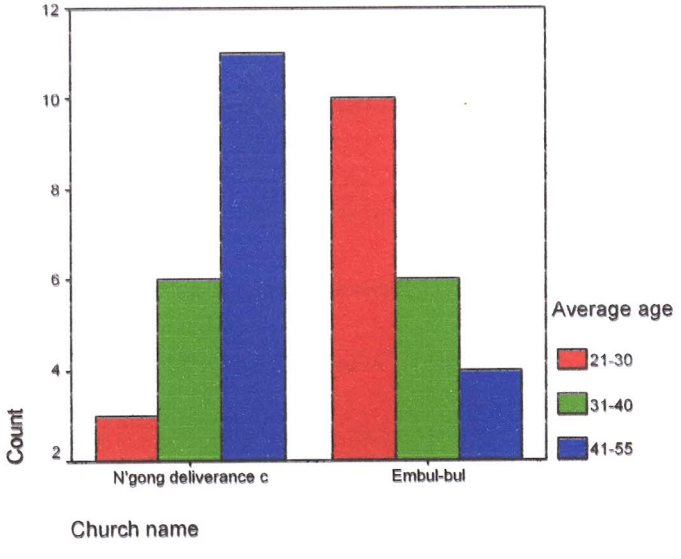

Figure 4. Showing the average age of the participants

Education

According to table 6 (see appendix B), it shows that, two people have a primary level of education, which is 5%; ten people have a secondary level education which is 25%; people with college level of education are 11 that make 27.5%; and also 15 people have university level of education equivalent to 42.5%.

The findings indicate that the leadership has all levels of education. However people with university level of education are more than the rest of the members from both churches (figure 5).

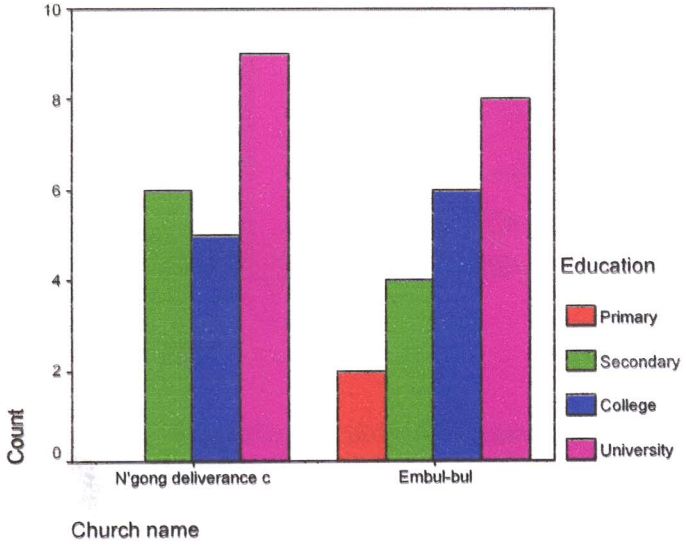

Figure 5. Education level of the participants

The Participants' Idea on MAP International

From table 7 (see appendix B), 13 participants that make up of 32.2% said yes an indicator that they knew MAP International. At the same time, 27 respondents that make up of 67.5% said no an indicator that they did not know MAP International.

Considering on each church level, seven people from Ngong knew MAP International and 13 people were ignorant of it. While 6 people from Embul bul knew about MAP International, and the others 14 did not know about it.

Although some participants knew about MAP International a bigger percentage did not know it. This means that MAP International must intensify its HIV/AIDS campaigns among the church leadership of both churches (figure 6).

