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# Faith-Based Initiatives in Response to HIV/AIDS in Kibera slums Nairobi, Kenya

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**Dedication**

I dedicate this work to my family and to the people living with HIV/AIDS. May they find true love and hope to face life with courage and determination.

## Table of Contents

<b>Acknowledgement</b> .....	<b>i</b>
<b>Dedication</b> .....	<b>ii</b>
<b>ACRONYMS</b> .....	<b>vi</b>
<b>ABSTRACT</b> .....	<b>vii</b>
<b>Chapter One: Introduction</b> .....	<b>1</b>
1.0 Background.....	1
1.1 Statement of the problem.....	2
1.2 Study objectives.....	3
1.2.1 Main objective of the study.....	3
1.2.2 Secondary objectives.....	3
1.3 Scope of the study.....	4
1.4 Significance of the study.....	4
1.5 Thesis layout.....	4
<b>Chapter 2: Literature review</b> .....	<b>5</b>
2.0 Introduction to the review.....	5
2.1 Defining faith-based organisations.....	5
2.3 Need for FBOs involvement.....	7
2.4 FBOs as hindrances.....	10
2.7 The theoretical framework.....	15
2.7.1 Theory of reasoned action.....	15
2.8 FBOS as agents of behaviour change.....	17
<b>Chapter three: Methodology</b> .....	<b>20</b>
3.1 Country profile: Kenya.....	20
3.1.1 Education and literacy.....	21
3.1.2 Economy.....	21
3.2 HIV/AIDS Incidences and Pervasiveness in Kenya.....	22
3.2.1 Strategic framework to combat the HIV/AIDS in Kenya.....	23
3.3 Study area.....	25
3.4 Study design.....	26
3.4.1 Surveys.....	27
3.5 The target groups.....	28
3.6 Data Analysis.....	29
3.7 Ethical considerations.....	29

3.8	Limitations of the study .....	30
3.8.1	Insecurity.....	30
3.8.2	Privacy of the respondents and the environment .....	31
3.8.3	Finance and time.....	31
3.9	My role as a researcher .....	31
<b>Chapter Four: Findings .....</b>		<b>33</b>
4.1	Introduction.....	33
4.1.1	Spiritual healing .....	34
4.1.2	Spiritual support and psycho-social support .....	35
4.1.3	Alternative employment or income generating projects .....	36
4.1.4	Support programmes for vulnerable and orphaned children.....	37
4.1.5	Di-stigmatising HIV/AIDS .....	39
4.1.6	Mobile clinics.....	40
4.2	Communication strategies by FBOs in the Kibera slum .....	41
4.2.1	Support groups and peer educator programmes.....	42
4.2.3	FBOs awareness and swop meetings.....	42
4.2.4	FBO leaders and counselling .....	44
4.3	Respondents' choice of FBOs.....	45
4.4	Challenges faced by FBOs in their response to HIV/AIDS .....	46
4.4.1	Problems of addressing sexuality openly.....	46
4.4.3	Challenge of condom promotion.....	47
4.4.4	Personal attitudes and beliefs.....	48
4.4.5	Stigma and discrimination.....	50
4.4.6	Lack of documentation or inadequate documentation .....	50
4.4.7	Perceptions about HIV/AIDS.....	51
4.4.8	Resource barriers.....	52
4.4.9	Differences and tensions between FBO leaders and people living with HIV/AIDS.....	52
4.5	Challenges faced by the beneficiaries (PLWHA) .....	53
<b>Chapter Five: Discussions.....</b>		<b>55</b>
5.1	Roles of FBOs.....	55
5.2	Evaluation of FBOs prevention Initiatives.....	56
5.2.1	Condom; a promoter of promiscuity or life saver.....	58
5.3	Care and support services .....	61
5.3.2	The dilemma of spiritual healing .....	66

5.4.1 Expanding and strengthening partnerships .....	70
5.4.2 Improve their records/documentations.....	71
5.4.3 Improve management skills. ....	71
<b>Chapter six: Conclusions and Recommendations.....</b>	<b>74</b>
<b>Bibliography.....</b>	<b>80</b>
<b>Appendices .....</b>	<b>86</b>
Appendix 1.....	86
Appendix 2.....	87
Appendix 3.....	88
Appendix 4.....	89
Appendix 5.....	90

## **ACRONYMS**

<b>ABC</b>	Abstinence, Being faithful and Condom use
<b>AIDS</b>	Acquired Immunodeficiency Virus
<b>HIV</b>	Human Immunodeficiency Virus
<b>FBOs</b>	Faith-Based Organisations
<b>PLWHA</b>	People Living with HIV/AIDS
<b>WWC</b>	World Council of Churches
<b>UNAIDS</b>	United Nations Joint programme On HIV/AIDS
<b>UNICEF</b>	United Nations Children's Fund
<b>MSM</b>	Men who have sex with men
<b>KNASP</b>	Kenya National AIDS Strategic Plan
<b>NASCOP</b>	National AIDS and STI Control programme
<b>NACC</b>	National AIDS Control programme
<b>OVC</b>	Orphans and Vulnerable Children
<b>CIPK</b>	Council of Imams and preachers of Kenya
<b>WCRP</b>	World Conference of Religious for Peace

## **ABSTRACT**

HIV/AIDS represents one of the greatest health challenges confronting the world. The epidemic has evolved to become one of the greatest hindrances to national health of most countries in the developing world. HIV/AIDS has slowed down economic growth, reduced life expectancy and negatively affected development. Responding to these challenges, different organisations have mounted exceptional responses that have drawn on the commitment and wisdom of people from all walks of life.

