STIGMA AND DISCRIMINATION AGAINST PEOPLE LIVING WITH HIV (PLHIV) IN THE METHODISTS CHURCH A CASE OF NJIA CIRCUIT, IGEMBE SOUTH SUB COUNTY, MERU COUNTY

BY

JEDIEL AKULA MIORO

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other University.

Signature:…………………… Date: ………………………………..

JEDIEL AKULA MIORO (C50/CE/14276/2009)
DEPARTMENT OF PHILOSOPHY AND RELIGIOUS STUDIES

SUPERVISORS

This thesis has been submitted with our approval as University supervisors.

Signature:…………………… Date: ………………………………..

DR. JOSEPHINE W. GITOME
DEPARTMENT OF PHILOSOPHY AND RELIGIOUS STUDIES

Signature:…………………… Date: ………………………………..

DR. ARUDO TOBIAS OPIYO
DEPARTMENT OF PHILOSOPHY AND RELIGIOUS STUDIES
DEDICATION

To the people living with HIV in Kenya and the world whose lives have been devastated by stigma.
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OPERATIONAL DEFINITIONS OF TERMS

**Antiretroviral (ARVs):** Drugs that reduce the levels of HIV in the bloodstream.

**At Risk:** Is the probability that a person may acquire HIV infection.

**Church:** The two major definitions are; church as an institution with sacred powers, dogmas, rites, canon, and traditions and (b) church as a community of believers or a group of Christians professing particular creed to the whole body of the faithful. In this study, both definitions are used. The context will determine which of the two ways the term will be used.

Church (Capital C)- in this study when referring to the universal church or to the name of a church for example Methodist Church.

Church (small c)- refer to a building or a congregation or to a denomination.
| **Circuit:** | This is the smallest organization of the Methodist church consisting of a number of local churches as may be decided by the conference. The churches grouped together must be financially capable of maintaining a superintendent minister and other officers as provided by the deed of the church order. |
| **Clergy:** | Refers to persons ordained to a sacred vocation such as priesthood. In this study it will refer to women and men who have been ordained to serve the church that is to officiate in ritual and to administer sacrament. |
| **Conference:** | Is the governing body of the Methodist church in Kenya. Conference is the final authority within the Methodist church for the interpretation of doctrinal standards of the church. |
| **Connexion:** | Consist of all Methodist churches, members and organizations within Kenya. It is governed by the conference. |
| **Death** | Theologically is the time the person’s body is separated from their soul. |
**Discrimination**

Is the unfair treatment of one person or group, usually because of prejudice, about race, ethnicity, age, religion, or gender. In this research it refers to the unfair treatment of the PLWHAs by the clergy and the church members because of their HIV status.

**HIV AND AIDS:**

AIDS is a fatal disease caused by HIV. HIV destroys the body’s ability to fight off infection and diseases which may ultimately lead to death. Currently Antiretroviral drugs slow down replication of the Virus and greatly enhance quality of life but not destroy HIV infection.

**Synod:**

This is an area (of the Methodist church) made up of a number of Circuits grouped in an area as designed and determined from time to time by the conference. The Synod must be financially stable to support a bishop. The bishop is in charge of a synod.

**Stigma:**

Is the shame or disgrace attached to someone regarded as Socially unacceptable. In this research stigma refers to the shame or disgrace to PLHIV who are socially unacceptable in the church.
**ABREVIATIONS AND ACRONYMS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARVs</td>
<td>Antiretroviral</td>
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<tr>
<td>CACC</td>
<td>Constituency Aids Control Council</td>
</tr>
<tr>
<td>CHAK</td>
<td>Christian Health Association Of Kenya</td>
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<tr>
<td>FGDs</td>
<td>Focus Group Discussion</td>
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<td>GOK</td>
<td>Government of Kenya</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ICRW</td>
<td>International Centre for research on Women</td>
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<tr>
<td>KAIS</td>
<td>Kenya Aids Indicator Survey</td>
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<td>KNASP</td>
<td>Kenya National HIV/AIDS Strategic Plan</td>
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<td>MAP</td>
<td>Medical Assistance Program</td>
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<tr>
<td>NACC</td>
<td>Nation Aids Control Council</td>
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<tr>
<td>NCCK</td>
<td>National Council of Churches of Kenya</td>
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<tr>
<td>NGOs</td>
<td>Non Governmental Organization</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PLHIV</td>
<td>People Living With HIV/AIDS</td>
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<tr>
<td>TASO</td>
<td>The Aids Support Organization</td>
</tr>
<tr>
<td>TOWA</td>
<td>Total War against Aid</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Joint Program on HIV/AIDS</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>WCC</td>
<td>World Council of Churches</td>
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ABSTRACT

Stigma and discrimination are great components that lead to seclusion of people living with HIV and AIDS. Stigma as been stated to be the highest killer than the virus itself. A global call by UNAIDS of zero discrimination by 2015 continue to be shadowed by increased stigma despite so much information on HIV and AIDS. This study sought to establish why stigma is prevalent against PLHIV within Methodist Church in Njia Circuit where love and care would be expected. This study focused on Methodist Church in Igembe south sub county. The study examined the level of knowledge on HIV and AIDS in Njia Circuit, Biblical teachings on the terminally ill and causes of stigma and discrimination with the hope of establishing the roots of stigma and discrimination. It also addressed the effects of stigma and discrimination on PLHIV. The literature review focused on four themes namely, level of knowledge on HIV and AIDS in the church, biblical teaching on stigma and discrimination on the terminally ill, causes and effects stigma on PLHIV within the church setup. Maslow theory was used in illustrating stigma against PLHIV. The theory shows that stigma lowers the self esteem of PLHIV resulting in self denial, non disclosure and suicidal tendencies. The study adopted survey research design. Data for the study is drawn from both primary and secondary sources. Field study was carried out in Njia Circuit which is found in Nyambene synod of the Methodist Church in Kenya. Data was collected by use of questionnaires, oral interviews and focused group discussion (FGDs). In this study, the researcher employed random and purposive sampling to select respondents. In cases where the number of respondents were either one or two in the category required by the study, purposive sampling was used. The sample size targeted by this study was 106 respondents comprising of PLHIV, orphans, church ministers, church members ,lay preachers of the Methodist Church, Bishop and constituency Aids control council Secretary. Both qualitative and quantitative methods of data analysis were employed. The data was then synthesized thematically according to the study objectives and presumed chapters. The research findings established there was stigma on PLHIV within the church in Njia Circuit. It was also clear that there was lack of information within the churches on HIV and AIDS. This perpetuated fear and low disclosure of one’s HIV status .The study recommends that for the church to fight stigma on PLHIV the church should look at issues such as information dissemination on HIV, encourage disclosure in churches, preaching openly on HIV and AIDS sensitizing of congregation on prevalence of stigma in church. This would alleviate stigma and make PLHIV feel accepted in the church and the community in general.
CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Acquired Immune Deficiency syndrome (AIDS) is a global pandemic which is one of the greatest challenges facing humanity. The spread of the disease is alarming over the world. Genrich (2007) notes that since the first case of Human Immunodeficiency Virus (HIV) was identified in 1981, over 30 million people have died of AIDS related diseases. According to UNAIDS (2013) report, the number of people living with HIV and AIDS, rose from around 8 million, in 1990 to 35.3 million by the end of 2012. According to UNAIDS (2013), Sub Saharan Africa has a population of 25 million PLHIV. This forms 68% of the PLHIV residing in Sub Saharan Africa. The report indicates that there are 1.6million estimated new infection and 1.2 million estimated AIDS deaths in 2012.

Kenya AIDS Indicator Survey (KAIS) (2012) indicates that Kenya as a nation has close to 1.6 million PLHIV and a national prevalence rate of over 6% of its population. KAIS (2012) report indicates that HIV Epidemic in Kenya is characterized generalized epidemic, primarily driven by heterosexual transmission. The report adds that the control of HIV and AIDS remains a priority in Kenya. According to KAIS (2012) the Government of Kenya (GOK) developed the Kenya National HIV/AIDS Strategic Plan (KNASP 111) for the 2009/10-2012/13
implementation period, continuing a comprehensive national response to the epidemic in partnership with civil society, the private sector and development partners. According to Igembe District Development plan (2008-2012), Igembe South District which is found in Eastern Province has a HIV prevalence rate of 6%. This is a high rate compared to the Eastern Province which stands at 4.7%. The report indicates that AIDS is the leading killer among the productive segment (15-45years) of the population. The report further adds that the threat to fighting HIV and AIDS is stigma which forces the PLHIV to hide their status in the region. With such high rate of infection one might expect PLHIV to be accepted but stigma and discrimination is still prevalent.

The large number of people infected and affected by HIV means that the Church cannot ignore the plight of PLHIV as they form part of the congregation. According to KAIS (2012), the virus is concentrated in the blood, vaginal fluid, semen and breast milk. Therefore, one gets infected with HIV through contact with the infected blood, infected mother to unborn baby during birth while breastfeeding and through unprotected sexual intercourse with the infected person.

Besides the rapid spread of the virus, HIV is also perceived to be different because of how it is transmitted. Wanyama, Were, kimani, (2007) notes that the spread of HIV and AIDS exploits one of the most complex areas of human life: sexual relationships. The author is of the view that these relationships are shaped by human knowledge, values, beliefs, customs and habits. Unfortunately, HIV and AIDS touch on human sexuality, which is not openly discussed in church and
African culture. This silence on sexuality makes PLHIV to be assumed to have got the disease as a result of sexual immorality whereas other modes of acquiring are normally ignored.

Herek (1999) describes HIV and AIDS related stigma as unfavorable attitudes, beliefs and policy directed towards people perceived to have HIV and AIDS as well as their loved ones and close associates. Campbell, Nair, Maimane, and Nicholson, (2007) describes discrimination as a negative behavior and stigmatization as any negative thought towards PLHIV. Mbonu, Bart van den Borne and Deveries (2009), classifies stigma to be external or internal. External stigma, according to the author, refers to the actual experience of discrimination. Internal stigma on the other hand, is the powerful survival mechanisms aimed at protecting oneself from external stigma.

There are different types of stigma. Ogden and Nyblade (2005) identified four different forms of stigma namely physical, social, verbal and institutional. Verbal stigma involves using powerful metaphors associating HIV with death guilt, punishment and horror (UNAIDS, 2005). Some of the names used to refer to PLHIV imply that they have no chance of living and are just waiting to die (Kafuko 2009). Physical stigma includes isolation such as separate sleeping quarters in the home, and separate seating area in the places of worship, (ICRW2010). Violence is particularly harsh form of physical stigma faced principally by women (UNAIDS, 2007). Both women and girls report increased
violence at the hands of their partner for requesting condom use, accessing voluntary testing and counseling, refusing sex within or outside marriage or for testing HIV positive (UNAIDS, 2007). Social stigma excludes PLHIV from family and community event, resulting in their loss of power and respect in the community (ICRW, 2010). Institutionalized stigma occurs when any institution such as a school, hospital church or organizations as employer practice stigma either actively or passively. Institutional stigma has been reinforced by religious leader and organizations which have used their powers to maintain the status quo rather than challenges negative attitude towards marginalized groups and PLHIV (Peter and parker, 2002).

Lamptey, Wright, fife (2002) and Herek (1999) points out that Stigma and discrimination were noticed since the initial stages of the disease. These authors are of the view that this was due to the fact that the first HIV case was among the homosexuals who were perceived as sexual deviants. In Kenya, it was linked with commercial sex workers. Therefore, HIV and AIDS related stigma is not necessarily a stigma of the disease rather it is often related to perceived lifestyle choice of the infected population.

Everywhere in the world HIV and AIDS has been accompanied by stigma and discrimination but stigma seems to be more prevalent in sub Saharan Africa than other parts of the world. Rankin, W., Brenan, S., Schell, L. and Rankin, S. (2005) attribute this to the communal life of the Africans. Shorter and Onyancha (1998)
Mugambi and Kirima (1976) agree with this African view that the sick are blamed for their illness when they think the disease is caused by a curse. Knox (2008) argues that in Africa, misfortune and suffering are usually interpreted as punishment from the ancestors for the breach of taboo or failure to perform a prescribed ritual or duty. He is of the view that deviation from traditional morality is likely to be interpreted as cause of illness leading to stigmatization of the sick. The author points out that the community and the sick may feel that the ancestors have withdrawn their protection as punishment to the sick person. This can cause alienation and anger towards the ancestors and possible despair on one's future.

Gitonga (2008) notes that in the Ameru worldview one of the root causes of sickness was either broken relationship with God (vertical dimension) or broken relationship with one's kinship (horizontal dimension). He adds that calamities such as outbreak of diseases took place as a result of punishment from God while all forms of individual illness or death resulted from curses due to disharmony in kinship system. This view is important in understanding why stigma on PLHIV within the Meru community where this study was carried out.

From the outset, was associated with a high level of stigma and discrimination. This prejudice rose in part because it was linked to groups such as gay men, prostitutes and intravenous drug users who were highly stigmatized. In 1982, when HIV and AIDS was reported in America, there was little information about the disease. In fact, PLHIV like Ryan White (Times Magazine, April 1990) was
barred from attending school for fear that other children may be infected. In India, according to Takyi (2011) in the 1980s, HIV/AIDS patients were considered as outcasts and some were given separate houses to live in and were prevented from coming into contact with anyone. A World Council of Churches (WCC) (1997) report indicates that as early as 1982 in Africa AIDS was viewed as a disease of people who had multiple sexual partners regardless of gender.

It is worth noting that the major obstacle to combating HIV and AIDS in Kenya is stigma. Stigma remains the highest killer than the scourge itself because it makes prevention and treatment difficult by forcing epidemic out of sight and underground. Stigma is therefore a key concept in HIV and AIDS control and calls for attention from all stakeholders. This provided the justification for this study given that the church is a central institution in fighting stigma and discrimination against PLHIV.

Stigma can play a useful role in reinforcing Christian morals and cultural norms. Hill (2007) argues that religious institutions should, with clear conscious, stigmatize and exclude members who are known and confirmed to have sinned. In doing so, the fear of exclusion would make others to behave well and comply with the moral and cultural expectations of their community. It would also preserve the institutional identity of the church and the moral fiber of the community. However, this argument is against Christian teaching of love for all and confirming those who have sinned implies judging others which Jesus condemned.
Information plays a big role in understanding HIV/AIDS. Little information, wrong information and confusing bits of information can bring about wrong responses towards the PLHIV. People who do not have sufficient information often lack the confidence to use it and to take appropriate action. People incorrectly think HIV can be passed through casual contact such as sharing plates or sitting next to someone in a church. Dube (2002) is of the view that the fast step in fighting stigma is to put people in touch with up to date and accurate information on HIV and AIDS. This includes how HIV is or is not transmitted, how HIV can be prevented, the difference between HIV and AIDS and how long PLHIV are expected to live. The congregation should be informed that PLHIV can live productive lives.

A UNAIDS report (2007) indicates that whilst ignorance is the cause of stigma research has shown that just giving information about the cause of diseases, is not enough to reduce stigma. In many instances, stigma remains even when people have the basic information about the causes of HIV and AIDS and how it is spread. Information may fail to help people to take sensible action if the people may not trust the information that they have even if it is correct. People may also fail to take action if they have contradictory information on HIV and AIDS in case where the faith healing of HIV and AIDS contradicts the medical view which depicts AIDS as incurable.
From Biblical perspective, stigma was rampant within the Jewish community for sicknesses like leprosy (Leviticus 13-14). The lepers were depicted as unclean people who were to be separated from the rest of the community (Luke 7:22). In the New Testament, Jesus took a revolutionary attitude to those who were stigmatized by the society. He showed them compassion by associating with them and even touched the lepers who were not acceptable according to the Jewish culture (Luke 5:12-16, 17:11-19). Christians are therefore duty bound in proclaiming hope, value and compassion to the PLHIV.

Across the globe, WCC sensed danger as the HIV and AIDS spread throughout the world, observing that HIV and AIDS is calling the church to be a healing community (WCC 1987). The WCC identified pastoral care, preventive education and social response against stigma on PLHIV as important in the fight against HIV and AIDS. African church leaders under the auspices of All African Council of Churches (AACC) met in November 2001, to draw an ecumenical plan of action for responding to the HIV and AIDS pandemic and their conclusion was that the most powerful contribution the church can make to combating HIV transmission is the eradication of stigma and discrimination. Dube (2002) notes that the National Council of Churches of Kenya (NCCK) organized regional advocacy forum of the church members across the country. During this forum the clergy were sensitized on stigmatization of PLHIV and how to support the infected and the affected. According to Vitillo (2007), the Roman Catholic Church presents similar views. He adds that the Church, in collaboration with other Catholic organizations, has
disseminated huge amount of information about stigma on PLHIV. Vitilo(2007) adds that While addressing the World Aids Day in 2005, Pope Benedict XVI, nb encouraged the ecclesiastical communities to eradicate stigma and feel close to PLHIV and their families.

Similarly, Nkinda (2001) points out that the Methodist Church in Kenya considers the care of the sick as an integral part of its mission. The health activities in the Methodist Church are coordinated by the Conference health coordinator in collaboration with Conference health committees with representation from all the ten synods of the church. The Methodist Church has incorporated HIV and AIDS advocacy, support and care of the affected persons in the society. These activities are carried out within the Connexion and coordinated by the HIV and AIDS coordinator who is based in Meru region. The Methodist Church has established links with other faith based organizations through the National Council of Churches of Kenya (NCCK) and is an active member of the Christian Health Association of Kenya (CHAK). The Methodist Church in Kenya and CHAK have collaborated in training of 17 Voluntary Counseling and Testing (VCT) counselors from the nine Synods. The Methodist health program dedicates a week every year to handle health matters. In 2001, the Methodist Health Week Program focused on HIV and AIDS as a national disaster. However, the program targeted only transmission, prevention and care with no mention of stigma and discrimination on PLHIV.
At the Circuit level, which is the lowest structure in the Methodist Church, there are few activities targeting PLHIV. Njia Circuit, which was the area of interest for this study, has established a faith based organization called Njia Circuit Orphaned and Vulnerable Children (O. V. C) program to coordinate HIV and AIDS issues mainly dealing with orphans. According to Circuit Report, the program collaborates with Methodist Hospital to conduct VCT within the Circuit. Most of the other activities are geared towards the support of the orphaned children. This implies there is a gap on stigma on PLHIV that this study hopes to address.

1.2 Statement of the Problem

As indicated in the background of this study there are over 1.6 million PLHIV in Kenya (KAIS report, 2013). The report further indicates Stigma is a major obstacle in combating HIV and AIDS because it leads to people avoiding voluntary testing and possibility of disclosing their status if found positive. Therefore, HIV and AIDS related stigma is important because it frequently shatters infected persons identity and self confidence, significantly decreasing their ability to manage the disease successfully.

Jesus associated and touched the leper (Mathew 1:40–42) who were ostracized and thus invites the church to do the same to the PLHIV in Njia Circuit.

The mission of the Methodist Church in Kenya is to ‘preach the Good news, set at liberty the afflicted and equip believers’. This mission of liberating the afflicted
means practicing his teaching of supreme love and making him known to all without discrimination. One wonders why the above mentioned biblical teaching, coupled with the mission of the church, no longer seem to compel the members to address stigma and discrimination on PLHIV. Why is there apparent discrepancy in the faith and practice of the Methodist Church in Njia Circuit in regard to stigma on PLHIV? This study investigates whether or not the Methodist Church is concerned about stigma affecting PLHIV in its membership. This study sought to establish why stigma is prevalent against PLHIV within Njia Circuit where love and care would be expected. This background leads to unanswered questions; is the Methodist Church aware of stigma affecting PLHIV in Njia Circuit? How come there is stigma in the church where love and compassion is expected? Why does the church offer material support and at the same time stigmatize the PLHIV? Is the church aware that its words, action or in action contribute to stigma and discrimination against the PLHIV?