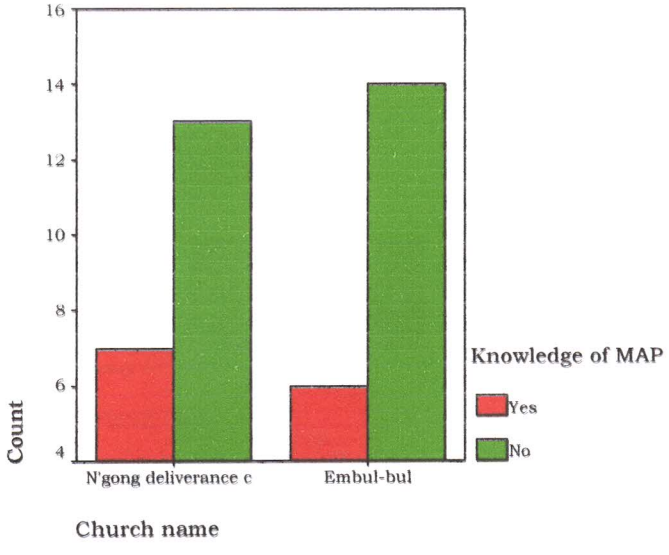

Figure 6. Showing the participants knowledge of MAP International

The Participate Exposure to HIV/AIDS Awareness from MAP International

From table 8 (see appendix B), the highest numbers of participants that make up 70% have, never had a chance to be exposed to HIV/AIDS awareness from MAP International. Other participants have been exposed for one year, which is the 10%. 20% of those who participated have been exposed more than three years.

According to the cross-tabulations of the two churches, there was an equal ratio for the two churches namely: those that have never been exposed, and those who have bee exposed for at least one year.

The majority of participants showed a high level of in exposure to HIV/AIDS awareness program from MAP International. Therefore the leaders of both churches did not seem to have understood or grasped the importance of HIV/AIDS awareness. The results of the study indicate that many participants did not give enough weight in regard to MAP International awareness program (figure 7).

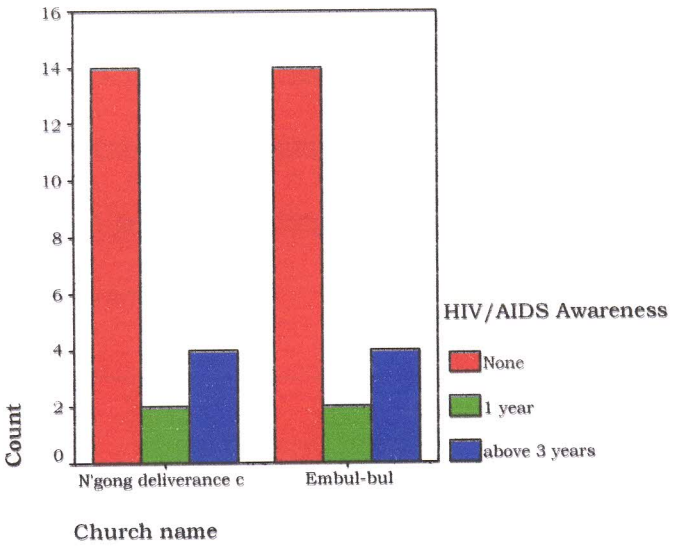

Figure 7. Showing the participants' exposure to HIV/AIDS awareness

The Participants' Motivation to get Involved in HIV/AIDS Awareness

From the frequency (table 9) (see appendix B), 70% of the participants had nothing to motivate them to get involved in HIV/AIDS awareness. Those who followed were 15% that wanted to be educated, equipped, trained and see its relevancy in order to help the community. The 12.5% were interested in counseling the youth especially in the church, carrying out pre-marital counseling, and also counseling the infected and affected. The other 2.5% had been sponsoring some students on pastoral care support on HIV/AIDS and this created an interest to get involved in the program of HIV/AIDS awareness.

Observing the two churches, it was noted that, one participant from Ngong church had an interest in counseling compared to four from Embul bul church. Those with a desire to be educated in order to help others were two from Embul bul in regard to four from the Ngong church. While Ngong had one who picked the interest through supporting a student on a pastoral program, Embul bul indicated none.