Worldwide there is evidence of FBOs contributions to health sector. They include providing care and support, building infrastructure, capacity building through training programs and mobilizing large numbers of volunteers to causes they consider worthy. However, FBOs have been accused of being “paper umbrellas” in the rain, exposing the people they are supposed to protect to the HIV/AIDS epidemic. This study seeks to find out how FBOs have responded to HIV/AIDS pandemic in the Kibera slum, Kenya.

I chose to carry out a qualitative study that sought to gather information on the current faith-based HIV/AIDS initiatives in Kibera slum. Through data that were gathered by qualitative interviews from FBO members and people living with HIV/AIDS (PLWHA) the research intent was to understand the deeper structure of the epidemic within cultural and contextual situations.

A strong emphasis has been on premarital abstinence and marital fidelity vis-a-vis condom use. This is attributed to the fact that the organisations’ religious principles and the values that guide them are not conducive of condom use. Some organisations have incorporated other interventions due to the ever changing nature of the virus. Some leaders emphasized the need for providing all the necessary information about condom use for the beneficiaries to make informed choices.

Conclusions were then drawn that FBOs in Kibera are using a multi-sectorial approach to the HIV/AIDS epidemic prevention, care and support interventions. In their comprehensive approach, the FBOs have not only geared their efforts towards behavioural change strategies, but also tackled issues like poverty that predispose people to the epidemic.

Various recommendations have been made, among them the need for FBOs to document their work, the need to expand their network with other secular organisations and the need to

expand their initiatives towards other vulnerable populations like commercial sex workers and men who sex with men.

## **Chapter One: Introduction**

### **1.0 Background**

The epidemic of the human immunodeficiency virus (HIV) and the resultant immunodeficiency syndrome (AIDS) continue to advance relentlessly all over the world. The epidemic continues to evolve, presenting more challenges and new opportunities as the world looks to the future. Areas that were a preserve of the epidemic are springing up with increased cases of HIV/AIDS incidences. Africa remains on the frontline for the disease, counting for the high cases of HIV/AIDS reported around the world (WCC 1997:7).

Globally faith-based organizations (FBOs) are an integral part of life and society found within every community. They have much credibility because of their involvement with the people in every aspect of their lives (Guiney 2012, Green 2003:3). They are central actors within the broader civil society in developing countries especially in Africa (Mallya 2010:131). As social and cultural institutions, FBOs shape social norms, beliefs, attitudes and peoples' reality with regard to sexual self- understanding. This makes them a crucial partner in HIV/AIDS prevention.

In Kenya, like any African country where religious beliefs play a major role in shaping peoples' personal identities, perceptions of diseases and the decisions they make regarding the diseases, faith communities have a pivotal role in determining how individuals, families and the whole community respond to diseases including the HIV/AIDS epidemic, which is the greatest health and development issue facing the country and the continent as a whole. Hayness highlights that "throughout the developing world, it is implausible to believe that religious factors can be isolated from life's general context. This is because, irrespective of which faith we refer to, religions provide necessary concepts and ideas to answer people's existential questions (Hayness 2007:14).

The effects of the epidemic are significant in Kenya, but slums areas have a higher prevalence rate, twice as high as the national rate according to the UN-Habitat report on AIDS in informal settlements (2010). Slums are characterized by poverty that makes HIV prevention efforts extremely challenging. It is believed that FBOs are best suited to spearhead HIV/AIDS prevention efforts by influencing behavioral change.

With the challenge of a high rate of unemployment people are moving to urban cities in search of employment. Due to failure to get employment, many have no opportunity but to move to informal settlements where they are connected by a common pillar of poverty and eventually disease, perhaps this explains why HIV prevalence rates are higher in slum areas than rural areas. For any meaningful gain in HIV/AIDS prevention efforts slum areas cannot be ignored.

The Kibera slum is hit by a double hammer of poverty and disease; the epidemic has exacted an enormous impact in the lives of the people, the epidemic has been called names, stories have been told just to indicate how serious and deeply rooted it is in our societies. From Kibera slum comes this story:

*A widow who lost her husband and her two children plus their spouses to the HIV/AIDS epidemic approached a local priest to ask for prayers. She wanted to know why God has been so “unkind” to her to let such a catastrophe befall her; the local priest is reported to have told her, we will pray so that God gives you strength to overcome this, but after that I will send you to your neighbors. The priest instructed her to go to the first ten homes from her home and pick a flower from such homes that have not buried any family member who have died of HIV/AIDS related sickness. It’s reported that the woman went back to the priest without a flower and confessed to the priest “I’m not alone; I did not find such a home”.*

The story tells how deeply the epidemic has eaten into the community and it is against such a background that this research was done.

Previous studies have pointed out linkages between the involvement of FBOs in activities aimed at HIV/AIDS prevention, care and support and their success in such countries (Green 2003:6-15, Bompani & Mallya 2010: 131-149). While recognizing the FBOs efforts in delivering health services around the globe, what has been missing is independent unbiased analysis of their work and how that work is perceived by others with similar initiatives in response to HIV like secular organizations. Against this background, the study will focus on the initiatives by FBOs in response to HIV/AIDS in Kibera slum.