1.3 Objectives of the Study

The study will be guided by the following objectives:

1. To establish the level of knowledge on HIV and AIDS within the Methodist congregation in Njia Circuit.

2. To examine the biblical teaching on stigma and discrimination on the terminally ill patients.
3. To evaluate the major causes of stigma and discrimination against PLHIV in Njia Circuit.

4. To investigate the effects of stigma and discrimination on PLHIV in Njia Circuit.

1.4 Research Questions

The study will be guided by the following research questions:

1. What is the level of knowledge of the congregants on HIV in the Methodist church in Njia Circuit?

2. How do biblical teachings perpetuate stigma and discrimination on the terminally ill patients?

3. Which are the causes of stigma and discrimination on PLHIV in Njia Circuit?

4. What are the effects of stigma and discrimination on PLHIV in Njia Circuit?

1.5 Research Premises

1. There is a relationship between the level of knowledge on HIV and AIDS and stigma in the Methodist church in Njia Circuit.

2. Biblical teachings on terminally ill patients contribute to stigma on PLHIV.

3. The causes of stigma against PLHIV are fear of death, and association of HIV with immorality.
4. Stigma against PLHIV hinders voluntary counseling and testing, lead suicidal tendencies and loss of jobs to PLHIV.

1.6 Justification and Significance of the Study

Firstly the study hopes to evaluate the conclusions drawn by some studies carried out on stigma on PLHIV within the church. Such conclusion include that the church is responsible for the stigma because of its association of HIV with immorality (Mageto, 2005, Michael, 2005, Dube, 2001, Shorter and Onyancha, 1998). Again these scholars hold the view that the church is silent on issue of sexuality and tend to view HIV as punishment for sin. Can this views hold in Methodist Church in Njia Circuit today?

Secondly this study provides information on the anomaly that exists among the Methodist Church member who may stigmatize the PLHIV which is against the Christian teaching of universal Love. Hopefully, the suggestions made in this study may help the member to the Methodist Church in Njia circuit who may be interested in alleviating stigma on PLHIV and increase their participation in church activities and on the national level it can help churches to make Christianity a healing community.

Thirdly the study will provide a base to other student of social sciences who might intend to do more research on the aspect of stigma that have not been covered by this study.
Fourthly, this study may enhance the understanding of Methodist Church in Njia circuit on the plight and PLHIV and encourage them for address the apparent stigma and discrimination against the PLHIV. By so doing the Methodist church will have responded to the global call by UNAID to zero discrimination by 2015. The study will also have contributed towards achievement of KNASP 111 call for comprehensive national response to HIV epidemic in partnership with the private sector.

Fifthly it is important to overcome stigma against PLHIV because of Jesus teaching in the Bible in Luke 5:12-16 where Jesus showed love all without discriminative. In Mark 6:34 when Jesus Saw a large crowd he had compassion on them because they were like a sheep without a shepherd. This does not mean he excused their sin but he longed to reach to them with his love and truth and power. If we look at the great crowd on our world with HIV and not be moved with compassion we have lost the plot.

Finally, there is no research known to the researcher that investigates stigma and discrimination against PLHIV in the Methodist Church. The data will fill the gap of literature on stigma and discrimination on PLHIV in the Methodist church in Kenya. By establishing the underlying causes and effects of stigma on PLHIV the study hopes to serve as a valuable input to effective intervention, thereby benefiting members of the Methodist Church in Njia Circuit.
1.7 Scope and Limitation of the study

The research focused on the role of the Methodist Church in addressing stigma on PLHIV within Njia Circuit. The study was limited because it was carried out in Njia Circuit and may not apply to all churches in the country due to social economic differences in the various parts of the country. PLHIV were not willing to be interviewed within the church set up, I therefore, interviewed them within their support groups. Church members responses on stigma were wanting to counter this to I used focused group discussion to seek clarification.

1.8 Literature Review

Introduction

The literature herein has been reviewed thematically, focusing on the various aspects of the objectives of the study. It particularly focused on the level of knowledge on HIV and AIDS within the Methodist Church, Biblical teaching on stigma and discrimination on the terminally ill, major causes of stigma and discrimination on PLHIV and the effect of stigma on PLHIV in Njia Circuit.

1.8.1 Level of knowledge on HIV and AIDS within the Church

Many church leaders find it difficult to incorporate issues to deal with stigma on PLHIV. Genrich and Brathwaite (2005) are of the view that information about HIV and AIDS and attitude towards PLHIV in the church is lacking possibly
because the church is not regarded as a high risk site in HIV transmission. They also indicate that most studies do not disclose much about practices related to stigma and discrimination. However, the numbers of PLHIV within the church has increased over time, ruling out this view that the church is a safe haven free of HIV and AIDS. This calls for information to be disseminated within the church hence the need for this study.

Lack of adequate knowledge about HIV and AIDS and how it is transmitted is considered as one of the causes of stigma and discrimination against the PLHIV. knox, (2008) argues that ideally HIV and AIDS stigma should be an element in ordination and training for the clergy as well as in local lay preachers training. He argues that with 34 million PLHIV in the world, there can be no more pressing demands for space on the training syllabus. However, people may doubt, disregard or disagree with public health information regarding low risk or non-risk contact provided to them by the public health professionals. This is not to suggest that HIV and AIDS stigma information does not play an important role in decreasing stigma, but that knowledge alone is insufficient to eliminate false beliefs regarding transmission or for that matter to eradicate stigma. This goes to show that in some cases knowledge does not translate to the right action or attitude that reduce stigma. Thus the need for paradigm shifts in information transmission on HIV and AIDS within the church that will translate into the right action.
According to Ogden and Nyblade (2005) lack of knowledge results in fear that HIV could be transmitted through ordinary daily interaction with PLHIV such as kissing, shaking hands, sleeping the same room and eating together with the PLHIV. He adds that despite the introduction of antiretroviral therapy (ART), AIDS remains a chronic and incurable condition surrounded by fear and myth. Many church members believe in these myths. Misconceptions about HIV and AIDS are common even among pastors and may fuel stigma that affect the PLHIV. Chitando (2007) gives an example of one of the pastors at a preachers workshop in Rural Zimbabwe in 2006 who described HIV as a “diseases that one gets from South Africa”, thus the pastor was convinced that HIV was not a Zimbabwean reality. vitillo (2007) attribute stigma on PLHIV to silence on HIV and AIDS which perpetuates myths about the mode of transmission and how it can be managed. These sources are important in understanding that myths and fears on HIV and AIDS have persisted over time and there is need to address t World Vision (2005) report indicates that, it is important that the church leaders themselves to take part in the fight against stigma on PLHIV in Africa. The church leaders can do this by initiating church based programmes designed to disseminate correct information about Aids. However, there is need not only to establish programs but also access their suitability and sustainability in addressing HIV and AIDS stigma. This study hopes to fill that gap by suggesting programmes that can be contextualized in different churches.
Mageto (2005) argues that the church’s initial response to the epidemic was characterized by fear of contagion and the consequence ostracism of the infected and affected. He concludes that in the beginning of the epidemic the church chose silence. It was unwilling to reopen the debates surrounding sex and the disease. Mageto (2005) points out church leaders around the globe issued inflammatory sermons, speeches and publications condemning promiscuous groups of people. Mageto adds that the assumption was that if one is a member of a given congregation, he or she is exempted from HIV and AIDS since this virus is transmitted only to those involved in illegal sex which could not involve church members. He is critical of the Methodist spokesman who advised Christians to maintain their matrimonial vows and whoever breaks them would be disciplined to save both their physical body and soul from eternal fire. The church was living in a spirit of self righteousness and belief that monogamous marriages would withstand the wave of the epidemic. Therefore, the message church leaders to the congregation distorted the truth allowing the virus to spread unabated. This study used this historical view of the church to show the need for change in its policies to deal with the various mode of transmission of information on HIV and AIDS. The study came up with a procedure of disseminating information within the Methodist Church in Njia Circuit. This will possibly help the Church to keep up with the recent development on HIV information trend and alleviate stigma which is usually associated with ignorance and myths. Consequently, the Church should
not only be consumers of information but also be able to apply the information on
daily basis within the Church programmes.

1.8.2 Biblical teaching on Stigma and Discrimination on the Terminally Ill Patients

HIV and AIDS stigma is complex social phenomenon as process that results in a
powerful and discrediting social label and change the way individuals view
themselves and are viewed by others. Stigma can be experienced internally (self
stigma) or externally (ICRW 2010). ICRW (2010) report indicates that internal
stigma can lead to person unwillingness to seek help as to access resources.
External stigma can lead to discrimination based on one’s perceived or actually
HIV-positive status or ones association with someone else with perceived as actual

The Christian teaching on stigma and discrimination draw heavily from the
biblical view point. In the Old-Testament stigma was prevalent in the Jewish
community for sickness like leprosy. In Leviticus 13-14, lepers were declared
unclean by the priest and therefore seen as social misfits. The leper was to wear
torn cloths and let the hair of his head be disheveled and was to cover upper lip
and cry out,“ unclean, unclean”. The leper was to live alone, and his dwelling was
to be outside the camp. (Leviticus 13; 45-46). In Deuteronomy 28; 27 curses are
cited which include God sending incurable diseases to apostate people. These
teachings have been used in churches as the basis for stigmatizing the PLHIV and needs to be corrected.

HIV and AIDS today, like leprosy in the Old Testament that had no cure, is viewed as being sent as punishment for sin (Numbers 12:10, 2nd King 5:27, and 2nd King 15:5). This may explain why PLHIV are being perceived as immoral and therefore sinful. Consequently, this forms the basis of stigma that is prevalent in the church. This is elaborated further in the episode where King Uziah was struck with leprosy for his support of idolatry (2nd Kings 15:5). Cochrane (2005) notes that religion feeds into the problem of stigma through: taboos, sanctions and silence about sexuality, much of it authorized by biblical teachings. Therefore, the concept of God punishing people for being unfaithful to him has its source in Old Testament theology. In the Old Testament, God is portrayed as a jealous monarch who cannot tolerate faithlessness. This down plays the universal love of God which needs to be emphasized.

There are scenes of judgment in the New Testament- for example, Mathew 25, which contains both the parable of the ten bridesmaids and the prediction of the last judgment. However, God is also viewed as a lover who loves the faithful and the unfaithful and sends rain on the righteous and on the unrighteous (Mathew 5 and 2 Timothy 2; 13).

The New Testament depicts Jesus as showing sympathy with the marginalized. Jesus took a revolutionary attitude towards those stigmatized and socially rejected.
In (Luke 5:12-16, 7:11-19), Jesus touched and heals the leper. Therefore then, the church is duty bound to be in the forefront in fighting stigma and discrimination against PLHIV. The church, just like Jesus, who moved from the Jewish condemnation of the lepers, should move away from associating PLHIV with immorality. Consequently, they should touch lives of the PLHIV positively.

Literature review has shown that HIV is viewed from Old Testament as a punishment from God. This research hoped to prove the validity of this view with a view of coming up with the strategy of alleviating stigma and discrimination against PLHIV.

1.8.3 Major Causes of Stigma and Discrimination against PLHIV

Nicolson (1996) argue that stigma and discrimination against PLHIV is due to prejudice and false notion that are rooted and grow out of ignorance and racism. Nicolson (1996) is of the view that theories of origin of HIV and AIDS reflect prejudice of the western people commonly believing that the virus started among Africans perhaps contracted from monkeys. This notion has some racial overtones and confirms western prejudice about African hygiene and sexuality according to the author. Shorter and Onyancha (1998) concur that racial overtone are present even today. They argue that Africans are more screened for health status than Euro-Americans coming to African countries. The author adds that this is happening today when HIV has spread to every country and in all levels of society. He concludes that imposing quarantine on people with HIV helps in
fuelling stigma and discrimination. This study sought to establish how history of HIV and AIDS and early years of pandemic fuelled stigma and discrimination a view of coming up with strategy of reducing stigma.

Moleny (2005) notes that in the early years of HIV and AIDS it was a disease that affected others and was linked with homosexuality lifestyle in US and Europe. Moleny (2005) note that it was linked with sex workers in Kenya. This is a view that HIV and AIDS does not happen to ordinary Christians who are perceived as morally upright. However, high prevalence of HIV shows there is need to correct this holier than though attitude and increase acceptance of the PLHIV within the church.

Wanyama et al. (2007) and ICRW report (2007) agree that one key area that continues to promote stigma is lack of knowledge on the basic facts about HIV and AIDS. However, foregoing authors agree that knowing the facts is just a half the story. People may know basic facts but treat them as simple slogans or rule which they follow blindly. Research by ICRW (2007) indicates that everyone has some information on HIV and AIDS. But few have enough information to overcome irrational fears associated with HIV and AIDS and its transmission. This fear of casual contact will often lead to isolation and segregation of PLHIV. Bujo (2007) notes, PLHIV are given separate plates, cups and rooms.

Wanyama et al. (2007) and Shorter and Onyancha (1998) indicate that AIDS being viewed as punishment to sinners by religious organization is a major cause
of stigma and discrimination for PLHIV. Dube (2002) notes that the initial response to HIV and AIDS focused on those biblical passages that associated illness with disobedience and punishment by God (Numbers 12:10, 2
King 5:27, and 2
King 15:5). However, the authors critics this view by saying that if the church entrenches the false notion of HIV and AIDS being an expression of anger by the divine majesty, it encourages judgmental attitude and thus discriminate those who suffer.

Shorter and Onyancha (1998) adds that when HIV and AIDS is conceived as a punishment for specific sins, there is a high level of denial among Christians living with HIV for they are in constant fear of being ostracized and being expelled from the Church and therefore hide in fear. A ICRW (2007) report indicates that some church do not believe in the efficacy of medical treatment. This indicates those adherent of faith healing believe a person can be healed by prayers. If PLHIV do not get better, they are seen as people of little faith and are further stigmatized.

Wanyama et al (2007) and Shorter and Onyancha (1998) agree with the view that due to the mystery surrounding the origin of HIV and AIDS, some perceive it as witchcraft. Among the Luo, Wanyama argues that HIV and AIDS is considered as, ‘Chira’ associated with bewitchment or curse of the forefathers for failing to perform their duties. Thus those infected with the virus are seen as outcasts who have been bewitched. They further argue that communities are less sympathetic to the victims if they think the disease has been caused by curse or witchcraft. They
add that witchcraft beliefs are potent cause of fear and aggravate the already existing fear of the disease.

In most of the communities, sexuality was not discussed openly. Wanyama et al. (2007) concur with the view that sexuality has been a controversial topic that many parents and religious community fear that if exposed to the youth will encourage promiscuity among them. Moleny (2008) is of the view that stigma is fuelled by Christians’ hung up about sex. He adds that sex within marriage is idealized as something beautiful and fulfilling but sex and sexuality are often in practice associated with temptation, immorality, sin and evil. Orabator (2005) supports this view by citing a case of Roman Catholic opposition to use of condoms where by late archbishop Cardinal Otunga on August 19th 1995 made a bonfire stoked by boxes of latex condoms and sex material. This action, coupled with Catholics opposition to the sex bill in 1990s, explicitly demonstrates the church failure to address the issues of sex and sexuality openly despite the fact that virus is mainly spread through sexual intercourse. This ignorance on sexuality has aggravated stigma and discrimination as PLHIV are viewed as sexual deviants who got what they deserved on account of their immorality.

Genrich (2007) is of the view that churches through their silence share responsibility for fear that has swept the world faster than the virus. She asserts that some congregation have reinforced racist attitude by neglecting issues on HIV and AIDS. She concludes that they do so because certain ethnic or racial groups
are not members of their congregation. Moleny (2008) argues that stigma of HIV and AIDS is somehow associated with ones fear of death and therefore one tends to deny or reject what they fear. Wanyama et al. (2007) argues that use of certain names like ‘victims’ tends to perpetuate and cause a lot of suffering to PLHIV. ICRW (2007) report put it clearly that stigmatizing words are strong and insulting. They have tremendous power to humiliate the PLHIV and destroy their self esteem. Wagura (Daily Nation April 2011) add that when parent die and leave children we hear of terminologies such as “AIDS orphans” and vulnerable children. She notes that there are no accident orphans or diabetic orphans. Therefore, for “AIDS orphans” people try to talk more on the cause of death and some take a moral ground on the person who has died and leave the bereaved to die with the stigma.

It is clear that there are numerous causes of stigma both within the church and outside. The study exposed that cause of stigma on PLHIV in Njia Circuit is similar to the causes highlighted in the Literature review. This study hopes that it has filled the gap between information and the accompanying behavior change.

1.8.4 Effects of Stigma on PLHIV

PLHIV do not always find the support they seek in church. Nicolson (1996) argues that fear and prejudice has caused Christians to close the door on PLHIV. The author notes that in America, because of homosexuality link, mainstream Church was slow to respond to the HIV and AIDS crisis. He further adds that African
countries initially responded with fear and denial. He adds that in Kenya, some churches neither permit those with HIV and AIDS to have their burial service in the church nor attend the church. Bujo (2007) concurs with this view and argue that fear and shame that accompany HIV and AIDS weaken social network and exclusion of PLHIV. The author argues that stigma has robbed so many of their friends due to the view that protecting against the virus involves protecting oneself from those who bear the disease. Michael (2008) concludes that the absence of others while one is suffering constitutes the greatest moral hardship similar to what Jesus experienced in Gethsemane when he felt lonely because his disciples slept instead of praying.

Lamptey et al (2009) argue that stigma and discrimination against PLHIV leads to avoidance of being tested for HIV and disclosing of status if tested. The author argues that most individuals in sub-Saharan Africa prefer not to know their status. This is based on the belief that it’s better to suffer from the disease quietly and hidden than to find out through testing because of stigma. Bujo (2007) notes that fear and shame that accompany the disease have also weakened the social network and caused social exclusion of the PLHIV. He notes especially in the case of the orphans who are normally cared for by the traditional system of social security namely the extended family. He adds that some of the orphans join the increasing number of street children making them more vulnerable to the virus.
Lamptey (2009) argues that stigma and discrimination make PLHIV more vulnerable to sickness and death because they are less likely to seek appropriate medical care and psychological support and are more likely to be denied services if they seek them. The author notes that PLHIV have tried to commit suicide before the disease itself does away with them. Manjok (2008) add that stigma and discrimination on PLHIV lead to crisis isolation and loneliness which make them develop suicidal tendencies.

Duff (2005), records that health care providers may face stigmatization because they offer services to HIV/AIDS positive patients. Caregivers, health professionals or volunteers risk what Goffman (1963) calls ‘courtesy stigma ’ This interferes with the willingness of health care workers to deliver their services to PLHIV and make their work more difficult. Therefore, the health care provider may find it difficult to attend to PLHIV because of stigma.

Lamptey et al. (2009) argue that many people with HIV have lost their jobs and denied medical cover, housing insurance and opportunity to travel because of their HIV status. Loss of jobs is also prevalent in the churches as Nicolson (1996) notes of a pastor whose family contracted the virus though blood transfusion was forced to resign.