All mentioned above were motivating factors in the church leadership towards HIV/AIDS prevention campaigns of MAP International. However, the majority of leaders seemed be not motivated at all. Therefore MAP International should come up with some good motivating factors so that the leadership should pick up the desire in their program (figure 8).

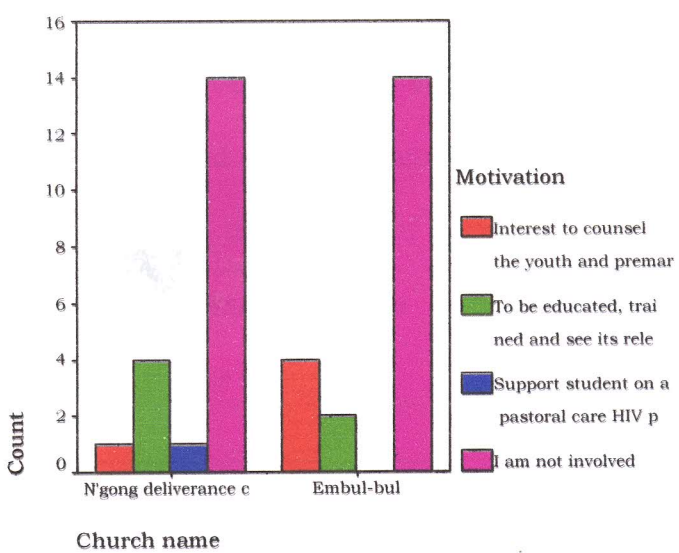

Figure 8. Highlights the participants' motivation

The Participants Benefits from the Program

According to table 10 (see appendix B), indicated that, 75% of the participants have never benefited from the program. This was followed by 17.5% of the participants who benefited from the program. Through MAP International campaigns, they acquired the ability to help, train others so that they can extend the care and

support to both the infected and affected in the community. Other participants of 7.5% said that, they had developed a good attitude towards the infected and affected communities.

Cross-tabulation of the two churches indicated that, five participants from Ngong had the ability to extend their acquired skills and knowledge to others and even to extend the care and support to the community compared to two from Embul bul who can do the same. It was also found out that one participant from Ngong has developed a good attitude towards the infected and effected in relation to the two from Embul bul. However, Ngong deliverance church is doing a recommendable job compared to Embul bul deliverance church as far as extending the program to their communities.

Those who benefited were very appreciative to MAP International for helping them to be exposed about the factors related with HIV/AIDS. One of the participant said that, he was in position of organizing funds for the HIV/AIDS campaigns. Another one indicated that he is creating jobs for the infected and affected communities (figure 9).

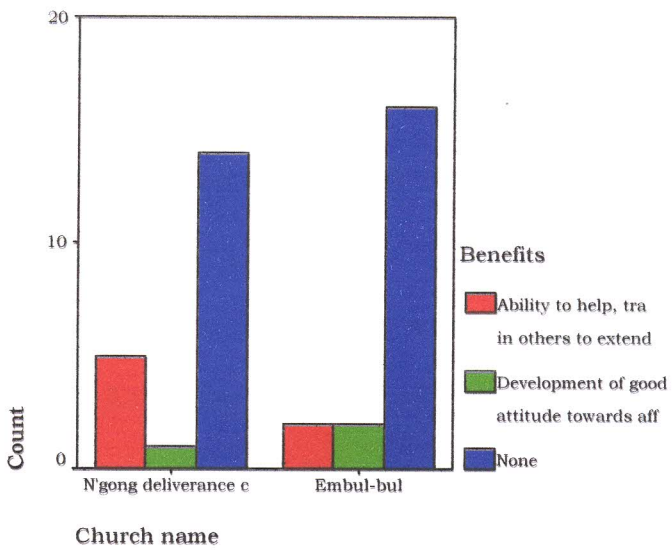

Figure 9. Showing the benefits of the program

Participants' Involvement in HIV/AIDS Awareness Program

According to the (table 11) (see appendix B), frequency, the participants that have been involved in HIV/AIDS awareness are 30%, others are 70% who had not been involved in awareness program. Considering the cross tabulation of the two churches, both churches had six participants that had been involved in HIV/AIDS awareness compared to 14 that have not been involved in the program from both churches (figure 10).