### **1.1 Statement of the problem**

For three decades with the epidemic communities have remained curiously silent and slow to react to the epidemic that has made such havoc in the community. In these homesteads the impact of the epidemic is highly felt, many people are either infected or affected, the same

applies to attendance of worship places; in every home there must be at least one person affiliated to a church, a mosque or other places of worship. This puts FBOs in a unique position to forge safer sexual behaviors, focusing behavior change communications strategies on the general population and scaling it up on key populations at risk, with an aim of realizing a HIV/AIDS free society.

Various FBOs in the field of HIV/AIDS have responded differently to the HIV epidemic. In most cases they have followed the scheme of denial- condemnation- active engagement (Chitando 2010:218). According to Chitando, in the initial stages, FBOs either completely denied the existence of the epidemic or minimized its impact, while in the second phase FBOs averred that the epidemic had eschatological significance and in the third phase religious groups have sought to provide effective response to the epidemic (Ibid :219).

Significantly few FBO efforts have been appreciated or documented; most of the literature on FBOs initiatives towards HIV/AIDS response is scarce and primarily addresses what FBOs are against rather than their efforts in HIV/AIDS prevention. There is very little evidence to show how the potentials of FBOs have been or can still be tapped in preventing the epidemic. It's against this background that this study examines their roles in HIV/AIDS prevention as well as care and support for those infected and affected.

## **1.2 Study objectives**

### **1.2.1 Main objective of the study**

Given the influence and social responsibility of faith based organizations in addressing issues that affect society, the study examines how faith based organizations have contributed towards the campaign against the HIV/AIDS pandemic in Kibera slum.

### **1.2.2 Secondary objectives**

1. To explore challenges faced by FBOs in HIV/AIDS prevention, care and support within Kibera slum.
2. To examine the communication strategies used by FBOs in their HIV/AIDS campaigns.
3. To explore the perceptions of people living with HIV/AIDS towards the FBOs response in Kibera

### **1.3 Scope of the study**

The study specifically focused on the initiatives put in place by FBOs in the thirteen villages of Kibera slum in prevention, care and support of people living with HIV/AIDS (PLWHA) in order to help them cope with the ever changing face of the epidemic and its challenges. The theory of reasoned action is used to guide this study.

### **1.4 Significance of the study**

The purpose of this research is to understand the deeper structure of a phenomenon within the cultural and contextual situation. According to World Council of Churches, socio-economic and cultural contexts are determinant factors in the spread of HIV/AIDS and they differ from place to place, countries, districts and even villages which results in different HIV/AIDS stories and current profiles (WWW 1997:13-17).

For all stakeholders in the field of HIV/AIDS prevention, care and support, this study will help them identify strengths and weaknesses to be improved. Most importantly it will recognize and cultivate understanding and appreciation of the work of Faith-Based Organizations. In cases of gaps in the study it will help to stimulate a desire for further research work.

### **1.5 Thesis layout**

The work is organized and presented in six chapters; chapter one is the introduction of the study. The second chapter is the review of related literature. Chapter three discusses the methods of data collections; these include the study design, the target group, surveys, ethical considerations and some of the limitations of the study as well as my role as the researcher.

In chapter four I present the study findings. Chapter five contains discussions of the study findings, and in chapter six I present conclusions and recommendations.

## **Chapter 2: Literature review**

### **2.0 Introduction to the review**

In the trying times of HIV/AIDS, FBOs have been accused of being a sleeping watchdog, a paper umbrella in the rain; they have been accused of blocking attempts by secular organisations towards HIV preventions, and they have been accused of harsh judgements on People living with HIV/AIDS based in some cases on misinterpretation of the scripture (Chitando 2007:21).

As a result, our religious institutions have been made into places of exclusion instead of places of refuge and solace where love and encouragement take centre stage. While in some cases these accusations have been regrettably justified, it has not been so always and everywhere. FBOs have always been in constant communication with their people on matters of health.

According to World Council of Churches, the very relevance of the churches will be determined by their response, and it's a challenge for the church to re-examine the human condition that promote the HIV/AIDS pandemic and to sharpen their awareness of peoples' humanity of broken relationships and unjust structures, and their own complacency and complicity (WWC 1997:2). Through this lens HIV has become a sign of the times, calling all faith-based organisations to a fresh resolve to address the challenges directly.

Faith in God has and continues to play an important role in the lives of so many people worldwide. Most people in the world identify themselves as members of one faith community or another and such faith communities are very significant in influencing people's behaviours and attitudes.

According to Jeff Levin, all religions promote belief systems known as doctrines. There are hundreds of doctrines that adherents are supposed to endorse, and these shared beliefs are supposedly expected to shape the behaviours of believers, guiding how they conduct their lives (Levin 2001:20)

### **2.1 Defining faith-based organisations**

There is no single generally accepted definition of a faith-based organisation. Different authors have given a number of definitions. In most cases the term faith-based organisation is used broadly to encompass any religious institution or organization influenced by faith.

According to the centre of Faith and Service (2003), a faith based organization can be a religious congregation (a mosque, synagogue, church or a temple) or an organization, programme or project sponsored or hosted by religious congregations. It can also be a body that is non-profit and founded by a religious congregation or religiously motivated incorporators or has a mission statement that is religiously motivated.