The foregoing reviewed literature indicates that stigma and discrimination have a multiple effect on the PLHIV. The present study examined the effects of stigma and discrimination on PLHIV in the Church and in the context of Njia Circuit.
1.9 Theoretical Framework

This study used Abraham Maslow theory of motivation, to evaluate stigma and discrimination against PLHIV in the church.

1.9.1 Abraham Maslow Hierarchy of Need Theory

Abraham Maslow’s (1970) Hierarchy of needs theory hypothesized that within every human being there exists hierarchy of five needs. These are physiological needs, safety needs which include security and protection from physical and emotional harm. The third level of need is social needs which include affection, a sense of belonging, acceptance and friendship. The fourth level of needs is esteem needs and they include factors such as self respect, autonomy and achievement and external factors like status, recognition and attention and the highest level of need is self actualization needs, that is the drive to become what one is capable of becoming.

According to Maslow, one must fulfill one need before going to the other. The church makes PLHIV feel insecure by associating their sickness with immorality and depicting them as social deviants. When the Church forsakes them they feel lonely and their self esteem is lowered due to both internal (self) stigma and external stigma. They look down upon themselves and feel that they are not useful again. When stigmatized by the Church where they expect love and compassion, they lose hope and death is close to them hence do not see the need to work hard to
participate in economic production. This denies them realization of self
actualization.

This theory being is applicable in the sense that once the Methodist Church
alleviate stigma in Njia Circuit, the PLHIV will be able to visit VCT centers and
hospitals where they are given appropriate advice on the use of Ant Retroviral
(ARVs). The Methodist church in Njia Circuit can boost self esteem of PLHIV by
showing them love and consequently they can be self actualized to reach their
goals in life. Once self actualized, the PLHIV can make public disclosure in the
church and help in alleviating the stigma. Once the Church helps PLHIV to
achieve self actualization suicidal tendencies are likely to be reduced.

Maslow’s theory is applicable in evaluating the effects of teachings of the
Methodist on PLHIV. When viewed as sinners who are being punished by God,
PLHIV may fail to disclose their status. PLHIV self esteem is affected when they
are stigmatized and seen as immoral by the Christians making them not to achieve
their goals in life. Therefore, if the Church fails to address stigma it limits the
potential of PLHIV to live full and productive lives and assert the right which they
are entitled and will hinder all prevention, treatment and care efforts.
1.10 Research Methodology

This section represents the research methods that were used in this study. This includes the research design, the study area, target population, sampling technique, sample size, research instruments, data correction and analysis procedure. Details about each section are discussed in the succeeding pages.

1.10.1 Research Design

The research design which was employed in this work was survey design. Survey is a method of collecting information by interviewing or administering questionnaires to a sample of individuals. It also includes participant observation. This design was appropriate because the work is qualitative. The survey design was most suitable because it enabled the researcher to conduct interviews to the selected PLHIV, Lay preachers, Church elders and Church Ministers without manipulation of respondents. Their view was important in understanding the prevalence of stigma and discrimination against PLHIV in Njia Circuit.

1.11.2 Study Area

Njia Circuit is the equivalent to a location in the Kenyan administrative unit. Methodist Church in Njia Circuit was chosen because it’s the most prominent church and one of the first churches in the Meru region. The Methodist Church owns and sponsors a number of schools and hospitals in Njia Circuit. Consequently, it is expected to be a leader in areas of education and health. The
Methodist Church is therefore expected to lead in enlightening people and responding to HIV and the accompanying stigma. Does the church use its health and education facilities to enlighten its congregation on issues of stigma and discrimination on PLHIV?

Njia Circuit was Significant because no serious and systematic study has been carried out on stigma and discrimination on PLHIV by a student of religious studies. This study has therefore, attempted to fill the gap by placing record for the present and future generations a study based on stigma on PLHIV with the context of the Methodist Church in Njia Circuit.

Though Njia Circuit has a prevalent rate of 6% which is at per with national prevalence it is far below the UNAIDS target of zero target by 2015. This study investigated whether stigma interferes with disclosure to sexual partners leading to new infection. Do people disclose their status openly in the church? This study was carried out in Njia Circuit of the Methodist Church in Igembe South District in Meru County. Njia Circuit is found in Nyambene synod which has 14 Circuits. The Circuit was randomly sampled from the 14 KLCircuits of Nyambene synod. Njia Circuit is made up of 10 churches namely Nchunguru, Thamare, Maili Tatu, Kithare, Kiraone, Thuuru, Ntui, Thathimwene, Thumbereria and Limoro. The Circuit is headed by a superintendent Minister who is assisted by a Circuit Minister who chairs the Circuit Health Committee. This structure is a sample of what happens in other Circuits in the Methodist Church.
1.11.3 Target Population

This study was carried out in Njia Circuit of the Methodist Church in Igembe South District in Meru County. Njia Circuit is found in Nyambene synod which has 14 Circuits. Population of Igembe Division where Njia Circuit is found to be 83,099 by the year 2012. Njia Circuit of the Methodist church has a population of about 2313 Christians of which 106 were sampled. The study population included Methodist Church members, clergy, Njia Circuit OVC members, and PLHIV and constituency AIDS control council secretary.

1.11. 4 Sampling Technique and Sample Size

The selection of respondent in this study was done by both random and purposive sampling techniques. Random sampling gave equal chances to the members sampled while purposive sampling was to ensure key persons amongst the respondents who had the right information required by the researcher. In this research, information from the respondent was collected regarding the level of knowledge on HIV/AIDS, biblical teachings on the terminally ill, causes and effects of stigma on the PLHIV.

The study sought information from 38 PLHIV. The researcher sampled 38 PLHIV from two support groups that operate in Njia Circuit. This support groups were established by PLHIV within the Methodist church in Njia Circuit. To select the sample of 38 out of 68, the researcher wrote 38 yes out of 68 small pieces of paper folded into equal sizes and shapes. Each of the 68 participants was allowed to pick
one piece at a time. The 38 PLHIV who picked yes were included in the study. Purposive sampling procedure was used to select the Synod Bishop of Nyambene Synod, 5 prominent elders within the Church, Constituency AIDS Council Secretary, 2 pastors from the Circuit, 15 lay preachers within Njia Circuit, and five members of Njia Circuit OVC. This information helped in achieving the objectives of the study.

1.11.5 Sample Categories and Sizes

The Bishop, Ministers and Other Leaders

Purposive sampling was used to pick the five elders, two pastors from Njia Circuit, the Constituency Aids Council Secretary and the synod Bishop. That gave a total of nine. This group represents the top cream in administration. They provided information on the role of the Church in addressing stigma on the PLHIV in the Methodist Church in general and Njia Circuit in particular especially at the policy making and implementation levels.

Lay Preachers

Most of the work of conducting Church service is done by the lay preachers in the Methodist Church. Fifteen of the thirty eight preachers were randomly selected for interviews. The lay preachers are allocated services on Sundays in the churches within Methodist Church. The information from this group was crucial in determining the level of knowledge on HIV/AIDS within the Church, effects and
causes of stigma and discrimination against PLHIV in Njia Circuit. That gave a total of fifteen respondents.

**PLHIV**

Two PLHIV support groups namely Rock Self Help Group which has 38 members and Kaimenyeri Self Help Group, which has 30 members, were purposively selected. 38 PLHIV were randomly sampled from the two groups for the interview. Information from this group was crucial in evaluating the level of knowledge on HIV/AIDS within the Church, biblical teachings on terminally ill, effects and causes of stigma on PLHIV in Njia Circuit since these two groups operate within Njia Circuit. That gave a total of 38 PLHIV.

**The Church Members**

This category of respondents represented the basic level. Njia Circuit has a population about 2313 Christians. The researcher used purposive sampling and selected 44 church members out of which 17 were women, 17 men while youth leaders were 10 to give a total of 44 respondents. This provided the Methodist Church view on stigma and discrimination against PLHIV. This information provided a more vivid picture on the problem associated with stigma and discrimination and how it affects the PLHIV.
Table 1: Sample Size for Category of Respondent

<table>
<thead>
<tr>
<th>Category of respondent</th>
<th>Sample population</th>
<th>Sampled</th>
<th>Percentage of Population sampled</th>
<th>Sampling method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bishop</td>
<td>1</td>
<td>1</td>
<td>100</td>
<td>purposive sampling</td>
</tr>
<tr>
<td>Circuit Minister</td>
<td>2</td>
<td>2</td>
<td>100</td>
<td>purposive sampling</td>
</tr>
<tr>
<td>Lay preachers</td>
<td>38</td>
<td>15</td>
<td>42.8</td>
<td>random sampling</td>
</tr>
<tr>
<td>Elders</td>
<td>5</td>
<td>5</td>
<td>100</td>
<td>purposive sampling</td>
</tr>
<tr>
<td>Constituent leader</td>
<td>1</td>
<td>1</td>
<td>100</td>
<td>purposive sampling</td>
</tr>
<tr>
<td>PLWHIV</td>
<td>68</td>
<td>38</td>
<td>55.8</td>
<td>random sampling</td>
</tr>
<tr>
<td>Ordinary church members</td>
<td>2313</td>
<td>44</td>
<td>2</td>
<td>random sampling</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2428</strong></td>
<td><strong>106</strong></td>
<td><strong>4.4</strong></td>
<td></td>
</tr>
</tbody>
</table>

1.11. 6 Research Instruments

This study employed the following research instruments:

**Questionnaire**

In the questionnaire, there were open ended questions. The different questionnaires were administered to PLHIV, church elders, orphans, clergy, church members and the lay preachers. The questionnaire allowed the PLHIV, orphans, church members, church leaders and clergy to give objective views on the level of knowledge on HIV and AIDS in the Church, biblical teaching on stigma and discrimination on the terminally ill patients, the causes and effects of stigma and
discrimination on the PLHIV. The questionnaire also allowed the respondents to give their views objectively on the role of the church in reducing stigma and discrimination on the PLHIV.

**Interview**

The study used both structured and informal interviews to obtain information from the PLHIVs, clergy, church members, church elders and the lay preachers. This allowed the respondents to be flexible and expressed their views freely taking into consideration individual differential situation changes and survey in new information. By interviewing the Bishop and ministers, the researcher was able to get information on the teachings of the Methodist Church.

**Focused Group Discussions (FGDs)**

The group discussion comprised of the PLHIV and church members to acquire data on the history, causes and the effects of stigma. FGDs involved organized discussions with PLHIV, Clergy and Church members to gain insights on their views, feelings and experiences on stigma and discrimination in the Methodist Church in Njia Circuit.

**Participant observation**

The researcher observed the church area to see how information on HIV and AIDS is presented in the churches. This was done by moving around in the community and within the churches during service.
1.11.7 Data Collection Procedures

The researcher visited the sampled lead persons namely the Synod Bishop, Superintendent Minister, Church ministers, Constituency AIDS Control Council (CACC) Secretary and PLHIV. The researcher contacted these respondents ten days before the intended interview dates to book appointments with them for the interview and also explained the purpose and objectives of the research. Prior preparation enabled the interviewer get adequate time for preparation in order to give the needed information. Questionnaires were distributed to all the sampled respondents including the Bishop, PLHIV, Pastors and the CACC Secretary.

1.11.8 Data Analysis Procedures

Quantitative and qualitative methods of data analysis were used to critically analyze the data. Field notes were condensed and systematically organized in cards. The raw data collected was organized, synthesized with secondary data and arranged thematically, the cumulative data were categorized according to research objective. The researcher came up with a coding scheme for data analysis. Data analysis and examination were done in light of the study objectives.

Qualitative data derived from reading church documents and field notes, was analyzed in the procedure that follows; data organization was the first step in which the researcher used note cards to record the available data. Field notes from interviews were edited as data was being organized. The researcher evaluated and
analyzed the data and determined the adequacy of information, the credibility, usefulness, consistency, and validity of premises/assumptions.

1.11. 9 Ethical Considerations

Stigma is a sensitive issue especially when it is associated with HIV/AIDS. Since the study deals with human participant the researcher prepared a consent letter that was signed by all the participants. Before beginning the study, the researchers informed all the participants of the research in detail and explained to them their rights. The researcher went through all the points of the consent letter with the participants and assured them of the confidentiality, anonymity and highlighted to them the aspect of voluntary participation. Potential respondents were informed about the general intended use of the data to be collected. Then researcher assistants left the questionnaires with the respondents to fill. Appointments were booked for the groups that were interviewed. The respondents were given reasonable time to prepare the needed information and to fill questionnaires.

1.11.10 Problems Experiences During Research

In some Churches some of the respondents did not understand English as Kiswahili. Their services are carried in vernacular (Kimeru). The researcher had to explain to them in vernacular which was tasking. Most of the visit had to be done during the Sunday church service. This brought a problem because the church programmes are busy and some respondents were impatient to fill the
questionnaires mostly when the service had ended. The researcher opted to meet respondents during the weekdays when they met for bible study and fellowship.

Some of the respondents like the clergy seemed not to be objective in the fear that they may depict the church as insensitive to the plight of the PLHIV. It was difficult to identify the PLHIV within the churches because of low disclosure. In fact no church had records to show PLHIV in their congregation. The researcher had to rely on information from the PLHIV support groups.
CHAPTER TWO

LEVEL OF KNOWLEDGE ON HIV AND AIDS WITHIN THE
METHODIST CONGREGATION IN NJIA CIRCUIT

2.1 Introduction

The first chapter laid down the tools and methods used in attaining the objectives the study set out to accomplish. This chapter explores the level of knowledge on HIV transmission, prevention and disease progression. Njia Circuit of the Methodist Church was sampled as an example of what happens in other churches and Circuits within the study area. The study explored the various ways in which the Church transmits information on HIV/AIDS to its congregants. This included usage of booklets, posters and pamphlets in passing of information on HIV and AIDS within the Church.

The relationship between the level of knowledge within the congregation and stigma is also addressed in this chapter. This is in line with the study premise which investigates the relationship between stigma and knowledge. Information dissemination on HIV and AIDS is considered an important component in stigma alleviation on PLHIV. The study sought to answer the question on how much information does the church in Njia Circuit have on HIV and AIDS and how it influences stigma on PLHIV.
The extent to which information alleviates stigma and promotes the well being of PLHIV is also explored. Level of knowledge on prevention and mode of transmission of HIV and AIDS is important as it influences the acceptance of the PLHIV within the Church. Therefore, in relation to Maslow’s theory of need, that guided this study, acceptance is an important component towards self-actualization of the PLHIV. Once accepted, the PLHIV are able to actualize and become productive members of the society.

Conflicting information on HIV and AIDS is prevalent in the churches today. The research addressed the various conflicting and false information on HIV and AIDS that are within the congregation in Njia Circuit. In addition, this Chapter focuses on the various forums for information dissemination within Njia Circuit. These forums are important in establishing the sustainability of HIV and AIDS information and its applicability within the Church context. The forums addressed: group meetings, prayer meetings, wedding functions and funerals. These Church activities are considered important in discussing and brainstorming on HIV and AIDS information within the Church.

This chapter attempts to explain the role of information in alleviating stigma on the PLHIV in Njia Circuit of the Methodist Church in Kenya. Specific focus was on the nature of information and mode of transmission of information in order to make it applicable in the Church set up and community in general.
2.1 Information on HIV and AIDS in the Church

Information forms an important component in reducing stigma and discrimination on PLHIV. According to Campbell et al. (2005), the first step in fighting stigma is to put people in touch with updates and accurate information about HIV and AIDS. It includes how HIV is and is not transmitted and how HIV can be prevented. People need to know the difference between HIV and AIDS, how long the PLHIV are expected to live. The fact that PLHIV can be productive members of the society, there is need for the church to know how to care and support them.

Chitando (2007) notes that, AIDS competent church is expected to be reservoirs of knowledge regarding development in HIV and AIDS research. He is of the view that Churches cannot abandon this crucial role to the medical experts. This view advanced by Chitando demonstrates that it is only when the entire congregation becomes HIV and AIDS literate that the idea of AIDS competent Church could be within reach. The importance of information on HIV/AIDS dissemination was echoed by a respondent (O.I 27/7/2013), the superintendent Minister of Njia Circuit, who reiterated on the importance of pamphlets and brochures to disseminate information within the Church. He was of the view that through co-operation with Non-Government Organization (NGOs) like UNAIDS; we can keep abreast of the latest development on HIV and AIDS information. He also emphasized the induction of HIV and AIDS information within the sermon where the preacher relates the day’s message in the Church service to the lives of PLHIV and issues of HIV and AIDS in general. The words of prophet Hosea are critical in
emphasizing the importance of information for the survival of the church. Hosea 4: 6 says that people perish because they lack knowledge. This view indicates that an informed church is essential for the wellbeing of all not just PLHIV. Similarly, Chitando (2007) emphasizes that the Church should produce booklets with relevant information on HIV/AIDS. He adds that the Church should make available simple but accurate information on HIV and AIDS. The material should also be translated into local language in order to reach majority of the people. However, our research findings established that information on HIV/AIDS was inadequately addressed within the Methodist Church in Njia Circuit as indicated on the table below.

**Table 2.0 Frequency of addressing issues related to PLHIV**

<table>
<thead>
<tr>
<th>Frequency of addressing issues related to HIV/AIDS</th>
<th>PLHIV(n)</th>
<th>(%)</th>
<th>CHRISTIANS(n)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a week</td>
<td>-</td>
<td>-</td>
<td>25</td>
<td>36.8</td>
</tr>
<tr>
<td>Once a month</td>
<td>4</td>
<td>10.5</td>
<td>40</td>
<td>58.8</td>
</tr>
<tr>
<td>Rare</td>
<td>12</td>
<td>31.6</td>
<td>3</td>
<td>4.4</td>
</tr>
<tr>
<td>Never</td>
<td>22</td>
<td>57.9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>100</td>
<td>68</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Researcher (2013)
On the frequency of addressing issues related to PLHIV during Church functions, majority of the PLHIV respondents (57.9%) said they have never been addressed while majority of the Christians (58.8%) cited that they are addressed once per month. 31.6% of PLHIV respondent said they rarely discussed them while 36.8% Christians said they addressed them once a week. Only 10.5% of PLHIV respondents indicated that they discussed about them once every month.

Focused group discussions with Christians indicated that issues on HIV are rarely addressed in the Methodist Church. Church secretary (0.1.24/8/2013) noted,

> In our church, there are no booklets brochures or posters on HIV and AIDS. There is little information on sex and HIV in the church. The preachers rarely mention HIV in their sermon. When they mention HIV and AIDS it is usually as a caution to the congregants that God sent an incurable disease to punish the sinners.