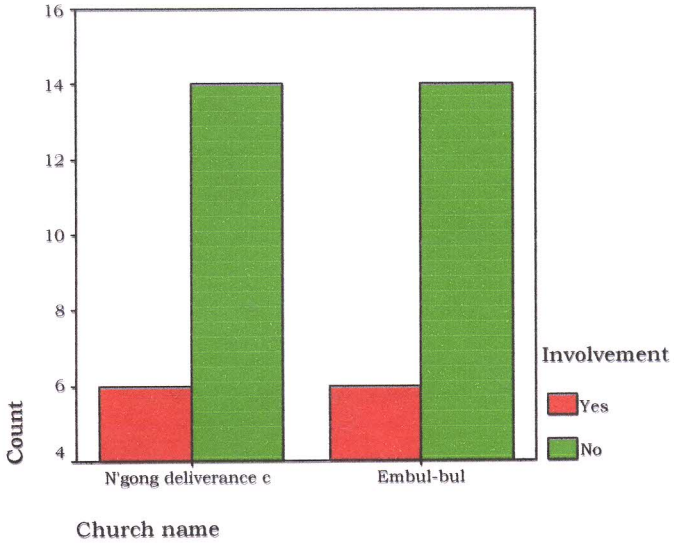

Figure 10. Indicating personally involvement in HIV/AIDS awareness

Participants' Comments

From the table 12 (see appendix B) it is indicated that, 17.5% of the participants had been involved in HIV/AIDS awareness through school ministry, crusades, markets, and films. Those had been active through drama, skits, and poems in colleges made up 2.5%. Those who were involved in seminars, hospitals, house to house were 5%. The rest who were the majority comprised of 75% of those who said they are not involved in any thing.

From the participants view, those who are not involved were many from both churches. At the same time Ngong deliverance church was more involved with schools, crusades, markets, films ministry compared to Embul bul deliverance church that preferred seminars, hospitals and house-to-house ministry (figure 11).

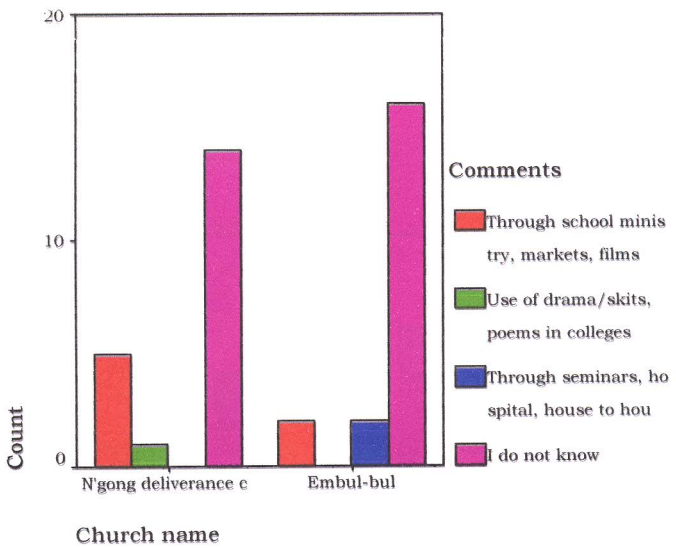

Figure 11. Showing the comments of the participants

Challenges of the Participates

According to table 13 (see appendix B), 7.5% of participates indicated that, the youth do not think that HIV/AIDS was a serious threat or problem to them. Another 7.5% of the participants said that, men at home do not give home-based care for the sick. 5% of the participants said that during the awareness program of the community, people want an assurance of support in case they found that they were HIV positive. This is also followed by 5% of the participants who said that, raising awareness seems to interfering with people's private lives. The assumption was that, HIV/AIDS is private matter related to private affairs. The rest of 75% had nothing like challenge.