According to UNAIDS' strategic framework, faith-based organizations are diverse in their forms, structures and outreach. In UNAIDS' experience, it is possible to distinguish these communities based on the way that they operate at three main levels, that is the informal social groups or local faith communities, for example: local women groups or youths, second are the formal worshiping communities with an organized hierarchy and leadership, for example major religious faith groupings (e.g. Sunni Islam, Theravada Buddhism or Catholic Christianity). Thirdly, the independent faith-influenced non-governmental organizations; for example: Islamic Relief and Tear Fund. These also include faith-linked networks such as the Ecumenical Advocacy Alliance, Caritas Internationalis, World Conference of Religions for Peace and the International Network of religious leaders living with HIV and AIDS (UNAIDS 2009).

According to the same report all three are important, but the latter provide the most HIV related services. However, it is my opinion that congregations are more in touch with the people than the independent faith organizations; hence it will be critical to look at their initiatives in response to HIV and AIDS.

For the purpose of this paper I will define faith based organizations as the congregations of churches and other places of worship as well as other non-profit religious organizations that are affiliated to these places of worship.

## **2.2 FBOs and HIV/AIDS initiatives**

FBOs' response in this paper refers to various initiatives by faith-based organisations to address the impact caused by HIV/AIDS; this may take various forms, which include training of religious leaders and some members of the congregations in HIV/AIDS management and in turn using them as pillars in the HIV/AIDS in mobilizing, motivating and inspiring their congregations to come out and speak openly about the epidemic.

In Sub-Saharan Africa, religious organisations have the largest number of people under their umbrella; these include ecumenical bodies, faith associations and denominations which have

shown intensified response to the challenges of HIV/AIDS through their commitments and in some cases declarations. FBOs in Africa are characterised by diversity with various modes of expression (Chitando 2007:4). Alongside Muslims, mainline Protestant and Catholic churches, and African Independent Churches have a significant presence and each of them has its own experiences in relation to HIV/AIDS pandemic.

The indigenous and traditional healers are also part of the faith-based organisations since their clients believe that there are spiritual forces at work in the services they offer. Given the number of people who seek the intervention of the traditional healers when in trouble, there is a great need for traditional healers to play a crucial role in the HIV/AIDS response and help with supporting and strengthening it.

### **2.3 Need for FBOs involvement**

When HIV/AIDS was first discovered, the whole world responded to it medically or saw it as a concern of primarily the medical personnel. Later on it became evident that it was not only a medical issue but it was everybody's concern as well. The society needed to get a clear understanding about the epidemic. A continuous interaction with people was necessary to help stamp out the epidemic, and our religious communities were perfect places to be involved.

Religious leaders have great influence in the lives of many people and so does faith (Levin 2001:20-21), and so when leaders speak out responsibly about HIV/AIDS they can make a powerful impact in the HIV/AIDS prevention campaigns at the community level. According to Chitando, the response of African churches to the HIV epidemic will to a large extent be determined by the quality of their theological education; churches with quick feet, long arms and loud voices must necessarily demonstrate compassion towards others (Chitando 2007:57).

FBOs are valued by the poor. Faith groups are present in most frontiers of poverty, division and conflicts. Faith-based organisations witness about bad governance, bribery, poor health and the developing culture of negligence in our societies since they are immersed in communities for long periods and know first-hand the changing living standards of the people (Guiney 2012:113). Faith has become part of the societal lens through which individuals view the society; faith values have become integral pillars in most people's lives, they control people's lives, their process of understanding and they influence their decision making. In most villages, Kibera included, there is a mosque, a temple or a church or a traditional healer.

It's because of this that FBOs are considered appropriate to be cornerstones in the HIV/AIDS prevention campaign.

According to Hayness, religious leaders and institutions are the most trusted institutions in developing countries; indeed religion is still central to the social, cultural and moral life of these communities (Hayness 2007:151). Hayness goes on to state that faith in God and connecting to the sacred in religion are central to daily life (Ibid 2007). According to Guiney, in many slum situations only the local FBOs remain there to provide a consoling presence and keep basic services going when government and other agencies disappear. They sustain communities in their most trying moments and carry out the basic development tasks of education and medical care (Guiney 2012:113).

Many scholars have argued that FBOs can provide strong support in HIV/AIDS prevention campaign. For example, Abdel-Hamed argues that because of the role of religious leaders, bringing them to the field of HIV and networking with them and using faith-based approach will be effective when tackling the problem (Abdel-Hamed 2010:95). Considering that worship places like churches, mosques or synagogues are stable institutions unlike political institutions that are dodged by worries about the next election and autocratic leaders are sleepless of being unseated, attachment to religious absolutes and age-old traditions ensures minimal disruption to the activities of the churches, mosques and other places of worship which makes them suitable for offering continuous and effective services in response to HIV/AIDS (Oladipo 2001:220).

FBOs are in a pivotal position to offer effective responses to the HIV/AIDS since they are an integral part of the society and since they are found within every community and wield a significant level of cultural, political, social and economic influence (Green 2003:4). FBOs are involved with people in all aspects of their lives and they have gained credibility in the course of time for the services they have offered. It is enough to say that faith is part of the societal lens through which individuals view the society.

While some will argue that religious groups are primarily concerned with giving their people spiritual services, contrary to this, faith-based organisations have also expressed their concern with the physical well-being of their communities. Guiney states that some secular agencies see faith as primarily about Sunday, Friday and Saturday, days set aside for worship, they relegate the sacristy roles and singing Alleluia or salaam to agents of faith and religion.