This view confirms the research premise that there is a relationship between the level of knowledge on HIV and AIDS and stigma in the Methodist church in Njia Circuit. The data from Njia Circuit demonstrates low frequency of information dissemination and this affirms the views of Genrich and Brathwaite (2005) that information about HIV and AIDS in the Church is lacking possibly because the church is not regarded as a high risk area in HIV and AIDS transmission. As Chitando(2002) clearly states,

> AIDS competent churches thirst for relevant knowledge in the context of HIV. Churches in Africa must have time in seeking late information on HIV prevention, treatment and care. There is no room for laxity. Graduates from the theological training Programmes must be reservoirs of knowledge in the era of HIV. They must challenge entire congregation to gain as much knowledge about the epidemic as possible.
Focused group discussions with PLHIV indicated that frequent information on the
HIV and AIDS can play an important role in alleviating stigma on PLHIV. Once
the congregants are enlightened, they are able to interact well with the PLHIV (O.I
22/8/13). This agrees with Campbell et al. (2007) assertion that if people in
churches are not well informed about HIV/AIDS, they have strange perception that
they can contract HIV by casual contact with a PLHIV. Campbell et al. (2007) is
of the view that what was proclaimed at ecumenical and global conference in
Africa need to be shouted from the pulpit of every congregation and taught in
every church forum. The need for church to become a leader in information
dissemination was stressed by Stephen Lewis UN Special Envoy for HIV/AIDS in
Africa, who spoke to religious leaders gathered in Nairobi in July, 2002

Who else, beyond ourselves is so well placed to lead? Who else has access to all
communities once a week, everywhere across the continents? Who else officiates
at millions of funerals of those who die of HIV/AIDS related illness, and better
understands the consequences for children and families? Who else work on a
daily basis with faith based, community based organizations? In the midst of this
wanton, pervading pandemic, it is truly like an act of divine intervention that you
should be physically present everywhere, all the time. I ask you again: who else,
therefore, is so well placed to lead (Igo 2007).

2.2 Depth of Knowledge on HIV and AIDS

According to UNAID (2011), AIDS is an epidemiological definition based on
clinical signs and symptoms. AIDS is caused by HIV, the Human
Immunodeficiency Virus. HIV destroys the body’s ability to fight off infection and
disease which can ultimately lead to death. Antiretroviral therapy slows down
replication of the virus and can greatly enhance the quality of life, but does not
eliminate HIV infection. Without HIV treatment your immune system can become
too weak to fight serious illnesses. HIV can also damage other parts of your body. Eventually you become sick with life threatening infection. This is the most serious stage of HIV infection called AIDS (UNAIDS, 2011). There is no cure for HIV, but with proper care and treatment most PLHIV can avoid getting it for a long time. According to UNAIDS (2011), if you have AIDS, you will need medical intervention and treatment to prevent death.

According to CACC coordinator (0.1.5/7/2013.), most of the people do not differentiate between HIV and AIDS. He adds that they usually say that those who are infected with HIV have AIDS and usually the conclusion is that PLHIV are likely to die anytime.

**Table 2.2: Difference between HIV and AIDS**

<table>
<thead>
<tr>
<th>Response view</th>
<th>Yes%</th>
<th>No%</th>
<th>Do not know%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV and AIDS are the same</td>
<td>65</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>A person can have HIV without becoming with AIDS</td>
<td>59</td>
<td>31</td>
<td>10</td>
</tr>
<tr>
<td>People who are healthy are not infected with HIV</td>
<td>9</td>
<td>91</td>
<td>0</td>
</tr>
</tbody>
</table>

The findings of the research indicated that the respondents had general information on the difference between HIV and AIDS. On the level of knowledge in reference
to the distinction between HIV and AIDS, the research findings demonstrated that majority of the respondents, 65% did not differentiate the two while 20 % did and only 15% indicated that they did not know. This signifies lack of adequate knowledge on the HIV disease progression. Lack of in depth knowledge may perpetuate the misconceptions and stigma associated with the disease. This is because HIV can be managed by use of ARVS whereas AIDS is the final stage and is likely to lead to death. Confusion of the two terms is likely to cause fear which fuels stigma on PLHIV as they are viewed as people who are likely to die any time.

2.3 Knowledge on the Mode of HIV Transmission and Prevention

Relevant knowledge on the mode of HIV transmission and prevention was also high among the respondents. The table 2.3 illustrates this.

<table>
<thead>
<tr>
<th>Respondents views</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Don’t know (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) A person can have HIV without becoming ill with AIDS</td>
<td>59</td>
<td>31</td>
<td>10</td>
</tr>
<tr>
<td>b) People who look healthy are not infected with HIV</td>
<td>9</td>
<td>91</td>
<td>0</td>
</tr>
<tr>
<td>c) Sexual contact is the primary means of transmission of HIV</td>
<td>73</td>
<td>22</td>
<td>5</td>
</tr>
<tr>
<td>d) A person can get HIV by being bitten by mosquito or any insect</td>
<td>2</td>
<td>97</td>
<td>1</td>
</tr>
<tr>
<td>e) HIV can be transmitted from mother to child through breast feeding</td>
<td>93</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>f) HIV can be spread through the use of contaminated needles/blades</td>
<td>95</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>g) A pregnant mother infected with HIV can decrease the charges of transmitting the virus to the unborn child by taking antiviral drugs</td>
<td>69</td>
<td>24</td>
<td>7</td>
</tr>
</tbody>
</table>
h) Antiretroviral treatment reduces the amount of HIV in the person’s body

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
</tr>
</thead>
<tbody>
<tr>
<td>h)</td>
<td>74</td>
<td>21</td>
<td>5</td>
</tr>
</tbody>
</table>

i) An HIV test can remain negative for a few months after someone is infected

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
</tr>
</thead>
<tbody>
<tr>
<td>i)</td>
<td>72</td>
<td>21</td>
<td>7</td>
</tr>
</tbody>
</table>

It is evident from the table above that the respondents gave divergent views on different items. 59% of the respondents do believe that a person can have HIV without becoming ill while 31% disagreed. 91% disagreed on the view that people who look healthy are infected with HIV while 9% agreed. On whether sexual contact is the primary means of transmission of HIV, 73% said yes it was while only 22% said it was not. On if a person bitten by a mosquito or any other insect can get HIV, 97% said no while 2% said yes. On whether HIV can be transmitted from mother to child through breast feeding, 93% said yes while 6% said no. On if HIV can be spread through the use of contaminated needles or blades, 95% agreed while 3% disagreed. 69% were of the view that expectant mothers can decrease chances of transmitting the virus to the unborn child while taking antiretroviral drugs while 24% disagreed. 74% agreed that antiretroviral treatment reduces the amount of HIV in the person’s body while 24% disagreed. Finally, 72% of the respondents agreed that an HIV test can remain negative for a few months after someone is infected while 21% disagreed; only 7% said they did not know.

It is also clear that a few respondents do not have adequate knowledge on the role of ARVS. 21% indicate as false the statement that ARVS reduces the amount of HIV in the body of an infected person. This indicates that increased attention is needed in educating the congregation on the antiretroviral treatment. ARVS are
important in ensuring that the PLHIV live a productive life and reduce wasting of the body which may lower self esteem and cause stigma.

2.4 Forum for Sharing HIV and AIDS Information

According to Superintendent Minister (0.1.20/7/2013), there are group meetings within the Methodist within the week. The meetings include fellowships for the youth, women and men. These fellowships meet regularly to pray, read the bible and even participate in merry go round for economic empowerment. He was of the view that this forum can provide a good opportunity for sharing of information on HIV and AIDS. This view concurs with the thought of Campbell et al. (2007) that information on HIV and AIDS need to be shared in an interactive and participatory setting. He is of the view that the ideal situation would be in a workshop or group meeting where people could reflect, contest and ask questions on the information they find unfamiliar. A pastor in the Methodist Church, agreed with this view and said that the Methodist Church should utilize various forums to share information on HIV and AIDS and even invite PLHIV as resource persons (O.I. 27/8/2013). These views are reflected in WCC (1997) which affirms:

Church should create safe spaces for telling one’s own story. Communication is therefore a practical step through which congregation can become teaching communities. The church, which is built upon and shaped around the master story of the gospels, can offer a forum where those who are afflicted can in trust and acceptance, let down their guards and share their stories.

Forums within the Methodist Church which were sampled included prayers, group meetings, wedding functions and funerals. The Table 2.4 below illustrates these
forums and activities that provide an opportunity for HIV and AIDS information sharing within Njia Circuit.

**Table 2.4 Church activities that provide forum for HIV/AIDS discussion**

<table>
<thead>
<tr>
<th>Activity</th>
<th>(n)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prayer</td>
<td>27</td>
<td>25.5</td>
</tr>
<tr>
<td>Group meetings</td>
<td>39</td>
<td>36.8</td>
</tr>
<tr>
<td>Wedding functions</td>
<td>10</td>
<td>9.4</td>
</tr>
<tr>
<td>Funerals</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>None</td>
<td>11</td>
<td>10.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>106</td>
<td>100</td>
</tr>
</tbody>
</table>

Majority of the respondents (36.8%) noted that group meetings are the main ones that can provide HIV and AIDS discussions while prayer services (25.5%), Funerals (18%), non-committal (10.3%) and lastly weddings (9.4%). (O.I 27/8/2013), a church Chairman and a preacher, indicated that during the group meetings like men, women fellowship and Youth fellowships, members have ample time to discuss HIV and AIDS issues. This is because the meetings are scheduled on different days of the week. He gave the example of women fellowship which meets for two hours in the evening (4.00p.m- 6.00p.m) every Tuesday. According to him, the group meetings could benefit from the experience of the PLHIV as they have more time to learn from one another.
2.5 Church Programmes on HIV and AIDS

The health activities in the Methodist Church are coordinated by the conference health coordinator in collaboration with representation from all the ten synods of the Church. The Methodist health programmes dedicate a week every year to handle health matters. In line with this view, Genrich (2007) argues that doing something means planning and implementing programmes of response to HIV. It involves identifying the resource persons with knowledge, skills and commitment to do the task.

Byamugisha (2011) emphasizes the importance of church based programmes designed to disseminate current information on HIV and AIDS. Byamugisha, a pastor in Uganda designed a programme within the order of service for the church to follow in Uganda. The research findings concurred with the above views. (O.I., 26/8/2013), a superintendent minister, reiterated that within the Circuit there is orphans and vulnerable persons committee which deals with HIV programmes for the orphan support. In the process of supporting the orphans, they organize seminars and programmes in Churches to enlighten congregants on HIV and AIDS. He reiterated however the need for more programmes to be established. (O.I.28/8/2013), the synod Bishop, was of the view that the church adopted a policy whereby the lay preachers and pastors set aside five minutes to discuss issues on HIV and AIDS. He however noted that this policy is yet to be implemented within the Circuits. The bishop attributes the failure to induct HIV
and AIDS in the sermon to the fact that most of the lay preachers have not been properly inducted and informed on matter of HIV and AIDS. He noted there was the need to develop and avail more materials, seminars and workshops in local language for the preachers. According to the bishop this would enable the preachers to teach and preach at the same time on the issue of HIV and AIDS. This confirms the views of Shorter and Onyancha (1998)

Lack of HIV/AIDS education in the church is accompanied by lack of learning materials about HIV and AIDS due to the fact that it is either scarce or unavailable in the language of the people or is unfairly distributed. If the church leaders are not trained in the matters concerning HIV and AIDS, they will remain ignorant and will even avoid talking about the pandemic because they do not know what they are talking about. However, if they are well informed about AIDS, they will understand more and will have more authority in talking about issues such as HIV and AIDS related stigma, as they will be talking of things that they already know about. Training is thus essential in alleviating people’s fears and prejudices, expanding HIV and AIDS projects. In a word, it is fair to say that training is an integral part of Christian response to HIV and AIDS related stigma.

2.6 Supports Groups

Support groups are organizations where people who share a similar predicament can meet each other in the same situation. Support groups enhance information transmission on HIV within the congregants. Genrich (2007) argues that support groups provide a powerful way of learning to cope with HIV and AIDS. The author is of the view that listening to others share their experiences helps those newly diagnosed members find ways of coping with their status. The research findings concur with these views as it established that within Njia Circuit, there are two support groups namely Rock and Kaimenyeri Group. These groups consist of PLHIV within the Circuit. According to (O.I. 20/7/2013) the chairlady of Rock support group, the group began in 2007 with a view of bringing the PLHIV
together. The group plays an important role in sharing and disseminating information on HIV and AIDS within the Circuit.

In focused group discussion with the Rock members, it was clear that Church activities like prayer meetings and group meetings provided them with an opportunity to share their information with the congregants. The members of the support groups help in brainstorming and coming up with suggestions that can shape a number of programmes. As the members of the support group interact with each other and the congregation they share their feelings. According to the chairperson of Rock support, their group has enabled them to feel accepted and loved. As they share their experience of being HIV Positive within the groups, they encourage one another and reduce fear and self pity. Consequently, this has boosted their self esteem that enhances their productivity in line with the Maslow’s theory. PLHIV Respondent noted that as support group the PLHIV work as team and feel strong as they visit churches to enlighten people on HIV and AIDS than when one does it individually.

The role of Njia Circuit O.V.C. support is visible in the Circuit. According to the superintendent minister, (O.I., 28/5/2013), the support group cater for the orphans in the Circuit by providing them with food and bedding like mattresses and blankets. According to church minister, to achieve these they have partnered with international organizations like Food for the Hungry which provides financial support. He emphasized that during the material support programmes, they also
discuss and share HIV information with the PLHIVs and orphans in the Circuit. He also pointed out that Methodist Church also offers prayer for the PLHIV to strengthen them spiritually.

2.7 Relationships between Information and Stigma on PLHIV

The study established that majority of the Christians in Njia Circuit are aware of the various modes of transmission and prevention of HIV as previously illustrated in table 2.3. However, the increase in knowledge does not translate to decrease in stigma. According to a PLHIV (O.I., 23/08/2013), Chair of Rock PLHIV support group, despite the high level of knowledge on HIV prevention and transmission, people still fear to share the utensils with her during the Church services. She asserts,

When I took the Holy Communion with the small cup used in the Methodist Church, the cup was washed and set aside and not mixed with others.

This clearly reflects the views of Sensaje (2011) who argues that a person might know how HIV is transmitted and therefore be aware that one cannot get infected via casual contact but refrain from using the same utensils with PLHIV. In support of this view Stein (2003) adds that people may doubt, disregard or disagree with public health information regarding low risk or non-risk contact stipulated to them by public health professionally. Therefore, knowledge alone may not translate into the right action that can alleviate stigma on PLHIV.

Campbell (2010) suggests that while it is important to move from ignorance to knowledge, information on its own is not enough. She argues that lack of
confidence in the information and how to apply it is the cause of inaction. The author is of the view that information may fail to help people to take the right action if people do not trust the information they have even if it is true. This view was echoed during the focused discussion group with the Christians when one of the participants was asked why she could not share the same utensils with the PLHIV and she answered,

I know I cannot get AIDS by sharing utensils but maybe I am wrong. People say it is wrong to share the utensils though they have been cleaned.

The respondent lacked confidence in the information that she had even though it was correct. As a result, she is unable to apply it appropriately by sharing or using utensils with PLHIV. She is also influenced by people’s opinion.

2.7 Conflicting Information

If the information that people get conflict with other information, confusion may arise. When HIV is portrayed as a curse for sin, it conflicts with the medical information that people have. This results to confusion often leading to denial of the real problem. In the focused group discussion with PLHIV a number of popular beliefs were brought out. They included that HIV is caused by witchcraft. They were of the view that it was commonly believed that the partner who falls sick first is the person who got infected first and brought HIV into the family. The discussion revealed that it was popularly believed that sex with virgin cleanses you of HIV and that at every time you have sex with another person your viral load goes down. It was also a common belief that if one partner is HIV positive, the
other one must also be HIV positive. The PLHIV noted that it was commonly believed water and prayers can cure you of HIV and AIDS. In the focused group discussion, the PLHIV brought out the view that some people believed that prayers and fasting are better than ARVs. It was also commonly believed that free ARVs are not as powerful as those that you pay for.

Campbell (2010) is of the view that medical information is often ignored when other reasons for illness are given. (O.I, 29/7/2013), a PLHIV in Rock group, concurs with this view and adds that HIV and AIDS is seen as a shame to a community and family as a whole. She concluded that it sounds better to say that someone has been bewitched because accusations of witchcraft are common in the community. The claim by preachers in the Methodist Church in Njia Circuit that through faith HIV and AIDS can be cured brings about confusion in the Church because it often conflicts with the medical view that HIV is incurable. According to (O.I, 01/8/2013), claims by some preachers that they have cure for AIDS has caused lack of adherence to ARVS by some of the members of the Rock Group. This occurs when the PLHIV are prayed for and they are told to throw away the ARVS. These confirms Khamalwa (2006) view that,

Instead of seeking medical help many people spend their meager resources in seeking religion and miracle healing. This explains the mushrooming of miracle churches especially in urban areas. The pasto/rs therein are doing everything possible to encourage them, assuring them that as long as they are members of their miracle churches, their sero status will change from positive to negative. These promises of miracles are often encouraging the PLWHV not to seek medical help. Faith in miracle cures has a negative role in the fight against the pandemic as patients who would otherwise benefit from the antiretroviral therapy (ARVS) fail to explore this option believing in miracle cure
Focused group discussion with PLHIV revealed that some of their group members had travelled all the way to Loliondo in Tanzania in search of the magical cure. However they revealed that the magical cup of herbal concoction did not heal them.

2.8 Conclusion

Information plays a crucial role in enlightening people with a view of helping them make decisions. People who lack sufficient information often lack the confidence to use it or take appropriate action. Therefore, the Church can make use of various modes of information transmission such as booklets, brochures and posters to make the congregants informed of the latest development on HIV and AIDS.

Information on its own however may not be enough to alleviate stigma on PLHIV. Therefore, the members of the Church may at times find it difficult to apply the information to their daily lives. This calls for the need for forum for discussion. In a discussion people are able to work on their doubts about the truth of the information and its relevance to their lives. This enables the Christian to change their behavior in relation to the information that they have. Discussions may help to build group confidence on an issue otherwise viewed negatively.

Misinformation and false believe and teachings like miraculous healing of HIV by preachers can cause conflicting information on HIV and AIDS. HIV and AIDS stigma thrives on beliefs and false information that may be ripe within a
community. This false information conflicts with the popular medical view that HIV and AIDS is incurable. This confirmed the research premise that there is relationship between stigma and the information the congregation has.

For the PLHIV to achieve self-actualization and be productive in the community as postulated by Maslow’s theory there is a need for them to be fully accepted and be loved within the community. Once people are furnished with the right information, they can apply it in their lives and hence relate well with PLHIV. In the environment of love and acceptance, the PLHIV are likely to develop self esteem.

The church can lead in alleviating stigma and discrimination on the PLHIV. These can be done by inculcating the HIV and AIDS information within the church programmes. The study sought to suggest ways and means of applying the information obtained from various sources to the daily programme of the Methodist Church in Njia Circuit. In doing so, the study fills the gap in knowledge and also its application in the Church and the community in general.
CHAPTER THREE

BIBLICAL TEACHING ON STIGMA AND DISCRIMINATION ON TERMINALLY ILL PATIENTS

3.1 Introduction

In the previous chapter it has been established that information on HIV transmission and prevention has not been adequately addressed within the Methodist church in Njia Circuit. The knowledge on mode of transmission and prevention within the church was explored and how the information is shared in different forums. In light of such information, this chapter investigates how biblical teachings on terminally ill patients have facilitated discrimination and stigmatization of PLHIV and in so doing test the premise that biblical teachings on terminally ill patients contributed to stigma on PLHIV.

Examinations of the biblical teaching on stigma on terminal illness provide a fundamental framework within which we can examine stigma against PLHIV in Njia Circuit of the Methodist Church. In line with this view, this chapter sought to establish the biblical teachings that can lead to stigma on the PLHIV. According to Stiebert (2003), the Hebrew Bible being the canon of Judaism and significantly part of the canon of Christianity too, is believed by many to have authority. He adds that the bible is read for guidance and for inspiration, comfort and for obtaining wisdom; it is believed to have social significance and to be a sign of knowledge and teaching that reach down to us through the ages. Because of its
continued relevance, believers looking for an answer to their question will ask what the bible says about stigma. Leviticus 26:16 indicates that lepers were stigmatized and excluded from many places and leprosy was considered as a punishment from God. This view to a great extent is in line with study premise that biblical teaching contribute to stigma on PLHIV. The present chapter examines the role of the teaching on leprosy and its application today in relation to PLHIV in Njia Circuit.