Cross tabulation of the two churches indicate that, one participant from Ngong deliverance church has a challenge of the youth while Embul bul had two. At the same

time, Embul bul had no men's challenge as compared to Ngong that has three participants. There were no challenges as regards to people's assurance of support if they did test positive from Ngong deliverance as compared to the two participants from Embul bul Church. Two Embul bul church leaders continued to say that, people thought that awareness also was a challenge interfering into people's private lives. The majority of participants had no challenge at all due to none participation in the program (figure 12).

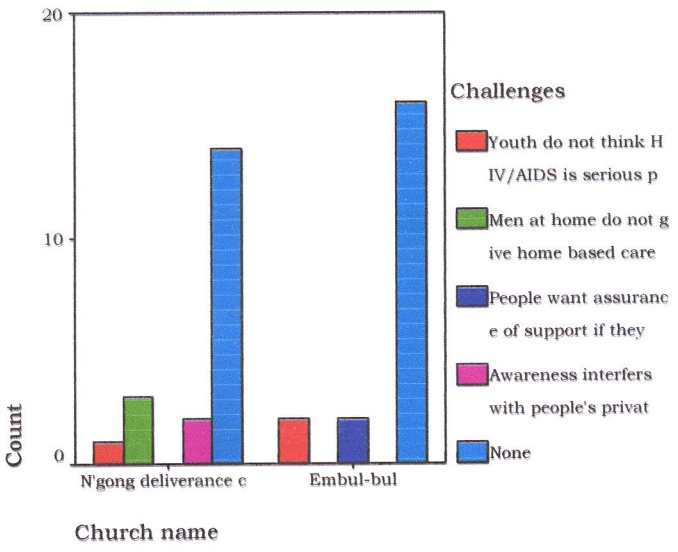

Figure 12. Showing the challenges of the participants

What MAP International can Offer to Improve on Participants' Awareness

The researcher asked the participants to offer their recommendations to MAP International on how to improve on their awareness programs. Their recommendations are drawn from the table of frequency.

According to table 14 (see appendix B), indicates that, 85% of the participants wanted MAP International to increase its HIV/AIDS campaigns to the entire church. 5% of the participants responded by saying that MAP International should support the

initiated projects to care for the infected and affected communities. The rest of the participants wanted MAP International to come up with provision for social programs for the youth who becoming more devastated by the epidemic.

From the Cross tabulation of the two churches, 18 participants from Embul bul preferred MAP International to improve on its awareness to the entire church. 16 participants followed this from Ngong who also wanted MAP International to increase its awareness programs to the entire church. Again Ngong church suggested that, MAP International need to support the projects that have been initiated for the infected and affected communities. Both churches agreed that it was very vital that MAP International come up with provisions for the social programs of the youth. The youth are considered to be a big percentage of the church and community (figure 13).

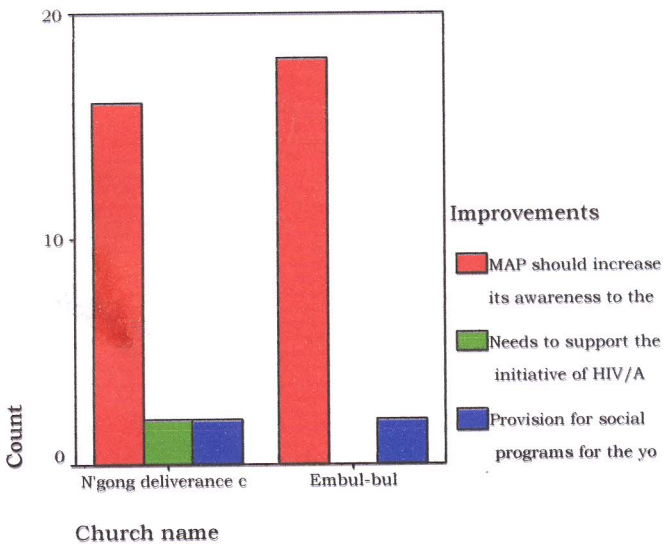

Figure 13. Showing the areas of improvements for MAP International

Summary of Findings in Relationship with the Literature Review.