However according to him, in reality the work and roles of religious groups extend far beyond these pastoral activities (Guiney 2012:114).

Faith-based organizations have increasingly been engaged as agents of positive change in the lives of their congregants due to their strong links with the local communities (Green 2003:16-17). Based on this strong link they have created a unique and valuable characteristic that makes them well placed within communities to create an enabling environment that supports sustained behaviour change since they have built a strong network within their communities to undertake the community development.

Since faith-based organisations have some ties to or are connected to religion they can command high support of their followers and high credibility with their target beneficiaries. Their credibility and access to the local communities are a great benefit when disseminating information and increasing knowledge of HIV/AIDS among the people. According to Deneulin and Bano religion is often mentioned by people as an important component of their wellbeing. Development programmes aimed at promoting peoples wellbeing or reducing poverty ought to incorporate this religious dimension, even if it may involve trade-offs with other important dimensions of wellbeing (Deneulin and Bano 2009:49).

Since faith-based organisations command a position of authority within local communities and given their strong ties to religious beliefs, they are able to move with speed so that no time is wasted on building trust and reputation within the communities. In this regard faith-based organisations will always emphasize religious teachings which discourage the activities that are risk behaviours (Messers 2004:41). In some cases the religious teachings alone have failed to achieve desired behaviour change without continuous reinforcement from the religious leaders.

Faith-based organisations in most cases are absorbed in the cultural practices making it easy to effectively do their work, for example the Nomiya Luo church that emphasizes male circumcision will be in line with a conventional approach of reducing the chance of contracting HIV/AIDS through male circumcision. In such cases they will command a greater cultural, spiritual influence because of the integrity and influence within the communities.

In most cases faith based organisations have existing structures to work from; in other cases they improvise. Churches and other religious communities have gathered under trees and on top of mountains to meet and carry out their services. They take this advantage as there is

already a meeting point which is considered holy and respect is commanded within its premises.

They have always had the power to mobilize large numbers of volunteers to contribute; this gives them added strength for the HIV/AIDS prevention. Faith-based organisations have a moral duty to act now and scale up the past work and respond by improving the already existing areas. This helps in reducing HIV/AIDS infection as well as inventing new ways of responding to the HIV/AIDS epidemic.

Religious organisations have been considered to be non-partisan. They serve the whole society and even the government enjoys their support. They have no barriers, serving both the rich and the poor. Faith-based organisations conform to a moral order. They subscribe to a system of checks and balances. Another unique characteristic of religious institutions is their credibility. They are held in high esteem and they are even expected to speak on behalf of the society. Moral authority is conferred on them that obligate them to speak about the moral decay in the society. The church and other religious organisations have among their intangible assets the capacity to imbue the poor with hope, a necessary ingredient for them to keep on going until improvement is affected. Furthermore religious organisations live on faith and hope and they endeavour to infuse hope in all people it serves (Oladipo 2001:219).

#### **2.4 FBOs as hindrances**

Factors that hinder FBOs' response to HIV/AIDS emanate from political, economic, cultural, gender and poverty issues. Lack of knowledge that makes FBOs competent in handling the epidemic is a major issue in the struggle against the epidemic. A community that is HIV/AIDS competent will mean a community whose members are knowledgeable about what HIV/AIDS is.

Messers notes that honesty and humility dictate that churches and other FBOs cannot pretend that they have been in the forefront in the fight against HIV/AIDS in the world if they have been a moral laggard in the struggle, not only failing to contribute of their substantial resources and energy but, worse yet, often creating pain and prejudices for the infected and posting roadblocks for public health officials (Messer 2007:151). To Chitando it's crucial that congregations receive the latest information relating to HIV/AIDS prevention; they need to be reservoirs of knowledge regarding development in HIV/AIDS research and its only when entire congregations become AIDS literate that the idea of AIDS competent congregations can be within reach (Chitando 2007:84).

Many HIV/AIDS local organisations throughout the world lack the competency and capacity to respond effectively to the HIV/AIDS epidemic in their respective communities. While it's expected that the target of FBOs leaders should incorporate prevention strategies that are clearly explained to all the community members, in most cases this is not the case. Leaders in African-instituted churches lack the skills and capacity to deal with HIV/AIDS; the leaders also have limited access to resources and they do not have strong bureaucratic structures. With this challenge, their ability to advocate for the rights of PLWHA is limited as well as the ability to use the right mechanism to stamp out the epidemic even though they might be having an interest in HIV/AIDS prevention. In light of this it is important to determine the ability and competence of faith based organisations in HIV/AIDS prevention within the community.

Lindquist argues that given the nature of faith-based organisations to exist at the grassroots level, the reasons why the churches have not used their positions to prevent the spread of HIV/AIDS is because discussion about sex and sexuality are taboo as the most common way to be infected with HIV/AIDS is through having sexual intercourse before marriage which the church preaches against (Lindquist 2005:60). The church in most cases has concentrated on preaching abstinence as the epidemic continues to move inside its congregants.

Chitando is of the opinion that theological belief and its rigidity have adversely affected the FBOs' response to the challenges posed by HIV/AIDS. He proposes a transformation of theological beliefs in Africa for FBOs to be in a position to meet the challenges posed by HIV/AIDS (Chitando 2007:21). Faith communities have the obligation and responsibility to address the physical effects of HIV/AIDS among their members and the community as a whole as well as all injustices that are exposed through the pandemic. While FBOs definitely need to hold on to the basic truths, the era of HIV calls for a fresh understanding of these truths.