In the New Testament Jesus makes a departure from alienation of the leper to association. In doing so Jesus emphasizes love for all without discrimination. In line with the Maslow theory that guides this study, this teaching of love can boost the self esteem of PLHIV hence making them feel appreciated in the community and consequently boost their potential in reaching self actualization.

3.2 Health, sickness and healing in the Bible

The first and most important point to underline in Old Testament (O.T.) theology of health, sickness and healing is that God himself created the first human being, Adam and Eve (Genesis 1-2). Therefore as a designer of the human body, God thoroughly understands its working (Hill, 2007). When Adam and Eve sinned in the Garden of Eden (Genesis 3), death and sickness came into being.

From the beginning of Israelites journey with God towards the promised land, God Emphasized through Moses that he was interested in their obedience to him and
will be able to protect them if they would but trust in him and follow his instructions.

If you listen carefully to the voice of the lord your God and do what is right in his eyes, if you pay attention to his command and keep all his decrees, I will not bring on you any of the diseases, I brought on the Egyptians for I am the lord who heals you (Exodus 15:26).

According to Hill, (2007) sickness could be a disciplinary measure on the part of God towards an earring member of his family. In the song of Moses, God proclaims himself to be the only or powerful or God “I put to death and bring to life, I have wounded and I will heal,” (Deuteronomy 32:39). The wounding would be part of Gods discipline, but the healing comes from the same almighty God, as further evidence on the caring relationship he maintains in his creation.

The Old Testaments highlights Gods sovereignty and his ability to heal. No sickness, not even death, is beyond his capability to overcome. God calls himself “the Lord who heals you” (Exodus 15:26). Moses took Yahweh at his words and called upon him to heal him disciple Miriam of her leprosy, which God did (Numbers 12:13). David describes God as the one who “heal all your diseases” (Psalms 103:3). However, this raises a number of questions in the era of HIV, can God cure HIV? What constitutes healing to a PLHIV? How has the issue of healing of diseases been integrated in the Methodist Church in Njia Circuit?

In the prophet, healing was frequency linked with social, political and spiritual aspect of life (Hill 2007). Hosea 14.4 promised spiritual blessings to the repentant
“I will heal their waywardness and love them freely, for my anger has turned away from them”. In the same book, God describes his relationship with his people as that of healing them (Hosea 11:3), which in the context is perhaps a reference to delivery them socially and politically from slavery in Egypt. In Jeremiah, we find the language of curing and restoring being used for the spiritual relationship that Israel (Jeremiah 3:22) and Jeremiah (Jeremiah 15:19) had with God.

The Jews anticipated a time of well-being. At that time, the Messiah would come as a healer, and sickness would be a thing of the past for God’s people. This aspect is most observed in the Isaiah’s prophecy.

Then will the eyes of the blind be opened and the ears of the deaf unstopped. Then will the lame can leap like a deer and the mute tongue shout for joy (Isaiah 35:5).

In the Gospel Jesus is depicted as a healer. John the Baptist sent his disciples to ask whether he was the Messiah. Jesus replied that his ministry accurately reflected the Messiah prediction of Isaiah 35:5,

Go back and report to John what you hear and see. The blind receive sight, the lame walk, those who have leprosy are cured, the deaf hear, the dead are raised and the good news is preached to the poor. (Matt 11:4).

In Corinthians 12:7-10, Paul himself sought relief from his thorn in the flesh.

“To keep me from becoming conceited because of this surpassingly great revelation, there was given to me a thorn in my flesh, a messenger of Satan, to torment me. Three times I pleaded with the Lord to take it away from me. But he said to me, my grace is sufficient for you, for my power is made perfect in weakness. Therefore, I will boast all the more gladly about my weaknesses, so that Christ’s power may rest on me. That is why for Christ’s sake, I delight in weaknesses, in insult, in hardships, in
persecutions in difficulties. For when I am weak, then I am strong (2 Corinthians 12:7-10).

Paul himself suggests medicinal remedy to Timothy to treat chronic illness, rather than advice him to seek a miraculous cure (1 Timothy 5:23). In Pauline theology, then, healing is real and may come through a miracle but it may come through time and medicine or it may not come at all. (Hill, 2007). Could this be biblical bases for use of ARVs by PLHIV today?

As an indicator that sickness can have spiritual causes, Paul also warned the Corinthian Church, where the practice of fellowship meals and the lord’s supper were problematic, that disregard for spiritual principles had already lead some of them into sickness and even death.

For anyone who eats and drinks without recognizing the body of the lord eats and drinks judgments on himself. That is why many among you are weak and sick, and a number of you have fallen asleep. But if we judged ourselves, we would not come under judgment. When we are judged by the lord, we are being disciplined so that we will not be condemned with the world (1 Corinthians 11:29-32).

3.2 Old Testament Teaching on Terminal Illness

In the Hebrew Bible, God Yahweh is in control of every aspect of life. Often he is also described as directly responsible for initiating illness or diseases. In the Law Book this is clearly demonstrated, for instance, in Deuteronomy 28:27-28,

The lord will smite you with the boils of Egypt, and with the ulcers and the scurvy and with the itch, of which you cannot be healed. The lord will smite you with madness and blindness and confusion of mind.
Leviticus 26:16 also promises that failure to carry out God’s command will culminate in wasting diseases and fever. Furthermore, a skin disease strikes Miriam after God has rebuked her for rebelliousness towards Moses. God’s inflicting illness as a form of punishment is a prominent teaching in the Old Testament. Jehoram is punished with severe sickness of bowels and great plague which affected his people and possession. He was being punished for leading the inhabitants of Jerusalem into unfaithfulness, killing his brother and making Judah go astray (2nd Chronicles 21:12-15). Nebuchadnezzar of Babylon (Daniel 4:28) and Uzziah of Judah (2 Chronicles 27:19), are punished for pride. Nebuchadnezzar becomes mad and Uzziah on the other hand develops a skin disease. God also sends plague among the people to punish David’s action of taking a census (2 Samuel 24:15) and inflicts the Philistines, who had taken possession of the ark with tumors, (1 Samuel 5:6-9). Plague alongside war and famine is proclaimed as a punishment for wickedness (Jeremiah 14:12, 16:4; Ezekiel 6:11).

The Old Testament indicates that just as God can inflict illness, he can also remove it. God restores Jeroboam’s withered hand when a prophet intercedes on his behalf. (1 Kings 13:4-6). God adds fifteen years to the lifespan of Ezekiel who was suffering from a terminal condition (2 Kings 20) and through the intervention of Elisha God restores Naman to health (2 Kings 5). From the above biblical teachings, it appears that illness and disease are punishment from God. It is indeed this point that informs this study and could be used as the basis for the stigma on PLHIV in the Methodist Church in Njia Circuit.
Death and dying in the bible

Understanding of death is important because most scholars assert that association of HIV with death is responsible of the stigma affecting PLHIV. Why would Christian fear death? Medically speaking death is the total and permanent cessation of all vital bodily functions. It happens when a person’s heart has stopped beating and the electrical impulses of the brain have permanently ceased, thus indicating that the last evidence of aliveness has irreversibility left the body (Glean, 2002). From theological perspective, this also the time that the person’s body is separated from their soul. Ecclesiastic illustrates this “then the dust will return to the earth as it was and the spirit will return to God who gave it (Ecclesiastics 12:7).

Glean (2002) is of the view that when the bible talk about death related to human being, it makes a distinction between physical death and spiritual death. Even while a live physically a person can be dead spiritually. Spiritual death according to Glean, (2002) is a state of being in which the human soul is separated from God and has not been enlivened by his spirit. Ephesians 2:2, 5 mentions that before we were Christians were dead in our trespasses and sin, but God made us alive together with Christ. In Timothy 5:6 Paul differentiates physical death and spiritual.

“The widow who is really in need and left all alone puts her hopes in God and continues night and day to pray and to ask for help but the widow who lives for pleasure is dead even while she lives.”
As a normal course experiences every human being will experiences physical death. If a person has not been spiritually enlivened, after their physical death they will be separated from God eternally. Christians, who have been spiritually enlivened during their life on this earth, will go on living in fellowship with God in their eternal life (John 10:25; 17:3, 1 John 5:20). Only those who are not enlivened spiritually by God’s spirit will experiences the ultimate “second death” (Rev 20:14; 21:8), being eternally separated from God (2 Thessalonica 1:9).

For a person with no hope and expectation of spending eternity with the loving creator and the universe, death is something to be feared. Christian believed that just as Christ was raised from the dead so will they be raised (Glean, 2002). Death is observed from the creation account, indicating that death is not a natural part of creation. The first reference to death is found in God speak to Adam when he says to him

“you are free to eat from any tree in the garden; but you must not eat from the tree of the knowledge of good and evil, for when you eat of it you shall surely die; Gen 2:17.

Therefore one of the consequences of sin was death. In the Pentateuch death continues, with its association with sin. This is suggested by the story of Cain and Abel (Gen 4:8) attested to by God’s punishment of sin with death (Genesis 6:13, Exodus 32:25-35, Leviticus 10, Numbers 25) indicated by the law use of death as the harshest form of punishment for the most heinous crime (Exodus 21:12, Leviticus 24:17-21). The scarified system within the Jewish custom where the
animals death and the subsequent rituals, men are ransomed from the death. That their sin and uncleanness merit death is also understood to represent the utmost degree of uncleanness (Number, 9:16, 16, 18:19:11-22, 29:11; 31:19).

Throughout the Pentateuch death is associated with sin in such a way that both are consistently portrayed negatively. According to Wright (2010) there is much in the psalms and wisdom literature that support the contention that the Israelites viewed death as the fate of all and considered sheol as the destiny of all (Psalms as the destiny of all, (Psalms 89:48, Ecclesiastics 9:9-10, Job 7:7-11) even the righteous (Job 14:13; Psalms 8:3).

3.2.2 Leprosy in the Old Testament

The analogy between AIDS and leprosy has been discussed by number of scholars (Gilkes, 2007, christesen 2011, Jantzen, 2009). Leprosy in the bible was a disease which there was then no cure, sometimes people could spontaneously recover. Leviticus offers a vivid picture of the plight of the leper. According to Leviticus 13: 46

When a man has lost his hair and is bald, he is clean. If he has lost hair from the front of his scalp and has a bald forehead, he is unclean. But if he dies reddish while sore on his bald head a forehead, it is an infectious disease breaking out on his head and forehead. The priest is to blame him and if the swollen sore on his head or forehead is reddish like an infectious skin disease the man is diseased and unclean. The priest shall pronounce him unclean because of his sore on his head. The person with such infectious disease must wear ton cloths let his hair be unkempt, cores and lowers part of his face and lay out unclean. Unclean as long as he has the infection he remains unclean. He must live alone; he must live outside the camp.
This passage indicates that people found to be suffering from infectious diseases were not to be with others. The priest was given powers to examine the sick person and determine whether he or she was clean or unclean, and then isolate the person or allow him or her space in the camp. If literary taken in a sermon today, it can be used to justify stigma on PLHIV.

The study established that people relate HIV and AIDS to leprosy was prevalent in the Methodist Church in Njia Circuit as illustrated in the figure 3.0 below.

**figure 3.0: Relating HIV to Leprosy in the church**

(Source; Researcher 2013)

The research established that there is a relationship between the Old Testament in reference to leprosy with teaching of HIV in our Churches today. 42% of the respondent indicated that the Old Testament teaching on leprosy still influences teachings on HIV with the Church and could lead to stigma. However, it was still
evident that the same is not applicable in some Churches with 34% of the respondent indicating it was rarely mentioned and 24% indicating it is not mentioned at all. One PLHIV anonymity observed (0.1 27/8/2013) notes that,

In our Church the preacher said that in the Old Testament there was an incurable disease called leprosy which has been replaced by HIV and AIDS today.

This clearly indicates that this teaching persist in the Church and need to be addressed.

3.2.3 Old Testament Teaching on Curses

Deuteronomy Chapter 28 teaching which indicates curse as one of the causes of terminal illness is also widely used in the Church today. (59%) of the respondent indicated that these teachings were used frequently in church. The view of curse as a cause for illness seemed to be popular in comparison to that of leprosy, probably because curses were also common within the African culture and were seen as causes of illness. This agrees with Gitonga (2008) argument that outbreak of diseases among the Meru people resulted from curses due to disharmony in kinship system.

3.3 New Testament teaching on leprosy

In the New Testament, attitude towards people with leprosy and other physical defect was characterized by discrimination and alienation. This could be attributed to the fact that the Old Testament teachings are continued in the New Testament. However, when Jesus came he accepted lepers and healed them in Mark 1:40-42.
A man with leprosy came to him and begged on his knees, ‘If you are willing you can make me clean’ ‘filled with compassion, Jesus reached out his hand and touched the man.’ I am willing he said ‘be clean immediately leprosy left him and he was cured.

The Jewish attitude towards lepers in the New Testament has some similarity with the way PLHIV are treated in the Church today. According to the rabbinic rules, since the leper was unclean, he was untouchable and there seemed to be no other hope for which to be healed other than coming to Jesus. Consequently, by touching the leper, Jesus risked both infection and ceremonial uncleanliness which could result in isolation. However, due to compassion, he healed the incurable and touched the untouchable (Grasmic 2000, Carson et al 1994).

The Methodist Church in Njia Circuit needs to learn from the compassion of Jesus in order to accept the PLHIV. The research sought to establish the frequency of usage of the teachings of Jesus on the compassion in the churches of Methodist Church in Njia Circuit. The table 3.2 below indicates that Jesus teaching on compassion for the lepers is rarely related in the Methodists Church in Njia Circuit.

**Table 3.2 Teaching of Jesus on Compassion in the Churches**

<table>
<thead>
<tr>
<th>Teaching of Jesus relating to lepers &amp; sinners in Church</th>
<th>(n) church members</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rarely mentioned</td>
<td>60</td>
<td>56.6</td>
</tr>
<tr>
<td>Never mentioned</td>
<td>20</td>
<td>18.8</td>
</tr>
<tr>
<td>mentioned Several times</td>
<td>26</td>
<td>24.6</td>
</tr>
<tr>
<td>Total</td>
<td>106</td>
<td>100</td>
</tr>
</tbody>
</table>
56.6% of the respondents said that teachings of Jesus relating with the lepers and sinners were rarely related in their Churches while 24.6% said they were mentioned several times. Only 18% indicated that these teachings were never mentioned. This calls for the need of the church to emphasize these teachings for they can help reduce stigma on PLHIV and increase their acceptance in the Church. In Maslow’s theory, acceptance would make one develop self esteem and enable PLHIV to actualize and become productive a member of the congregation.

Jesus further emphasized the need to move from associating the sickness with sin and blaming the sick for their situation. The account in John 9:1-15 of the healing of the man, blind since birth testifies this,

John 9:1-5. As he went along, he saw a man blind from birth, his disciples asked him “Rabbi who sinned, this man or his parents, that he was blind,” neither this man nor his parents sinned “Jesus said” but this happened so that the work of God may be displayed in his life.

This illustrates that God is not bound by the law of cause and effect that was dominant in the Old Testament and even churches today. This view if used in the church can help in reducing stigma on PLHIV in the church in Njia Circuit.

In Paul’s letter to the Galatians 8:7 Paul points out sins will find one out for God is not mocked. One will reap what they sow. These verses clearly indicate that choices have consequences and therefore those who sin will reap the fruits of their sinful nature. This view was echoed by PLHIV, who noted that,
During the church service the preacher said that so many people are reaping what they sow yesterday, last week, last year or so many years ago. He added that if someone contracts this ‘new’ disease, they are reaping the results of a sinful life.

In Colossians 3:5, Paul warns Galatians, you must put to death then the bodily desires at work in you such as sexual immorality, indecency, lust, sin passion and greed because of such things God’s anger will come upon those who do not obey Him. When taken literally in the church such teaching may depict the PLHIV as sexual immoral people and lustful. In fact, in the focused group discussion with PLHIV it became clear that most of the PLHIV have been stigmatized due to the fact that HIV is associated with sex and immorality. Therefore the PLHIV are depicted as lustful people who are unable to control their sexual desires. This view is echoed by Dube (2002) who asserts that,

The issue of spirituality and HIV/AIDS brings us closer home since the bible is not just a collection of literature but rather a book that is read by million in search of all answers to use, obviously its interpretation in the light of HIV/AIDS is unavoidable. As individuals and faith communities have tried to explain HIV/AIDS, they turned to the bible. It is notable that most of the interpretation were negative and saved to stigmatize those affected and infected since they relied on text that associated illness with punishment sent by God on those who are immoral and disobedient (Deut 7:12-18, 28:27-28)

According to Sheila (2005), when Jesus welcomed the sick and disabled with open arms, he presented potent model for his followers. The manner in which Churches and their members respond to PLHIV is an indication of the degree of seriousness with which they follow the example of Jesus. Therefore, a response of love and compassion and an open arm response are demanded of God’s people. It is a mandate that the Methodist Church in Njia Circuit can use to reduce stigma on the PLHIV and embrace them in the community of believers. This view is stressed by
the statement of the African church leaders meeting in Namibia in 2000 which stated:

Our tendency to exclude others, our interpretation scriptures and our theology of sin has all contributed to promote the stigmatization, exclusion and suffering of PLHIV. For the churches, the most powerful contributions it can make to combating HIV transmission, is the eradicating stigma and discrimination. (WCC 2000 p 35)

3.5 Biblical teachings within the Methodists Church in Njia Circuit

The research established that there are common teachings within the Methodist Church that are drawn from Old Testament and New Testament. These teaching are related below in figure 3.3.

**Figure 3.3 Common Methodist Church Teaching**

![Bar Chart]

Majority of the respondent 48% indicated that HIV is a punishment from God while 26% indicating that it was a sign of end time and yet another 26% also said that HIV comes from Satan. From these findings, the research established that the Old Testament teachings that sickness is a punishment from God is widespread
and need to be addressed to reduce stigma on the PLHIV. However, it would not be fair to depict all the PWLHIV as sinners. Nuibusah (2005) argues that there is a view that AID is a punishment from God. This indicates that anyone who has HIV is a sinner. The author point out that not all sinners are HIV positive and not all HIV positive are sinners and immoral. He concludes that we need to give further thought to women and men who have been infected by their wayward spouses. These views were reflected of a PHWHIV anonymity observed (0.I 27/8/2013) who notes that,

I contracted HIV from my husband who was a military officer. I did not know his status until when he died. A year after he died I was frequently sick, I decided to visit the hospital where I was confirmed positive.

The New Testament teachings on end of time have also been used to illustrate that HIV is one of the signs of end time. However, this findings seems to contradict Jesus teachings in the sermon on the mount found in Mathew 5 which argues that he makes his sunrise on the evil or good and sends rains on righteous and on the unrighteous this view is also reflected in 2nd Timothy 2:13 that if we are faithless he remains faithful for he cannot deny himself. This indicates God’s universal love.

3.5 Conclusion

Biblical teachings on terminal illness and their interpretations are important in understanding stigma on PLHIV in Njia Circuit. Varied interpretation of the
scripture in sermons as established by the research may to great extent result to stigma on PLHIV.