According to the three research questions that led to this study, the findings show that, the Church leadership needs to act with responsibility and commitment in this era

of HIV/AIDS epidemic if the scourge is to be thoroughly dealt with. The leadership has not played her role as a healing community to respond effectively to the HIV/AIDS epidemic so as to make a significant impact on HIV/AIDS prevention campaigns of awareness. Again the findings show that leadership in both Churches is not fully equipped with knowledge, appropriate skills and materials to engage meaningfully in the HIV/AIDS campaigns awareness. The leadership of these two Church has responded with two perceptions one with a closed fist and the other with helping hand. Therefore MAP International must continue its effort to cause an impact on leadership of both Churches with HIV/AIDS campaigns awareness.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

Introduction

This study was an attempt to investigate the perception of leadership towards HIV/AIDS prevention campaigns of MAP International in Embul bul Deliverance church located in urban center and N'gong deliverance church located in the slum area. Therefore in this chapter, the conclusions of the research findings, recommendations, and further study are presented.

Conclusion

This study was based upon three significant research questions:

1. What are the perceptions of church leaders about HIV/AIDS prevention campaigns of MAP International?
2. What are the factors that affect their perceptions?
3. What are their suggestions pertaining to the improvement of the approaches used by MAP International?

The sample consisted of 40 participants. Data collection was by means of open-ended questionnaire and semi-structured interview guide. Using qualitative methods helped in data analysis. On the basis of the above research questions, the following conclusion is made:

Majority of the participants indicated that the church felt that HIV/AIDS is a threat to the church members and church ministry. A number of the participants said

that the church experienced HIV/AIDS cases among its members. The participants believed that the central concern for the Church leaders was to have more awareness from MAP International. The participants urged MAP International and the church leadership to organize seminars, conferences, and workshops on HIV/AIDS prevention as often as possible.

From the findings in both churches, it was evident that there is a need to intensify HIV/AIDS awareness among the Church leadership by MAP International. The participants' understanding of what MAP International does offer is still low. MAP International campaigns of HIV/AIDS prevention is not well integrated in the programme of the churches. Concerning challenges faced in awareness, many participants indicated that they eagerly desire MAP International to do a little more in her efforts of HIV/AIDS prevention campaigns than what is presently on the ground. This could be achieved if the general leadership of both Churches commit themselves to MAP International.

Recommendations

In light of the above, the researcher made the following recommendations that can be useful to MAP International and the two Churches.

1. There is a need for MAP International to extend HIV/AIDS awareness to the entire church leadership. It is apparent that the level of HIV/AIDS awareness from MAP International is very low.
2. There is a need for all the church leaders to get involved in awareness campaigns of MAP International if the church and the community are to benefit in its struggle against the HIV/AIDS epidemic.

3. The few that are active with MAP International should endeavor to educate other church leaders on the issue of HIV/AIDS awareness. This can be achieved through seminars, workshops and pulpit.
4. MAP International can provide practical assistance beyond just educating people about HIV/AIDS epidemic. This can be in form of medical and financial support especially for the infected and effected community.
5. Church can use the occasion of HIV/AIDS as a platform for sharing the love of Jesus Christ to infected and affected people and the whole community. People need to know that there is hope beyond this earthly life. The Church is a healing community that can be extended to outside its walls to those without hope of Christ. People need some one who can love them, care for them, pray for them and extend compassion to them. This can be achieved through a holistic ministry of the gospel.
6. The Church may need to evaluate as to whether the pulpit and the Bible studies are being adequately used to address what appears to be a real crisis in their midst. Gichinga has stated it well by saying that, when human persons do not understand a phenomenon, they tend to be afraid of it, to ignore it, or to handle it unwisely. If such a phenomenon is not understood or understood only very little, then the response to such a phenomenon mostly likely will be poor and minimal. If, however, such a phenomenon is better understood, then one will expect that there will be a better response to it (2004, 136).
7. A financially support budget should be set apart to sustain the HIV/AIDS awareness programme of the Church to the communities.
8. The Church should establish a care-support center for the infected and affected.