Addressing the flaws of tradition of some FBOs, Ammicht-Quinn and Hacker call for the renegotiating of Catholic ethics for human dignity. They argue that even though it speaks eloquently about HIV/AIDS crisis as far as women are concerned, innocent women living with HIV/AIDS receive tepid response (Ammicht-Quinn and Hacker 2007:96). They further point to the official church calling leaders and governments to serve PLWHA, but investing little energy in empowering them. In addition, recommended solutions are measured in terms of consistency with official teaching about sex, but are not tested as regards feasibility and

effectiveness, nor accompanied by concrete plans for implementation (Ammicht-Quinn 2007:97). Individuals are called sinners, but global structures of sin are not called equally to accountability; as a result, the church response does not relate to the situations of real people, and does little to change the conditions. In such cases PLWHA will not be served until the powerful change their own destructive patterns of behaviour.

For a comprehensive understanding of HIV/AIDS required for a meaningful prevention measures, the history of the epidemic points to the fact that HIV/AIDS was first discovered among the gay community and was referred to as “Gay disease” causing many religious leaders to be outspoken in their condemnation (Happonen 2010:63, Terry et al 1993:33). Since most religious institutions are still slow in accepting the gay communities and have in most cases side-lined them, this has made them shy away and not coming out openly to declare their HIV/AIDS status. This has hindered prevention efforts as the gay community is kept out of the HIV/AIDS campaign while they remain an integral part of the group at higher risk of contracting HIV.

FBOs have been seen as a hindrance to the prevention efforts of HIV/AIDS by some authors. These authors highlight the resistance of religious leaders to condom use, the stigmatization of people living with HIV/AIDS and labelling HIV/AIDS as an immoral disease and also the way in which religious leaders limit free and open discussion about sexuality.

For example, Messers claims that religious barriers that oppose condom promotion can lead to ineffective prevention strategies. He argues that resistance of religious leaders to open discussion of sexuality and their distrust of certain strategies of the disease prevention hinder the ability to prevent the spread of the disease or in most cases increase the seriousness of the epidemic (Messers 2002:101-103). Some writers have even accused particular religions of encouraging a behaviour that leads to HIV/AIDS. They argue that Western Christianity seems to have encouraged in Africa an unprecedented liberty in sexual behaviour contrary to the African communitarian taboo and ritual approach of sexual relations; as a result sexual behaviour is now seen as an individual concern (Phiri 2002:41).

Religious organisations have been accused of being conspicuously absent in the campaign to HIV preventions and it must now rise up and move with speed for an effective HIV prevention care and support. Tsele argues that religious community in general and the church in particular must be called to account for their absence from humans that seeks solutions to Africa’s crises (Tsele 2001:205). He argues that without religion as its base, development

will be reduced to an appendage of capitalist ideology and, therefore, will not offer much to the poor in Africa (Ibid).

## **2.5 The changing contexts of FBOs**

The climate for faith in development is rapidly changing. Donor scepticism is being replaced by active interest (James 2009:6). There has been a resurgence of interest in the developmental roles of faiths, even in such non spiritual organizations like the World Bank (Samuel 2001:238-239). According to him such secular organisations are now actively trying to engage with faith dimension to development. They are particularly interested in local religious institutions' expressions of faith like churches, temples, mosques or Zakat committees (Ibid 2001:239).

A question that needs to be answered is what does the church bring to such a relationship with other secular organisations like the World Bank and the rest? According to Vinay Samuel the “church brings its presence, the church is where the poor are and the church provides dignity to the poor” (Samuel 2001:239). It is such a presence of churches and other religious organisations that makes them appropriate in addressing issues that relate to health and poverty. HIV/AIDS is another cause of widespread poverty due to the deaths of people at their reproductive age.

As donors are questioning the role of state in service delivery, they are realising that in Asia, Africa and Latin America, FBOs have always been important in providing development services (James 2009:7, Hayness 2006:28). This is because poor communities are largely faith -based. In most villages there is a mosque, a temple, a church or a traditional healer.

In recent years, numerous religious leaders and faith-based organisations have begun to engage with partners in the secular development community in relation to health issues in the developing world at community, national and international levels when such partnerships work well, it reflects sustained dialogue, genuine willingness to work together and a clear sense of objectives (Hayness 2007:150).

Even though literature points at the resurgence of religious organisations in development and specifically on health issues, the reality at present is that faith-based organisations are no longer the sole players in the field; neither are they the best players. As FBOs seek to strengthen their legitimacy in this field, they have an obligation to demonstrate that faith-based organisations bring something substantive to the table of development. With well

adopted prevention strategies, faith-based organisations have something to contribute to the reduction of HIV/AIDS in the community and in achieving the millennium goals of combating HIV/AIDS and other diseases. While launching their millennium development goals report in 2000/2001 there was a clear inference to its recommendations for better developmental outcomes: to achieve the millennium development goals in the shortest time allotted - just 15 year- would require utilisation of all currently under-used human resources, including those of faith-based organisations (Hayness 2007:15). Given that the evaluation of the achievement of the millennium goals is just two years away, FBOs need to scale up their efforts, working independently or supplementing the work of other organisations with the same agenda to achieve this aim of realisation of the millennium goal of combating HIV/AIDS, malaria and other diseases by 2015.