One disease, which is mentioned in the Old Testament and which offers some parallel with HIV/AIDS because it is too widespread and contagious is leprosy. Leprosy is occasionally described as constituting a punishment for disobedience against God’s will; Miriam and Uzziah are struck by it. Leprosy rendered a person unclean. The study established that this Hebrew view was prevalent within the Methodists Church in Njia Circuit. Thus within the sermon the preachers do depict the PLHIV as sinners who are being punished for their immoral actions.

In the New Testament, Jesus is seen responding to every opportunity to relieve pain and affliction. Jesus sends the twelve disciples with instruction to heal the sick raise the dead and cleanse lepers and cast the demons (Matt 10:8). However, the research revealed that the teachings of Jesus are not widely used in sermon in Methodist Church. This indicates there is a gap in the teaching of the Church that needs to be emphasized to form the basis for the teaching on stigma on PLHIV within the Church set up.

The findings in this chapter affirm our premise that biblical teachings on terminally ill patient have influenced the stigma and discrimination that is affecting the PLHIV in the church today. When the PLHIV are likened to the lepers of the Jewish culture they feel insecure and isolated. This is likely to lower their self esteem and hamper their progression into productive stage referred to self
actualization in the Maslow’s theory which forms the backbone of this study. So far, this study has concentrated on the biblical teaching on the terminally and their influence on stigma on PLHIV. This is with a view of making the gospel relevant in the church today. This would concur with the views of Okure (2005) that,

Biblical interpreter is one who reads the biblical text to discover life. An interpretation that fails to do this becomes suspects and should be regarded inauthentic for it has failed to be in tune with universal intention of God to liberate, save and sustain life.

However, this view on stigma would be incomplete without looking at the cause of stigma on PLHIV. Therefore, the causes of stigma on PLHIV become the concern of the next chapter.
CHAPTER FOUR

CAUSES OF STIGMA AND DISCRIMINATION ON PLHIV IN
METHODIST CHURCH IN NJIA CIRCUIT

4.1 Introduction

It is evident from chapter three that terminally ill patients were stigmatized in the Jewish culture. It was also established that some of the Old Testament teachings have been used in the Methodist Church in Njia Circuit and to great extent contribute to stigma on PLHIV. Although Jesus lived in a Jewish community that stigmatized the terminally ill patients, his attitude contrasted with theirs. Jesus touched and healed the lepers who were stigmatized. In the light of such information, this chapter focuses on the causes of stigma on PLHIV in Njia Circuit in the Methodist Church in Kenya.

This chapter shows how association of HIV and AIDS with immorality has contributed to stigma on PLHIV. This is in line with the assumption of the study that association of HIV with immorality is one of the causes of stigma and discrimination being meted on the PLHIV in the church today.

Fear makes the PLHIV to feel insecure within the church and therefore in line with the Maslow’s theory that guided this study, the PLHIV are traumatized. Consequently, their self esteem is also lowered when they are perceived as immoral within the church community. These makes them feel unwanted and are
not likely to achieve self actualization which is the highest level in the Maslow’s (1970) hierarchy of needs theory. The fact that the HIV and AIDS is incurable has caused a lot of fear within the church and community in general. Such fears as revealed by this research play a great role in perpetuating stigma on the PLHIV within the Methodist Church in Njia Circuit. The research focused on the role of fear in perpetuating stigma within the congregation.

The chapter shows how silence on HIV and AIDS within the church has to a great extent contributed to stigma that is facing the PLHIV today. It evaluates the causes of silence within church and its justification. It will also concentrate on the role of biblical teaching in perpetuating stigma on PLHIV. It evaluates how interpretations of the Bible in sermon during services in the churches in Njia Circuit, play a role in perpetuating stigma and discriminations on PLHIV. Therefore, the teachings in the church service are considered important in addressing stigma in PLHIV in Njia Circuit.

Insufficient information plays a key role in a causing stigma on the PLHIV. Therefore, the study focused on the role of the information dissemination and on how the information can be shared within the church. The study also established the need for adequate delivery and regular dissemination of HIV and AIDS information as crucial in reducing stigma on PLHIV.

The research into causes of stigma on PLHIV in Njia Circuit revealed that there are numerous causes of stigma on PLHIV in Njia Circuit. These causes include
fear of HIV and AIDS, silence on HIV and AIDS, association of HIV with immorality and silence on sexuality, Biblical teachings that depict HIV as punishment from God and lack of information on HIV and AIDS.

**Cause of stigma among the different categories of youth, women and men.**

Respondents’ demographic data is presented in the following figures.

**Figure 4.1 Respondents Age**

Majority of the respondents 31(30%) were between 21 – 30 years of age followed by 27(26%) who were 41 – 50 years and 25(25%) were 31 – 40 years. Only 19(19%) were 50 and above years.
The respondents’ gender was 50 – 50 per cent. Male respondents were 53(50%) while female respondents were 54(50%).

Most of the youth (70%) give view that stigma was caused by association of HIV with immorality and felt that they are mostly targeted as they are presumed to be sexually active and therefore mostly targeted in sermon as one youth narrates in (0.1.7/10/2013)

The preachers during the sermon are fond of referring to the youth as easily tempted by their bodily desire who are likely to engage in immoral activities. They caution the youth that HIV and AIDS will wipe them out unless they change their sexual behaviour and avoid fornication. We fell as if HIV is actually targeting the youth. We feel that the church has not done well in giving them counseling on sexually matters. In our church there are no seminars for the youth on HIV and AIDS. In fact not a single workshop has been held to address our sexual need and how to ensure purity and

![Figure 4.2: Respondents Gender](image-url)
abstinence. We are only told to abstain until marriage without being told how.

Within the women fellowship it was commonly viewed that stigma on HIV was mostly due to gossip and insult. It was common concluded that during women fellowship the PLWHIV were uncomfortable and would often avoid going for the fellowship because of gossip about their HIV status.

The 50% of the men felt that silence on HIV and AIDS was the major cause of stigma on PLWHIV. Men were of the view that open discussions were needed to address the science that was common among congregation.

4.2 Fear of HIV and AIDS

Fear of HIV and AIDS pandemic constitutes one of the factors that fuel stigma on PLHIV. According UNAID (2005), several studies have identified the fear of contracting HIV virus through casual transmission as a key factor contributing to the stigmatizing attitudes of people who avoid associating with PLHIV. To emphasize this fact, ICRW (2006), states that based on the assumption that HIV and AIDS is often thought to be highly contagious, people suspect the PLHIV to be a threat to the community as a whole. Fear of HIV and AIDS makes the PLHIV to be feared and isolated. This is likely to affect their self-esteem, consequently limiting their productivity. Evidence of fear in the research was clearly illustrated by a PLHIV, (0.1. 25/8/2013) who stated that,

In the church the PLHIV prefers to sit at the back bench to avoid contact with the rest of the congregation. In one incident I tried to hold a baby of one of the members but she held the baby firmly because she feared that I may infect her
child with HIV. In fact she pinched the baby to cry so that she can go out and move away from where I was sitting.

The fear of death leads to the fear of PLHIV. It was established in the focus group discussion with the PLHIV that the cause of fear may be due to insufficient information as earlier discussed in chapter two. The research findings thus confirms the views of Brown, Smith, and Morrison (2005) who posit that the sources of stigma include fear of illness, fear of being infected and fear of death. Such fears evoke a common reaction among the church members that result to stigma as a way of coping with fear. One Christian (O.I 24/07/2013) noted that the congregation was filled with fear when one of the PLHIV declared that he was HIV positive. In fact the silence that prevailed in the church attested the prevalent of fear. The focused group discussion with the PLHIV indicated that the changes in the bodies of the PLHIV due to constant infection caused fear among the people due to the wasting of the body. These changes were noted mostly among the PLHIV who were not on ARVs. It was evident from the research that fear of HIV and AIDS causes the PLHIV to be isolated and stigmatized even within the church where they would expect love and care.

4.3 Association of HIV with immorality and silence on sexuality

Sex is not evil or bad or something to be ashamed of. According to the bible God created sex. When God finished the creative activity he looked at what he had done and evaluated it as very good. (Genesis 1:31). One of the purposes of sexual intercourse is procreation. God’s blessing of Adam and Eve is followed by the
command, “be fruitful and increase in number” (Genesis 1:22). However sex is not
intended only for procreation. It is also meant for enjoyment.

May you rejoice in the wife of your youth. May her breast satisfy you always. May you ever be intoxicated with her Love (Proverbs 5:18-19).

The bible has stories of sexual practices that can help to break silence about sexual issue. These is a story of rape and sexual violence, the story of Tamar and Ammon (2 Samuel 13:1-2), male power ones women bodies the story of David and Bathsheba (2nd Samuel 11:1-5), Survival sex the story of Tamar and Judah (Genesis 38:1-16), sex as a gift from God the story of creation (Genesis 1:26-31) and Health sexuality based on equality and mutual love (songs of songs) (Dube, 2005).

Paul in New Testament instructs people to get married in order to fulfill their sexual desires in Corinthian 7:2 since there is so much immorality, each man should have his own wife and each woman her own husband. The husband should fulfill his marital duty to his wife and likewise the wife to the husband. The biblical teaching is that marriage vows should be followed forsaking all others, being faithful to him or her as long as the two of you shall live (1 Corinthians 7:39). Often when churches Discuss sexuality it is to advocate for abstinence before marriage and faithfulness within marriage. These principles are important. However, UNAIDS statistics have shown that the highest rate of HIV infection is among married couples. This challenges the teachings of faith communities (Dube, 2005).
HIV as phenomena may arises from sexual immorality, which like all sin may have consequences in 1 Corinthians 6:18 Paul says;

Flee from sexual immorality. All other sins a man commit are outside his body, but he who sins sexually sins against the body.

This is not to say that sexual sins are worse category than all other sins but sexual sin by its nature is particularly self destructive. HIV has a moral dimension because it is largely spread through heterosexual relations in Africa (Rupert, 2005). Rupert adds that HIV and judgment of God are connected as illustrated in Hebrew 13:4)’’ God will judge the adulterers and the sexually immoral”. Brandy, (2010) concurs with him and argue that everything in the world is under the judgment of God . However the danger of emphasizing that HIV is part of the inbuilt judgment of God on morality is that we think in terms of those wicked people out there, as though we ourselves inhibit some superior moral (Rupert, 2005). Paul’s message is not on the wrath of God but mercy of God in Roman 3:9

Jews and Gentiles alike are all under sin as it is written there is no one righteous, not even one. All have sinned and fallen short of Glory of God.

HIV/AIDS unfortunately touches on human sexuality which is not openly discussed in Church and also in African culture. Associating HIV/AIDS with immorality instigates stigma. Bauteyerga, Kidanu, Nyblade, Mac Qaurrie, and Pande, Yichalaliko (2003), notes that the understanding that HIV and AIDS is transmitted mostly through sexual intercourse fuels the belief that a person contracted HIV because of his or her unacceptable behavior. Therefore, the
PLHIV are assumed to have ‘misbehaved’. These views are echoed by (O.I 20/8/2013), a pastor in Njia Circuit who was of the view that PLHIV are stigmatized because HIV and AIDS is perceived as a disease for prostitutes and adulterers. According to a preacher in the Methodist Church (anonymity observed),

Many of the people in the Methodist church are assumed to be morally upright and therefore are not expected to be HIV positive. Therefore, the church criticizes the use of condom and expects that everyone will stick to their marriage partners and those who are not married to abstain from sex all together, (Interview, 25/8/2013)

The preacher clearly indicates that association of HIV with immorality is prevalent in Njia Circuit. Notably, this study established that HIV and AIDS is significantly associated with immorality as shown in Figure 4.0 below

**Figure 4.3: Common Biblical Teachings in Church**
Most of the respondents 51% said that sickness as a result of immorality was a common biblical teaching in their church followed by 37% who said that sickness was the wage of sin. Only 12% said that HIV was leprosy of today.

It is important to note that once perceived as immoral, the PLHIV are viewed as people who got what they deserved. They are consequently labeled as people of loose morals and deviant in the society. This research findings confirm the view of Messer (2004) who notes that as the pandemic swept across Africa, many Christians sought to justify their judgmental, non-involvement with prevention effort and care by blaming the infected for immoral behavior.

4.3 Silence about HIV and AIDS

Silence on issues concerning HIV and AIDS and sexuality is a cause for stigma and discrimination on PLHIV. Campbell et al (2007) defines such silence as lack of social space to talk about HIV and AIDS. The author adds that as a result, PLHIV are hindered from expressing their feelings about the disease if they wanted to, for fear of facing a great deal of stigma. Boestex (2007) attributes the silence to the fact that people are ashamed to speak about being infected with HIV. This is because they view it as a scandal and therefore people are afraid to talk about it. The church has not done much to create a forum for open discussions on HIV and AIDS; this perpetuates the culture of silence. The reason for the silence could be possibly due to the fact that the majority of the members in the faith
based organization still lack the knowledge, experience and practical skills needed for intervention. The study agree with the view of Mageto (2005) that,

The powers of evil are great and silence is its voice. To choose to remain silent is almost declaring that the Church is part of the epidemic. Even when the church has spoken or acted in some context, it often has humiliated the suffering neighbors more. The church must fight to overcome the spirit of silence and take its role in AIDS prevention and cure.

Breaking the silence on sexuality and HIV is important as Igo (2007) notes that talking breaks the silence and discrimination and allows faith to come to light. The author is of the view that it provides an opportunity to highlight how the gospel brings hope and change in our families, among our relatives, in our church meetings, and workshops we can make HIV and AIDS normal part of our conversation teaching and preaching. In line with this view, during the global consultation of AIDS it was said:

Our difficult in addressing issues of sex and sexuality has often made it painful for us to engage, in any honest and realistic way, with issues of sex education and HIV prevention. For years the church has warned against evil of sexual immorality, of pre and extra marital sexual relations, but perhaps too little has been done to enable Christians to celebrate the gift of human sexuality that God has given to us. All would agree that the main method in which the HIV is transmitted from one person to another is through sexual contact. Yet surprisingly sexuality, has received very little, attention in theological discussions on the pandemic, apart from warning against high-risk behaviour. (WCC, 2004p33).

Issue about sexuality is not openly discussed within the churches in Njia Circuit. A PLHIV (0.1. 27/8/2012) anonymity observed noted:

During the preaching in the church service, the preachers use idioms and names like ‘bad behavior’, ‘doing those things’ and ‘sleeping around’. They avoid as much as possible using names in the local language that are associated with sexual
organ. Most of the members feel shy and embarrassed when such names are mentioned.

Thus avoiding talking about sex in a direct way may explain the silence about talking about HIV and AIDS. This assertion concurs with the view of Hadad (2005) and Cloette (2010) that people do not actually mention HIV and AIDS by name. They habitually refer to it as this ‘thing’.

PLHIV anonymity observed (O.I 25/8/2013) was of the view that silence on HIV/AIDS is motivated by the culture of silence over-certain other matters such as sex. He adds that discussing sex issues are usually regarded as a taboo in Meru culture and even in the Church. It is often believed that when one talks about sex and related issues, it will increase promiscuity in Meru society. This view confirms the assertion of Campbell et al. (2007) that in conservative traditional communities strong social norms and inhibitions prohibit even social talk about sex, especially young people, holding that those who are willing to talk about HIV and AIDS and sex are considered bad while those who do not are ‘good’.

The research study established that the church leaders and members are silent on HIV and AIDS and the welfare of the PLHIV in the church. PLHIV in the focused group discussion were of the view that the Church does not include HIV and AIDS programme in the order service. They added that the Church is silent and when it speaks it utters condemnation of the PLHIV blaming them for their infection. Similar views were echoed In a UNAIDS theological workshop in Windhoek by
Revered Vittillo of the Roman Catholic Church who narrates his experience when a pastor of a parish in Scandinavia invited him to speak about AIDS in the Church.

Upon arrival, he seemed very concerned about what I would say, I reassured him that I will never cause a scandal in his pulpit. He then admitted that he had never included the word AIDS in any of his homilies or public prayer even though this epidemic had already deeply affected numerous people in his country. (UNAID 2005 p 20).

This clearly indicates that silence on HIV and AIDS has been a common feature within the churches worldwide.

### 4.5 Biblical teachings

UNAIDS (2005) reports indicates that Christian theology has sometimes unintentionally operated in such a way as to reinforce stigma and to increase the likelihood of discrimination. This is because the Bible at times is read and interpreted in such a way as to encourage stigmatized attitudes and practices within the church. Peter and parker (2002) agree with this view and add that religious doctrines, moral and ethical position regarding sexual behavior and sexism and denial of the realities of HIV/AIDS have helped create the perception that PLHIV have sinned and deserve their punishment. Similar views were expressed by a PLHIV, (O.I 26/8/2013) who articulated that PLHIV are seen as immoral and sinners who needed to repent their sins. Most of the respondents in focused group discussions indicated that biblical teachings contribute to stigma and discrimination of PLHIV.
(O.I 25/8/2013), chairperson of the Rock support Group, revealed that songs sung in the Church also cause stigma to PLHIV. One song *dawa ya Ukimwi ni Kuwa mwaminifu katika ndoa na inashinda kondom zote zinazotolewa,* (the cure for AIDS is being faithful to one’s spouse which is better than all the condoms being given.) When such songs are sung in church, the PLHIV feel that they are being attacked indirectly and portrayed as immoral people. To assert this, a preacher in the Methodist Church anonymity observed (O.I 26/8/2013), clearly reflected that HIV has become a manifestation of sinful humanity. He added that the epidemic can be interpreted as fulfillment of the curses cited in Deuteronomy 28:22 which include God sending incurable disease to a sinful world and HIV and AIDS is a sign that the end of the world is coming soon as indicated in Luke 21:5-28. This view agrees with the assertion of Kafuko (2009) that HIV and AIDS is seen as a result of disobedience and failure to adhere to religious teaching regarding sexual relations. Such views fuel sigma to the PLHIV who feel discriminated and alienated from the church.

**4.6 Lack of information**

Stigma and discrimination on PLHIV can be perpetuated by lack of information. Lack of information gives rise to the environment where myths and stereotypes that surround the disease flourish and this leads to irrational fears and anxiety linked to association and contact with those who are thought to be infected (MIAA 2006). To emphasize the importance of information Messers (2004) points out that religious communities will never have enough finance and resources to
provide funds necessary for promoting education, prevention, treatment and care but can contribute their share. He emphasized that it does not cost one cent to preach every Sunday that discrimination of PLHIV is a sin and against the will of God.

Researchers own observation of the ten churches within Njia Circuit of the Methodists Church indicated that there were no posters, brochures or booklets within the church with information on HIV and AIDS. This was also confirmed by a PLHIV, who notes:

There is no space in the church calendar or programmes for PLHIV. Most of the time, we force our way into their programmes so that they can give us a chance to speak on the plight of PLHIV. At times they limit us for a few minutes under the pretence that the Church schedule is busy (Interview, 15/9/2013).

Confession by the Synod Bishop (O.I 26/9/2013) that they have delegated the role of information to the Methodist Hospital confirms the church non-involvement in dissemination of information on HIV and AIDS. This is a gap that needs to be addressed as Chitando (2007,p23) puts it:

Churches cannot leave this crucial role to the few medical experts within their ranks is only when the entire congregation becomes AIDS literate that the ideals of AIDS competent church would be within reach.