Recommendations for Further Study

The researcher could not come up with a comprehensive study due to the scope of the paper, time limitations. Therefore the findings may not apply to other churches or denominations.

1. And in this regard, the researcher does recommend further study that will incorporate different churches and denominations. Such a research could be an eye opener to other significant factors that promote or inhibit the perception of leadership towards HIV/AIDS prevention campaigns of MAP International in raising awareness.
2. The researcher did not find out to what extend do the leaderships implements their acquired skills and knowledge from MAP International right to the grass roots of the communities. This can be a good subject for further research.
3. The researcher had expected more church leaders to be involved in MAP International campaigns than what was the actually case. Further study can help to establish why the leader seems to be passive.
4. A study could be done among the church members to get their perception towards HIV/AIDS prevention campaigns of MAP International.

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APPENDIX A

QUESTIONNAIRE

Questions for interview with church leadership

The researcher's interview questions are based on his chapter one of this study. The researcher's interest is in the perception of the church leadership and HIV/AIDS activities in regard to MAP International campaign of HIV/AIDS awareness in the church. The respondents will be guaranteed of confidentiality of any information they give to the interviewer. According to Weiss, there is no magic question in qualitative study. Any question is a good question if it directs the respondents to the study and makes it easy for him/her to provide the data (1994, 74).

1. Gender: _____
2. Marital Status: _____
3. Designation in the local church: _____
4. Average age: 18-20__, 21-30__, 31-40__, 41-55__, and 56-
5. Education: Primary_____, S.Sec. _____, College_____. University_____
6. Do you know MAP International? Yes_____ or No_____
7. For how long have you been exposed to HIV/AIDS awareness program from MAP International?
8. What motivated you to get involved in HIV/AIDS awareness program from MAP International?
9. What are some of the benefits you have derived from the program?
10. Have you personally been involved in HIV/AIDS awareness? Please give your comments.
11. According to your knowledge, what could be the major challenge you have faced in raising people's awareness about HIV/AIDS?

12. What can MAP do to improve on your involvement in HIV/AIDS awareness to the communities?

APPENDIX B

FREQUENCY TABLES

Table 1

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	25	62.5	62.5	62.5
	Female	15	37.5	37.5	100.0
	Total	40	100.0	100.0	

Table 2

Marital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	13	32.5	32.5	32.5
	Married	27	67.5	67.5	100.0
	Total	40	100.0	100.0	

Table 3

Designation in the local church

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Women fellowship leader	7	17.5	17.5	17.5
	Welfare leader	1	2.5	2.5	20.0
	Prayer leader	2	5.0	5.0	25.0
	Consultant	1	2.5	2.5	27.5
	Pastor	5	12.5	12.5	40.0
	Youth leader	9	22.5	22.5	62.5
	Choir/worship leader	6	15.0	15.0	77.5
	Deacon	1	2.5	2.5	80.0
	Elder	5	12.5	12.5	92.5
	Development leader	1	2.5	2.5	95.0
	Sunday school teacher	2	5.0	5.0	100.0
	Total	40	100.0	100.0	

Table 4

Church name

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	N'gong deliverance church	20	50.0	50.0	50.0
	Embul-bul	20	50.0	50.0	100.0
	Total	40	100.0	100.0	