Tsele argues that development must be enriched through the faith dimension: “No matter how advanced materially a country maybe, without the dimension of religious experiences and values that progress cannot pass for development” (Tsele 2001:211). He goes on to state that if the developing countries are to mount a formidable challenge to the crisis as defined, they cannot resort to the tried tested modes of development that have been with us for the last three decades; they must embrace a new model that is premised on the realisation that unless religion and religious institutions become active players in this field, developing countries are doomed to repeat the same social and economic failures already experienced (Tsele 2001:216).

The belief that there can be no true or sustainable development without spiritual advancement is, in one form or another, still the belief of the majority of people in the world today. The collective wisdom of the world’s major religions makes quite clear that unless more than a mere improvement of people’s material conditions is aspired to, even that goal will fail”. Human beings cannot as the Christians say ‘live on bread alone’ (Tyndale 2002:45)

## **2.6 Linking, Prevention, Care and Hope**

An HIV prevention, care and support effort needs to be based on an understanding of the cultural and social contexts in which infections occur. Religious communities will find it relevant to use their religious background to communicate their preventive messages. The use of religious scriptures is a foundation for most religious organisations. They stress abstinence and marital fidelity. Faith-based organisations have emphasised the compassionate character of God to appeal to people to be compassionate for those infected and affected by HIV/AIDS.

It is through caring for people those changes in attitudes; behaviours and the environment happen (WCC 97:83). The process of caring is linked to response of people as they move towards their own change and healing (Ibid).

We have now lived for three decades with the epidemic, with no conventional cure and no significant signs of subsiding in the development countries. Its impact has led to hopelessness and despair bringing serious questions about the future. It is against such a background dominated by uncertainty that FBOs must provide hope. The starting point according to Chitando has to be an honest admission that the HIV epidemic has caused untold suffering and death (Chitando 2007:74). He admits that it sounds hollow and insincere to proclaim a message of hope in such a context. However, the church and other religious organisations have no choice. Their very identity demands that they bring a sign of hope.

It is a call for faith-based organisations to grasp this harsh reality of human suffering and recognize the need to transform the present situation. The active participation of faith-based organisations in response to the challenges of HIV/AIDS will be the sign of hope needed by both the infected and affected people. It will help them develop a realistic understanding of vulnerability and risk, know the different preventive options and relate these to their own personal values. Such a hope will motivate them to choose the desirable behaviour, to practice relevant skills and develop activities of compassion and care (WCC 97:83-84). It is therefore the task of faith-based organisations to revive the hope by giving preventive messages that prepare people to take care of themselves and others and to show support for them.

## **2.7 The theoretical framework.**

In the absence of conventional care for HIV/AIDS, changing high risk behaviours remains the only way for its prevention to realise the behaviour change people need to change their attitude towards the epidemic and the attitude towards people living with HIV/AIDS (Terry et al 1993:31-32). Change of behaviour, attitude and practices might come from personal influencers, who have great influence on the people that trust and follow them. Faith-based leaders fall in this category of change agents within the society or at an individual level and become very relevant in addressing HIV/AIDS prevention measures.

### **2.7.1 Theory of reasoned action**

The theory of reasoned action (Ajzen and Fishbein, 1980) was first introduced in 1967 by Fishben in an effort to understand the relationship between beliefs, attitudes, intentions and

behaviour. According to the theory of reasoned action, human beings are usually quite rational and make systematic use of information available to them (Ajzen and Fishbein 1980:5). This theory like any theory based on behaviour change holds more promise of offering some cumulative guide to the development of effective behavioural interventions for HIV and AIDS (Terry et al 1993:37).

The theory of reasoned action has the premise that HIV/AIDS pandemic can be managed by controlling human voluntary action. The theory tries to point out ways to encourage behaviours that reduce the probability of getting the disease and discourage behaviours that have high probability of spreading the disease.

According to the theory of reasoned action, a person's intentions are a function of two basic determinants, one personal in nature and the other reflecting social influence (Terry et al 1993:9). The personal factor refers to the person's judgement that performing behaviour is good or bad. The second determinant of intention is the person's perception of the social pressure put on him to perform or not perform the behaviour in question (Ajzen and Fishbein 1980:6). Based on this argument, a person's attitude toward behaviour is determined by the set of salient beliefs he holds about performing the behaviour and which makes it critical for faith-based leaders to influence the attitude of their followers' beliefs about the disease.

FBOs can be useful in influencing what constitutes acceptable attitudes and behaviour concerning sex, and what can and should be done to counter HIV infection. The person's attitude towards the behaviour is proposed to be influenced by his beliefs about the consequences of performing that behaviour and the extent to which other people would want them to perform the behaviour. For example, using a condom is likely either to reduce one's risk of contracting HIV/AIDS or reduce sexual pleasure, and the person's evaluation of the outcome. It will be the role of FBO leaders to create a positive attitude towards performing the behaviours that reduce the chances of contracting HIV/AIDS.

According to Ajzen and Fishbein, in determining the strength of perceived normative pressure to perform a behaviour, the persons' desire is taken into account since even if the referent is perceived to think that it is good for the subject to use a condom for sexual intercourse, this information will have little influence on the person's subjective norms if he or she is not motivated to comply with the referent's wishes (Ajzen and Fishbein 1980:14). Given that most religions teach abstinence before marriage, faithfulness to one partner and

the value of life, it will be the role of the religious leaders to stress the need for observing these virtues, also when they exist outside these religions.