Information per se according to the research findings may not alleviate stigma. This is because it has been marred by failure to translate such information into action due to false belief about HIV and AIDS and lack of avenue to share the information in an interactive manner.
4.7 Gossip and insult

Gossip is a conversation about the personal details of other people’s lives whether rumors or fact especially when malicious in nature (Banda, 2010). Gossip therefore is malicious and degrading. According to Banda (2010), gossips are frequently damaging to the lives and livelihood of those who are being gossiped about. The focused group discussion with PLHIV established that gossip made most of the PLHIV not to attend church service, a PLHIV anonymity observed remarked that,

Most of the women fellowship visited me to see how thin I had become. Some said they were sympathetic by the way the disease had devastated me. I heard them gossiping home as they went home that my days are numbered. This angered me so much that I stopped going to church altogether.

This confirms the assertion of Banda (2010) that, Gossip about PLHIV generally focused on speculation about whether a person has HIV, usually because of visible signs of illness, the insult is the view that that once a person is assumed HIV positive, people speculates about how he or she contacted the disease. Gossip lowers the self-esteem of the PLHIV and reduces their potential and productivity in the church and community in general. Wanyama et al. (2007) and ICRW (2006) stressed that stigmatizing words like victims tend to penetrate and cause a lot of suffering to the PLHIV. These words have tremendous power to intimidate the PLHIV and destroy their self esteem. In line with the Maslow’s theory that guided this study such words make the PLHIV insecure and therefore they cannot actualize and meet their desires in life.
Gossip and insult make the PLHIV to feel uncomfortable due to prejudice and demeaning language being aimed at them. Therefore, unfriendly language used against the PLHIV puts them in a position where they become target of gossips. Insults and other forms of verbal abuse occur when the community learns about the HIV positive status of a person. The person’s health situation becomes a major topic of discussion among people surrounding him or her (ICRW 2006). This is because there are speculations on how the person contracted HIV. The research findings concurred with this view. The respondents indicated that the major way of knowing about the HIV status is through gossip as indicated in the table below.

**Table 4.11 Main way people know if someone has HIV in your congregation**

<table>
<thead>
<tr>
<th>Main way people know if someone has HIV in your congregation</th>
<th>PLHIV %</th>
<th>Christian %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infected persons disclose status</td>
<td>11</td>
<td>24</td>
</tr>
<tr>
<td>Rumour/ Gossips</td>
<td>48</td>
<td>47</td>
</tr>
<tr>
<td>The person looks ill &amp; has lost weight</td>
<td>41</td>
<td>29</td>
</tr>
</tbody>
</table>

Majority of those PLHIV 48% indicated that main ways in which people know if someone has HIV in their congregation is through gossips and rumors followed by 42% through the persons look and weight loss and finally only 11% of those infected have disclosed their status. Other respondents who included Christians, pastors and preachers said that majority 47% knew about a persons’ status through
gossips and rumors, another 29% through looks and weight loss and finally 24% through the infected persons disclosing their HIV status.

The PLHIV in their focused group discussion were of the view that due to gossips they were not willing to share information on their HIV status. Obscene words were commonly used within the Church congregation. A PLHIV anonymity observed (O.I 27/7/2013) narrates on an occasion within the Methodist Church in Njia Circuit when she heard whispers that the murderer has come death is here. This hurts her to the extent that she started crying.

**Conclusion**

Stigma and discrimination against PLHIV is caused by lack of information. The findings of the research established that dissemination of HIV and AIDS information in the church is lacking. The lack of information gives rise to an environment where myths and stereotypes that surrounds the disease, and in turn cause feajurs of casual contact with PLHIV.

Stigma feeds on silence and denial with 61% of the respondents indicating that issues of HIV and AIDS are never addressed in the church. Therefore, the study establishes that the stigma on PLHIV is not adequately addressed in Njia Circuit in the Methodist Church. The church has not done much to create a forum for open discussions on HIV and AIDS; this perpetuates the culture of silence.
HIV and AIDS is seen as a result of disobedience and failure to adhere to religious teaching in relation to sexual relations. Within the church the teaching of love for all as indicated by the teaching of Jesus.

Do not judge others and God will not judge you, do not condemn others, and God will not condemn you, fulfill others and God will forgive you Luke 6:37.

Jesus teaching on love is a key principle in Christian living. Jesus said that the greatest commandment is love.

Love the Lord with all your heart, with all your soul and with all your mind. The second most important commandment like it is love your neighbor as you love yourself. The whole Law of Moses and the teaching of prophets depend on those two commandments. It is important to contextualize the information within the religious cycles and inculcates the information in sermon (Mathew 22:37).

Paul clearly illustrates the overall importance of teaching of love.

I may be able to speak the language of human and of angels, but if I have no love my speech is no more than a noise gong or hanging bell. Love is patient and kind, it is not jealous or conceited or proud. Love is not ill manner or selfish or irritable, love does not keep record of wrong; love is not happy with evil but is happy with the truth. Love never gives up, and its faith, hope and patience never fails and is eternal (Corinthians 13:1-17).

It is important to contextualize information in HIV and AIDS and include the information in sermon. Testing HIV positive is widely a traumatic experience and some turn to the Church for spiritual support yet some churches have responded negatively to the PLHIV. In this study, there was clear manifestation of judgementalism as many people believed that the PLHIV are to be blamed for their condition and therefore deserved what they got.
The association of HIV with sexual immorality is prevalent within the congregation. This is possibly due to the fact that HIV is transmitted through sexual intercourse. This chapter has highlighted the causes of stigma on PLHIV. They include fear of HIV and AIDS, lack of information on HIV and AIDS, gossip and insult, and silence of the Church on HIV and AIDS. The next chapter looks at the effect of stigma on PLHIV in Njia Circuit of the Methodist Church.
CHAPTER FIVE

EFFECT OF STIGMA ON PLHIV IN NJIA CIRCUIT OF THE
METHODIST CHURCH

5.1 Introduction

After discussing the causes of stigma in the previous chapter, it is important to analyze the effects of stigma on PLHIV. This chapter examines the various effects of stigma on PLHIV in Njia Circuit. The discussion focuses on the effects of stigma on the disclosure of one’s status within the church. It looks at how stigma influences disclosure of one’s status and also assesses the frequency of disclosure within the church.

The chapter further addresses how stigma influences voluntary counseling and testing among the church members and the community in general. In so doing, the study sought to justify the study premise that stigma against PLHIV hinder voluntary counseling and testing. It also looks at how stigma instills fear on the PLHIV making them unable to interact with the rest of the members of the church.

Using the Maslow’s theory that guided this study, the chapter focuses on how the effects of stigma interfere with the self esteem of the PLHIV and their ability to reach the productive stage referred to as a self actualization in Maslow’s theory.

The role of stigma in making the PLHIV vulnerable to death is also addressed in this chapter. It further addresses isolation, loneliness and blame which face the
PLHIV due to the stigma meted to them by the church in Njia Circuit. This chapter also looks at loss of jobs and leadership positions within the church due to stigma that affects the PLHIV. Finally, it explores the denial of burial in some instance as result of stigma that affects the PLHIV within the church.

5.1 Influence of Stigma on Disclosure.

The disclosure of HIV positive status is very important for the management of the HIV and AIDS. Campbell et al., (2007) posit that disclosure may motivate partners to go for voluntary counseling and testing (VCT), thus reducing the risk behavior as well as increase support and adherence to ART. Therefore, HIV positive disclosure is one of the strategies that can be used by PLHIV to cope with the disease. Makoae Potillo, Leana, UYS, Dlamin, Greffim, Chirwa, Tecla, Kohi, Naidoo, Mullan, Durheim, Watland, Hotzemes (2008) insists that some PLHIV disclose HIV status to reduce gossip and rumors while others disclose their status to solicit support from loved ones and community members. While it is hoped that disclosure of HIV and AIDS status will help PLHIV to gain acceptance and support, they may face blame, discrimination and even isolation due to stigma. Therefore, stigma to a great extent waters down the benefits of disclosure within the church.

Lamptey et al. (2009) indicates that stigma and discrimination against PLHIV lead to people avoiding being tested and when tested for HIV, they do not disclose their status. The authors are of the view that people in sub-Saharan Africa do not prefer
to know their status due to the stigma on PLHIV. Secretary to CACC in Igembe south sub-county, concurs with this view (O.I 20/8/2013), and notes that there low cases of testing within the district as few people are willing to be tested. He notes that women are mostly tested when they visit prenatal clinic and men are only tested by proxy, he adds that due to stigma within the community they do “moonlight” testing at night because most of the people would not like to be seen being tested during the day, a PLHIV (O.I 26/7/2013) further adds that stigma discourages people from being tested and when tested they do not reveal their status. This confirms the views of Kofi Annan formally secretary general of United Nations declared on the World AIDS Day 2002.

Fear of stigma leads to silence and when it comes to fighting, AID silence is death, it suppresses public discussion about AIDS and deter people from finding out whether they are infected. It causes people, whether a mother breastfeeding a child or a sexual partner reluctant to disclose their HIV status- to risk transmitting HIV rather than attract suspicion that they may be infected (UNAID 2002 p30).

The research established that disclosure of HIV is very low in the Methodist Church in Njia Circuit. The study established that 63% of the respondents would not share their test result with anyone.
Figure 5.1: PLHIV open about their status

Majority of the respondents (63%) said that in their church PLHIV are not open about their status while 37% are open about their status. This clearly indicates that disclosure is very low even among the church.

The research findings further illustrated that the church has not provided enough opportunities for PLHIV to disclose their status. Majority of the respondents, (72%), indicated that members of their congregation are not given forums to disclose their HIV status while 28% are given such forums. This indicates the need for the church to create different fora for disclosure. Therefore, people hide their positive status if they think they will be ridiculed or suffer personal harm. Zou, J. Yamanaka, Y John, M. Watt, M. Ostermann, J. Thielman, N(2009) asserts that disclosure of HIV status to pastors and other members of the religious community
can facilitate the emotions healing and support and that religion can provide mechanism for coping. On the contrary, majority (34%) of the respondents in this study would rather share their test result with their partners and family members as indicated by the table 5.3 below.

<table>
<thead>
<tr>
<th>Person to share HIV positive test results with</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner</td>
<td>36</td>
<td>34</td>
</tr>
<tr>
<td>Parents</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Family</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Friend</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Pastor</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Church members</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Overseer</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>106</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Majority of the respondents 34% and 20% indicated that persons share HIV status with partners and family members respectively. However, 15% can share with parents, 13% can share with friends, 10% can share with pastors, 6% can share with church members and lastly 2% can share with overseers. This confirms the view of stein (2003) that fears of stigma represent an impediment to disclosure by PLHIV of their sero status to others including church members and sexual partners which can interfere with effective risk reduction.
5.2 Blame, Shame and Isolation of PLHIV

ICRW (2010) describes isolation as when the PLHIV are excluded from family and church and lose power and respect in the community. Isolation include therefore loss of social networks, decreased visits by neighbors for fear of contagious and reduction of daily interaction with family and community and exclusion from family and community events (Ogden and Nyblade 2005).

Isolation leads to one feeling lonely. Loneliness is not merely being alone or single but the experience of not being appreciated for who you are and that nobody understands you. Loneliness is the result of communicative crisis and loss of supportive relationships. It manifests because of a feeling of reflection and a lack of being loved or cared for (Banda 2011). This study agrees with this view and established that most of the PLHIV feel lonely. These views were confirmed by PLHIV (O.1 20/8./2013) who noted as follows.

I felt lonely and discouraged when nobody seemed to care. I felt worthless and lost a sense of belonging to anyone. Even in the church, I felt alone in the midst of the congregation, everyone including the pastor looked at me suspiciously nobody offered a shoulder to lean on, I felt alone in the world.

Similar sentiments were echoed by a PLHIV, anonymity observed

I hid in the house when the church visited my home. I told my children to lie that I gone to Nairobi. The church minister conducted the service while I hid in the house I did not want to be seen by the church members because I had lost a lot of weight (Interview 24/8/2013).

This views suggest that self stigma by PLHIV may make them to isolate themselves from the public. The research finding established that isolation of the PLHIV was as result of stigma that was being meted upon them. In fact, due to
isolation some of the PLHIV stopped attending church services as admitted by a PLHIV anonymity observed (O.I.23/8/2013),

In the church, I noted that some church members were avoiding me. When I sat next to them on bench some moved further to create space between me and them, this action made me to stop participating in any church activities including Sunday Service Worship, until this day I stay at home in order to avoid being avoided and rejected in the Church.

The Findings of the study also established that blame and isolation of the PLHIV was common within the Methodist church in Njia Circuit. 60% of the respondents indicated that blame and isolation of PLHIV was common in the church as indicated in the figure 5.4 below

**Figure 5.2: Responses in Church to those PLHIV**

![Figure 5.2: Responses in Church to those PLHIV](image)

Majority of the respondent 33% indicated that initial response from those infected was blame followed by acceptance and isolation with each 27% and finally denial at 13% of the respondents. To confirm these finding (O.I 27/7/2013) asserts that
when he made a pastoral visits in the homes of church members within Njia Circuit, he noticed that there are very many sick people who did not attend church service. When he inquired from the sick persons some revealed that they were PLHIV who were formally members of Methodist Church in Njia Circuit. They informed him they could not attend the church service because they were stigmatized when people gossiped about their status in the church. This is an indication that the PLHIV were not comfortable in the church and therefore decided to stay away from attending church service. This research finding confirm Nuibuasah (2005, p35) view that,

> Stigma turns diagnosis into accusation, this accusation bring shame to patients and their families. Some families hide their sick from public eye and the scorn associated with the disease and accepts it as punishment from God.

Due to the isolation of PLHIV, they also feel ashamed of their status. According to Machyo (2007), shame is defined as a feeling of being unlovable and that one’s life has a basic flaw in it. This study agrees with Machyo in that the PLHIV feel unlovable because of their condition and identify HIV as a flaw in their lives. These findings agree with UNAID (2013,p 50) report which argues that,

HIV related stigma is linked with delayed HIV testing, non disclosure to partners and poor engagement with HIV services. People who experience stigma and discrimination report a rage of negative effects including loss of income, isolation from communities and inability to participate as productive members of the community as a result of their HIV status. According to survey conducted via people living with HIV stigma index, instances of stigma and discrimination exact profound psychological cost resulting in feeling of guilt, shame and suicidal thought.
Most of the PLHIV in the focused group discussion claimed that they felt shameful when people stare at them suspiciously because of their HIV status. Shame is an attack on the persons self respect and human dignity and therefore interferes with one self esteem. This in line with Maslow’s theory that guided this study affirms that any attack on self esteem may hinder one from achieving self actualization which is the climax of one’s ability and productivity in life. The effect of shame on one’s personality is clearly illustrated by PLHIV (O.I 25/8/2013), who asserted:

> When the church neglected me, I felt ashamed and worthless and walked with my head held down. I even stopped going to church because of shame.

### 5.3 Suicide and Vulnerability to Sickness

Suicidal person feels he or she has exhausted all possible options. Life has no meaning and no future so why continue to endure in extreme unhappiness and despair? The obsessive believe that nothing will ever change for better leaves him or her feeling helpless with the only conviction that death is the only way out (Graham 2002).Kelly (2010) in agreement with Graham observes that it is not unusual for AIDS related stigma crisis to lead to suicide. The injustice of stigma and discrimination brings untold suffering and unhappiness into the lives of PLHIV. The stigma severe all that ties them to humanity and for some the outcome is suicide. Our study agrees with Kelly (2010) and Graham (2002) that suicide is a common option for the most of PLHIV. From the focused group discussion with PLHIV, it was clear that stigma weakens a person to an extent that he or she feels that life is not worthy living. This may push the person to consider
suicide as an escape from the world of suffering where nobody seems to care. On this view a PLHIV anonymity observed) narrates:

When I was rejected in the church where I expected support, I felt worthless and decided to commit suicide. In fact I took a bottle of pesticide and opened it ready to drink only to be interrupted by my son who entered in the room. (Interview, 27/8/2013).

The focused group discussion of PLHIV revealed that suicide is a common reaction among them especially when they learn about their HIV status and when they feel rejected by the church. They lose hope when they face uncertainty and become stressed and afraid about the terrible suffering HIV may bring. Suicide is also considered when HIV has developed into AIDS. At this stage, the PLHIV prefers to die in order to escape the pain which they go through (Hadad, 2005). This view was echoed by the PLHIV who narrated in the focus group discussion how the members of their support groups who had reached full blown stage of AIDS told them that they would have committed suicide if they had a chance.

Stigma may lead to PLHIV refusing to take ARV medication in order to accelerate their death. This was demonstrated clearly by the confession of PLHIV anonymity observed (O.I 25/8/2013) who asserted that because of stigma, he lost his self worth and stopped taking medication to speed up the process of dying and escape from the burden of stigma. This to a great extent interfered with the effectiveness of ARVs that he was taking.
5.4 Denial of Leadership Position in the Church

In the bible leprosy was associated with uncleanness; a person suffering from the diseases was not allowed to serve in the priesthood, as indicated in this verse:

If a descendant of Aaron has an injections skin diseases or a bodily discharged, he may not eat the scared offering until he is cleansed. (Lev, 22:4).

This verse makes it clear that ceremonial uncleanness was to severe that it prevented a priest from ethic offering as eating a scared offering and disqualified him from appearing in God’s presence (Cloette, 2010). This reality is similar to what this research study has shown about relieved PLHIV from their duties and responsibilities, they hold in churches.

Within the Methodist church, there are leadership positions for the lay members according to the rules that govern the church that are commonly referred to as the standing orders. Leadership positions are rotational and the leaders are democratically elected by the members of the congregation superintendent minister describe the church election in the following manner;

Church leaders are elected through the secret ballot presided over by the church minister, the election are normally are announce two weeks before the election date. During the Election Day the members give proposal orally. Those proposed normally move out to allow voting. The secretary is usually elected first so that they can take minutes of the proceedings. The leaders are expected to serve for a period of two years. The standing orders limit the term of service for the new officials to two terms of two years each. (Interview, 24/8/2013)

Though leadership does not attract any pay the research findings revealed being given responsibility in the church boost one’s self esteem. Being elected as a
leader in the church is an indication that one is being valued in the church. Consequently, when recognized and accepted one is able achieve their full potential referred to self actualization in Maslow’s theory. This was clearly noted PLHIV, who noted that,

Being the chairman of the church or part of the executive implies that people do appreciate you and you feel good and motivated to work hard even in your own business. As one performs tasks in the church they are able to display their leadership potential and exercise their God given talents. (Interview 25/8/2013)

Lamptey et al. (2009) notes that PLHIV have lost their jobs and denied medical cover and responsibilities in social institutions like churches and schools. The current study concurred with this view and established that the PLHIV are denied chances to lead in the Methodist church due to their HIV status. A PLHIV anonymity observed narrates as follows:

Besides being a Sunday school coordinator, I was the chairperson of the evangelism team and the secretary to the women fellowship and a member of our women choir in our local Methodist church. I have resigned from this position because of the way I have been treated. Most of the members of the church withdrew their children from the Sunday school where I was teaching. In the choir there was a lot of gossip and murmur whenever I arrived for practice. I cannot fit any longer in the church leadership. (Interview, 27/8/2013)

Focused group discussion with PLHIV indicated that during the church election, they are not proposed for any post in the church for the fear they may be dying any time leading to unnecessary repeat of elections. The study revealed that apart from leadership, the PLHIV have been excluded from church activities like preparing the lunches for preachers and pastors on Sunday. These duties within the Methodists church in Njia Circuit are undertaken by the women fellowship who
draw a duty Rota to include all women in the fellowship. Denial of leadership positions make the PLHIV feel insecure and lower their self esteem, this denies them the opportunities to self actualize.