Table 5

Average age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	21-30	13	32.5	32.5	32.5
	31-40	12	30.0	30.0	62.5
	41-55	15	37.5	37.5	100.0
	Total	40	100.0	100.0	

Table 6

Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary	2	5.0	5.0	5.0
	Secondary	10	25.0	25.0	30.0
	College	11	27.5	27.5	57.5
	University	17	42.5	42.5	100.0
	Total	40	100.0	100.0	

Table 7

Knowledge of MAP International

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	13	32.5	32.5	32.5
	No	27	67.5	67.5	100.0
	Total	40	100.0	100.0	

Table 8

HIV/AIDS awareness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	28	70.0	70.0	70.0
	1 year	4	10.0	10.0	80.0
	above 3 years	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Table 9

Motivation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Interest to counsel the youth and premarital	5	12.5	12.5	12.5
	To be educated, trained and see its relevance	6	15.0	15.0	27.5
	Support student on a pastoral care HIV program	1	2.5	2.5	30.0
	I am not involved	28	70.0	70.0	100.0
	Total	40	100.0	100.0	

Table 10

Benefits

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Ability to help, train others to extend care supp. comm	7	17.5	17.5	17.5
	Development of good attitude towards affected and infect	3	7.5	7.5	25.0
	None	30	75.0	75.0	100.0
	Total	40	100.0	100.0	

Table 11

Involvement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	12	30.0	30.0	30.0
	No	28	70.0	70.0	100.0
	Total	40	100.0	100.0	

Table 12

Comments

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Through school ministry, markets, films	7	17.5	17.5	17.5
	Use of drama/skits, poems in colleges	1	2.5	2.5	20.0
	Through seminars, hospital, house to house	2	5.0	5.0	25.0
	I do not know	30	75.0	75.0	100.0
	Total	40	100.0	100.0	

Table 13

Challenge

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Youth do not think HIV/AIDS is serious problem	3	7.5	7.5	7.5
	Men at home do not give home based care for the sick	3	7.5	7.5	15.0
	People want assurance of support if they test positive	2	5.0	5.0	20.0
	Awareness interfers with people's private life	2	5.0	5.0	25.0
	None	30	75.0	75.0	100.0
	Total	40	100.0	100.0	

Table 14

Improvement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MAP should increase its awareness to the entire church	34	85.0	85.0	85.0
	Needs to support the initiative of HIV/AIDS infected and af	2	5.0	5.0	90.0
	Provision for social programs for the youth	4	10.0	10.0	100.0
	Total	40	100.0	100.0	

CURRICULUM VITAE

Personal data

Name:	George William Sempebwa
Date of birth	June 10th, 1962
Marital Status	Married
Name of wife	Martha Kaaya Sempebwa
Children	Joshua Kaaya, Rebecca Kaaya and Joana Kaaya
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Academic Qualification

2006: Master of Divinity in Mission -Nairobi Evangelical Graduate School of Theology (NEGST).
2000: Postgraduate Diploma in Education-Makerere University, Kampala
1990: Bachelor of Arts in Theology- East Africa School of Theology, Nairobi
1981: UACE (A-level), Kampala High School
1980: Secondary School Certificate- Ndejje Secondary School, Kampala
1976: Primary School Certificate- Old Kampala Primary School, Kampala

Work / Ministry Experience

1994-2003:	Senior Pastor at Full Gospel Church Kampala
1991-1994:	Associate Pastor at Full Gospel Church Kampala
1992-2003:	Part-time Bible College teacher at Glad Tiding College Makerere
1995:	Acting-Principal of Glad Tidings Bible College Makerere
1994-1995:	Part-time Mbuya Pentecostal Bible College teacher
1997:	Part-time Kampala Pentecostal Bible College teacher
2002:	Missionary trainer –Kampala Trumpet Ministries
1982:	Technician in Uganda Television ministry

Ministry Interest

Missionary / Pastor
Church Planting
Bible College trainer