5.5 Denial of Burial

Burying the dead is one of the duties of the Methodist church, in fact it has laid down procedure and programmes for the burial of its members in its standing orders. According to (O.I.23/8/2013), the burial of church members is usually conducted by the church minister and at times may delegate the role to the lay Preachers. Focused group discussions with PLHIV revealed that in most of the burial of PLHIV the church minister preferred sending lay preachers. PLHIV noted that burial for other members were elaborate and at times attended by more than one church minister. This finding confirms the views of Hadad (2005), that there are reports of PLHIV being denied decent and dignified burial by the church. This research study agrees with this view for it established that it is a common practice for families to burn the goods of people who have died of HIV related illness. This perpetuates fear of PLHIV and fear of contracting HIV from causal contact.

Denial of burial persists within the Methodist church in Njia Circuit as confirmed by PLHIV anonymity observed (O.I 25/9/2013) who asserted that a pastor in their church refuse to burry a PLHIV on the pretence that he had ceased to be a member due to his long absence in the church . It was well known that the absence of
PLWIV was as a result of being sick for a long time. In some instances, the research study established that the lay preacher may threaten not to perform death rites for PLHIV as PLHIV (O.I 26/7/2013) indicated that in one of the church a lay preacher threatened the congregation that those who will not change from their immoral ways, they will die of AIDS and the church will refuse to perform the burial rites for them.

5.6 Conclusion

The chapter has highlighted the effect of stigma on disclosure within Njia Circuit. It outlines the importance of disclosure on the war against HIV and AIDS. It is evident from the research study that disclosure of HIV testing is very low in Njia Circuit. This is a situation that needs to be addressed. Disclosure normally leads to acceptance and support from the church. However, the research established the contrary, those who disclosed their status are stigmatized; this lowers the self esteem of the PLHIV and cannot achieve self actualization as argued in Maslow’s theory that guided this study.

This chapter has also demonstrated that blame and isolation of PLHIV is prevalent in Njia Circuit and affects the PLHIV. When the PLHIV are blamed for their status, they feel stigmatized and isolated from the church members. Such feeling of rejection in the church where they would expect support makes them to avoid going to church. Isolation and blame lead to PLHIV to feel ashamed of their status. This attack of their self dignity put them in a personality crisis which leads to low
self worth. It was also noted that PLHIV develop suicidal tendencies when stigmatized. Suicidal tendencies are due to the fact that HIV has no cure and once stigmatized PLHIV see life as meaningless with no purpose and no future. Suicidal tendencies are common to most of the PLHIV mostly when they are faced with stigma. This draws to the attention of the church the need to come up with policies to alleviate stigma and save lives of the PLHIV. It was also noted that some PLHIV may be reluctant to visit health facilities because of fear of stigmatization which may accelerate an early death for them.

The study also noted that PLHIV were denied leadership position due to their HIV status. In some instances, they were relieved from minor duties like preparing food for the preacher, this calls for the need to come up with policies that will encompass making PLHIV acceptable in leadership position. When stigmatized, PLHIV are likely to resign from their position. It has been noted in this chapter in some instances that PLHIV have been denied decent burial. Though these instances are few, they make them feel stigmatized in the community even at death.

Given the varied effects of stigma of PLHIV in Njia Circuit, war on HIV and AIDS is far from being worn without addressing the stigma within the church context. The Methodist church in Njia Circuit should not behave like the proverbial ostrich hiding its head in time of HIV and AIDS crisis. As discussed above, stigma hinders disclosure of HIV status and makes the PLHIV to feel ashamed of themselves. Consequently, the PLHIV is likely to commit suicide. As
indicated in the Maslow’s theory acceptance and compassion are important towards developing or achieving self esteem which leads to self actualization. Therefore, the church should strive to include the PLHIV rather than isolating them to make the gospel of Jesus of love and compassion for all a reality.
CHAPTER SIX

SUMMARY CONCLUSION AND RECOMMENDATIONS OF THE STUDY

6.0. Introduction

This chapter summarizes the entire study. First it presents the synopsis of the main findings. Secondly, it presents recommendations from the study. Finally it proposes areas for further research.

6.1. Summary of Finding and Conclusions

The study was inspired by the concern that stigma on PLHIV persisted in the church where love and compassion would be expected. The main purpose of the study was to look at stigma and discrimination against PLHIV in Methodist Church in Njia Circuit. It analyzed the level of knowledge of HIV and AIDS within Njia Circuit. It also assessed the Biblical teachings on the terminally ill patients. Finally, the study tried to establish the causes and effects of stigma on PLHIV within the church.

The first objective of the study was to establish the level of knowledge on HIV and AIDS of the congregants in Njia Circuit. The study established that there was lack of materials such as brochures, booklets and posters on HIV. However, the congregants have general information on HIV possibly from the media and books but lacked in depth knowledge on mode of transmission and HIV and AIDS
disease progression. Focus for discussions with the PLHIV indicated that knowledge on its own may not be sufficient to alleviate stigma. This calls for forums within the church where there can be open discussion on HIV and AIDS. In a discussion, people are able to work on their doubts about the truth of the information that they have and its relevance to their life. Once people are furnished with the right information, they can apply it in their lives and hence relate well with PLHIV. In the environment of love and acceptance, the PLHIV are likely to develop self esteem which is an important component of the Maslow theory that guided the study. It was also noted that HIV and AIDS Misinformation and false beliefs and teaching like miraculous healing can interfere with adherence to ARVs among the PLHIV. The findings supported our first premise that there is a relationship between the level of knowledge on HIV and AIDS and stigma affecting PLHIV in the Methodist Church in Njia Circuit.

The second objective was to establish the biblical teachings on the terminally ill patients. It was noted that the Hebrew view of the leper was used in the church in Njia Circuit to refer to the PLHIV. The study established that the stumbling block on action against stigma on PLHIV is the prevalence of belief in the churches that HIV and AIDS is God’s punishment for promiscuity. These result in PLHIV being blamed for their situation. This negates the fact that PLHIV may be infected in different ways not necessarily through immoral sexual behavior. These findings are in support of a second premise that biblical teaching on terminally ill patients contribute to stigma in PLHIV. When the PLHIV are depicted as immoral they
feel insecure and their self esteem is lowered. Consequently, they cannot be self actualized to become productive members of the church. Their talents may remain untapped.

The third objective sought to investigate the causes of stigma on PLHIV within the church in Njia Circuit. These causes include fear of HIV and AIDS, silence on HIV and AIDS, association of HIV and AIDS with immorality and silence on sexuality, biblical teachings that depict HIV as punishment from God and lack of information on HIV and AIDS. This findings support the premise that fear of HIV and AIDS, death and association of HIV and AIDS with immorality are the causes of stigma and discrimination on PLHIV. Therefore fear of HIV and AIDS and association of HIV with immorality may instill a sense of insecurity and make unable to reach the next level in the Maslow’s theory.

The fourth objective addressed effects of stigma on PLHIV in Njia Circuit. It was found that stigma on PLHIV deter people from ground for V.C.T. and disclosed their status once tested. This in fact, confirmed the research premise that stigma on PLHIV hinder V.C.T. and disclosure. Other effects of stigma on PLHIV included blame, shame and isolation of PLHIV, suicide tendencies and being vulnerable to sickness, denial of leadership positions in the church and denial of burial. This finding answered the research questions that sought to establish the effects of stigma and discrimination on PLHIV in Njia Circuit.
In the face of HIV related stigma the church is expected to be a safe haven for PLHIV. It is clear from the research study that the church in Njia Circuit has not so far been effective on dealing with stigma on PLHIV as it should. There is still an opportunity for improvement. To alleviate stigma on the PLHIV, the church needs to have paradigm shift from alienation to association. The church should therefore be transformed from a community of stigma to a community of healing. This would make PLHIV feel accepted in church and community in general and therefore reach productive level referred to as self actualization by Maslow theory. Therefore, through love by the church the PLHIV would realize that though they are afflicted by the virus, Jesus who died on the cross carried away all their pain and since he lives, they will live forever more.

6.2.0 Recommendations

For the Methodist Church in Njia Circuit to fight stigma on PLHIV effectively, they need to look into some issues and take appropriate action. These issues include information dissemination of HIV, encourage disclosure in churches, preaching openly on HIV and AIDS, sensitizing of congregations on prevalence of stigma in churches and home based support network through the churches.

6.2.1. Information Dissemination on HIV

Provision of information, education and communication materials in raising awareness among congregation on HIV and AIDS is important. The provision of accurate and timely information implies dispelling doubts, fears, myths and
misconceptions associated with HIV and AIDS. Information in local language should be availed to benefit all the members. In order to achieve these, Methodist church Njia Circuit can collaborate with UNAIDS and NACC which provide free publication in order to make the literature available on a regular basis. The church can develop customized booklets and posters to communicate information on HIV and AIDS.

6.2.2. Encourage Disclosure

PLHIV should be encouraged to give testimonies and share their experiences in an effort to deal with HIV in church services and other religious gatherings. Disclosure increases the visibility of the PLHIV resulting in acceptance and support.

6.2.3. Speaking Openly on HIV

Church ministers and preachers should speak openly, compassionately and non-judgmentally about HIV and AIDS. This will dispel the culture of silence and make the church vocal on HIV and AIDS pandemic and acknowledge the presence of the disease in the church. This creates a conducive environment and a culture of love and care for PLHIV.

6.2.4. Sensitizing Congregations on the Prevalence of Stigma on PLHIV in Church

Congregation should be sanitized on HIV/AIDS stigma and discrimination and the consequences it has on the PLHIV. Therefore, there is need to create awareness
and recognition of existence of stigma and different form of stigma. People should be made aware of the causes and effect of stigma established by this study and the benefit of reducing stigma on PLHIV.

6.2.5. Discuss sexuality openly in church

The church in order to fulfill its mission as a place of redemption, hope and healing, need to promote the Christian teaching that emphasizes the goodness of human sexuality while also highlighting the responsible use of sex in a way that does not bring death. After all the HIV and AIDS crisis present the church with a great opportunity to teach people good sexual behavior that come from God’s words in appositive way.

6.3. Areas for Further Research

More research is needed in the areas of stigma. A comparative study of HIV/AIDS stigma and discrimination in Christian and Muslim communities in Kenya would be appropriate. It would probe into certain beliefs within these faith communities which can stigmatize in order to establish why people hold such beliefs.
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APPENDICES

APPENDIX I: QUESTIONNAIRE FOR ORDINARY CHRISTIANS, PREACHERS AND PASTORS.

I am Jediel Akula Mioro, a student in the department of Philosophy and Religious studies of Kenyatta University. This study aims at addressing stigma and discrimination against people living with HIV/AIDS (PLHIV) in Methodist Church with special reference to Njia Circuit. Thank you for accepting to take part in this questionnaire. All information forwarded herein will be treated with confidentiality it deserves. Thank you in advance.

1. Age
   - 21-30
   - 31-40
   - 41-50
   - 50 and above

2. Gender
   - Female
   - Male

3. Marital status
   - Single
   - Married
   - Divorced
   - Separated

4. Education level:
   - Primary
   - Secondary
   - Tertiary Level
   - University

5. Is there a difference between HIV and AIDS?
   - Yes
   - No
   - Don’t know

6. A person can have HIV without becoming ill with AIDS
   - Yes
   - No
   - Don’t know

7. People who look healthy are not infected with HIV
   - Yes
   - No
   - Don’t know

8. Sexual contact is the primary means of transmission of HIV
9. A person can get HIV by being bitten by mosquito or any insect

Yes [ ] No [ ] don’t know [ ]

10. HIV can be transmitted from Mother to child through breast feeding.

Yes [ ] No [ ] don’t know [ ]

11. HIV can be spread through the use of contaminated needles/ blades

Yes [ ] No [ ] don’t know [ ]

12. A pregnant woman infected with HIV can decrease the changes of transmitting the virus to the unborn child by taking antiretroviral drug.

Yes [ ] No [ ] don’t know [ ]

13. Antiretroviral treatment reduces the amount of HIV in the person’s body

Yes [ ] No [ ] don’t know [ ]

14. An HIV test can remain negative for a few months after someone is infected

Yes [ ] No [ ] don’t know [ ]

15. Do you have fear of becoming infected if you share the same utensil with PLHIV?

Yes [ ] No [ ]

16. Do you have fear of becoming infected if you drink from the same common cup with a PLWH?

Yes [ ] No [ ]
17. Do you fear becoming infected if you use the same toilet with a PLHIV?
   Yes [ ] No [ ]
18. Do you have fear of becoming infected if you are baptized in the same water with PLHIV?
   Yes [ ] No [ ]
19. Do you agree with the following statement
   HIV is a punishment from God  Yes [ ] No [ ]
20. PLWHAs have not followed the word of God.  Yes [ ] No [ ]
21. PLHIV are cursed  Yes [ ] No [ ]
22. PLHIV themselves to blame.  Yes [ ] No [ ]
23. PLHIV are promiscuous  Yes [ ] No [ ]
24. In your congregation are there people who are living openly with HIV and AIDS
   Yes [ ] No [ ] not sure [ ]
25. Are people in the Methodist church encouraged to disclose their HIV status?
   Yes [ ] No [ ] not sure [ ]
26. What is the main way people know if someone has HIV in your congregation
   Infected persons disclose his/her status [ ]
   Romour/gossip [ ]
   The person looks ill and has lost weight [ ]
27. Which of the biblical teaching below common in your church?

(i) HIV is leprosy of today

(ii) sickness are as a result of immorality

(iii) Wages of sin is death.

28. How often are the old testament teaching in Leviticus 13:45.46. Quoted inform church in relation to HIV.

   □ Severally
   □ Rarely
   □ Not mentioned

29. Deuteronomy 28:27 cites a curse of one of causes of terminal illness. Do you agree with this statement?

   Yes □ No □

30. How often the teachings of Jesus on relating with the lepers and sinners are related n your church.

   (i) Rarely □ Never mentioned □ Severally □

31. Do you think this teaching relate to PLHIV

   Yes □ No □

32. If a family member has HIV, would you keep it a secret?

   Yes □ No □

33. Do you think biblical teaching contribute to stigma discrimination on PLHIV.
Yes □ No □

34. Leviticus 13: 45-46 depicts the lepers were stigmatized and disseminated 
do you think this should apply to the PLHIV

Yes □ No □

35. If you test HIV positive, would you share your results with anyone

Yes □ No □

36. If you test positive with whom would you share the test result?(You may 
tick more than one box)

Partner □ parent □ family □ friend □ pastor □
Church member □ Overseer □

37. What are the church activities that provide for HIV/AIDS discussion

Prayer service □ group meeting □ wedding functions □ funeral □
one □

never □

38. How frequent are issues related to PLWHs addressed during church 
functions3

Once a week □ once a month □ less than once a month □ rarely □

Never talked about □

Thank you for your cooperation.
APPENDIX II: QUESTIONNAIRE FOR PLHIV

I am Jediel Akula Mioro, a student in the department of Philosophy and Religious studies of Kenyatta University. This study aims at addressing stigma and discrimination against people living with HIV/AIDS (PLHIV) in Methodist Church with special reference to Njia Circuit. Thank you for accepting to take part in this questionnaire. All information forwarded herein will be treated with confidentiality it deserves. Thank you in advance.

1. Name options

2. Gender: male □ female □

3. Age 21-30 □ 31-40 □ 41-50 □ 50 and above □

4. What are your church responsibilities

5. What is your occupation
   Marital status married □ divorced □ separated □

6. Education level: primary □ secondary □ tertiary level □ university □

7. Which of the following church teachings is common in the Methodist church
   (May tick more than once)
   a) HIV is a punishment from God □
   b) HIV is a sign of end time □
   c) HIV comes from Satan □
8. In your church are the PLHIV open about their status.
   Yes □ No □

9. What is the main way people come to know if someone has HIV in your church?
   Infected person discloses their status □
   Rumour/gossip □
   The person looks ill and has lost weight □
   Others specify ________________________________ □

10. What was the initial response of your church to PLHIV?
    Blame □ acceptance □ denial □ Isolation □

11. Do you know PLHIV in Methodist church who had the following happen to him or her because of their status?
    i) Gossip about yes □ No □ not sure □
    ii) Teased yes □ No □ not sure □
    iii) Lost respect within the church yes □ No □ Not sure □
    iv) Excluded from participating in some Church activities. Yes □ No □
    v) Denied leadership position in church Yes □ No □ Not sure □
    vi) Lost friends within the church. Yes □ No □ Not sure □
    vii) Required to take HIV testing in order to marry in the church.
12. The role of Methodist church in fighting stigma against PLHIV can be improved by (tick the appropriate one)

- Church working with PLHIV
- Awareness creation
- Guidance and Counseling
- Involvement of PLHIV in pastoral care.

13. Are people in your congregation given forum to disclose their HIV status?

- Yes
- No

14. How frequent are issues related to PLWH addressed during church function?

- Once a week
- Once a month
- Rarely
- Never talked

15. Whom would you be comfortable to share your status with? (you may tick more than one box)

- Partner
- Parent
- Family
- Friend
- Pastor
- Church member
- Others specify__________________________________
APPENDIX III: INTERVIEW GUIDE FOR THE MINISTERS AND THE BISHOP

I am Jediel Akula Mioro, a student in the Department of Philosophy and Religious studies of Kenyatta University. This study aims at evaluating stigma and discrimination against people living with HIV (PLHIV) in Methodist church with special reference to Njia Circuit. Thank you for accepting to take part in this questionnaire. All information forwarded herein will be treated with confidentiality it deserves. Thank you in advance.

1. Name (optional)......................................

2. Gender: male □ female □

3. Highest level of formal education
   
   Primary □ Secondary □ Post secondary □ University □  Any other…………………………………………………………………………………………

4. What is your position in the church?

5. For how long have you served in this position?

6. What are some of the challenges the church encountered in the initial stages?

7. Does the Methodist church have programmed on HIV/ AIDS?
   
   Yes □ No □
   
   If yes which are they?

8. What is the biblical teaching on stigma and discrimination on the terminally ill?

9. What was the initial reaction of the Methodist church to the PLHIV?
10. What are the causes of stigma and discrimination against PLHIV the church?

11. How does the Methodist church treat PLHIV the church?

12. To what extent has the Methodist church succeeded in reducing stigma on PLHIV in Njia Circuit?

13. What are some of the effects of stigma and discrimination on the PLHIV?

14. Does the Methodist church collaborate with the government or NGOs in fighting stigma and discrimination against PLHIV?

15. Does the Methodist church give responsibility to the PLHIV in the church?

16. What are the causes of stigma Against PLHIV?

17. Has the church come up with a policy framework on PLHIV?

18. To what extent has the Methodist Church succeeded in reducing stigma in PLHIV Njia Circuit?

19. Does the Methodist church collaborate with the government and NGOs in fighting stigma and discrimination against PLHIV?

20. Does the Methodist church give responsibilities to PLHIV?

21. What can the clergy do to reduce stigma on PLHIV in their congregation?

22. Are there any notable changes in the way church treat PLHIV?
APPENDIX IV: MAP OF KENYA SHOWING THE LOCATION OF MERU COUNTY
APPENDIX V: LOCATION OF NJIA CIRCUIT IN IGEMBE SOUTH SUB-COUNTY (LOCATION OF AREA STUDY)