Since HIV/AIDS is propelled by behavioural factors, theories about how individuals change the behaviours have provided the basis for most preventive efforts, even the nature of faith-based organizations at the grassroots levels in all parts of the society, religious leaders exert influence over and receive trust from their followers (Guiney 2012:113). This research will be guided by the theory of reasoned action arguing that due to their influence, religious leaders have the capacity to change behaviours of their followers by not only changing perceptions of the disease but stamping out the epidemic by exposing the receivers to persuasive communication in the hope that they will be influenced by the information (Ajzen & Fishbein 1980:221).

### **2.8 FBOS as agents of behaviour change.**

Religion's role in combating HIV/AIDS is controversial, yet improvements in the HIV/AIDS depend on the necessity of changing behaviours, and in this respect religious leaders and faith-based organisations can play a significant role (Haynes 2007:155). The reality of HIV/AIDS challenges humanity to change its attitude towards sexuality (Masicame 2005:13). Men and women are called upon to abstain from sexual intercourse before marriage and to show marital faithfulness to one another; these are considered as the perfect ways of living according to most religious teaching. However, religious organizations need to reach out to those who have not lived up to this.

Changing attitude is not an easy thing and the religious communities are required to make it a process of constant teaching. According to Masicame, since HIV/AIDS is mainly transmitted through sexual intercourse, both the church and the society are urgently called to begin looking at human attitudes and behaviours concerning sex in order to break the silence (Masicame 2005:13). Appropriate theological reflection, public awareness campaigns and openly talking about the epidemic are required. For FBOs to be involved as agents of behaviour change they must be willing to offer sexual education that includes HIV and AIDS related issues openly and constantly.

However, prevention is not simple or easy since it demands complete discipline from an individual point, as Messers noted. Prevention requires behavioural change that is difficult and demanding since these are very complex psychological and physical issues (Messers 2007:96). However it still remains the only option available for now since there is no cure at

sight. Using appropriate language can be a practical manifestation of a changed behaviour since words can comfort, annoy, heal or hurt, make us feel included or excluded; what comes out of our mouth reflects our own thinking and can easily influence the action and attitude of others. Changing behaviour can as well mean staying out of the way if we cannot provide a message of hope, a gift of loving care, or theology of life (Ibid 2007:96-97)

Sexual behaviour in the African setting including marriage is very highly influenced by the socio-, cultural and religious norms. Since some religious communities still accept such norms, it is appropriate for FBOs to be in the fore-front to influence behaviour change, not to eradicate the norms, but to help the congregants understand risk behaviour that fuels HIV/AIDS within our society. For instance women have been seen as vulnerable to the HIV/AIDS epidemic by the fact that they are not very much involved in decision making within the homesteads and this includes sexual matters (Phiri et al 2003:11). While polygamy is still valued within some religious institutions it has in some cases shifted focus from the once respected unit that brought people together, to an opportunity for men to keep unhealthy relationships that promote the spread of HIV/AIDS in many cases.

The total change of attitude towards this rests with our faith-based organisations. They should educate people in the dangers of such practices if not well executed, they need to take responsibility. The most effective but also demanding way to prevent the spread of HIV is to empower individuals so that they can refrain from self destructive choices (Knox-Seith 2005:25). This can be achieved by the church and other FBOs by being part of an education program that aims at behavioural change (Kerimere 2010:109, Messers 2007:82).

In order to obtain a total change of behaviour FBOs need to have a balance between safe and rational solutions; the individual's views of morality and sexuality might be inclined to the use of condoms and sexuality but it will be appropriate for FBOs to discuss the course of action open to individuals and to pose alternative solutions, especially when talking to young people. What should accompany the religious norms is a strong emphasis on the epidemic based on strong knowledge of the same since in some instances people's behaviour and practices do not conform to what their society claim as the norm.

According to Messer most religions champion celibacy in singleness and fidelity in marriage, but there is overwhelming evidence in every culture that persons have multiple partners, experience same sex relationship, frequent sex workers for commercial sex and engage in

sexual contacts outside marriage (Messers 2004:41). This force the religious communities to address what people are engaged in and not what people wish they could have been doing.

Despite the fact that HIV/AIDS has no conventional cure, it can be prevented and controlled by creating an atmosphere where the attitude can be changed positively. FBOs can make this credible by its attitude, trust, openness, warmth, and acceptance towards the epidemic and the PLWHA (Ndlovu 2005:36).

Uganda is considered an African success story in reducing HIV prevalence rate. The reason is the early and significant mobilization of Ugandan religious leaders and organizations in AIDS education and preventive education (Hogle et al 2002:6). They mobilized the society in implementing the ABC campaign which included abstinence, being faithful and condom use.

For proper implementation of behaviour change, communication that reaches the general population and key targets, FBO leaders who are influential in the community in which they serve, need to make it a patriotic duty to spread the word. Spreading the word involves not just information and education but also fundamental a behaviour change approach in communication and motivation (Ibid: 4).

Faith based organizations can influence behaviour change to promote prevention through a variety of ways ranging from the reactive passive, like inviting or allowing AIDS educators to address congregations, to be more active, like using the prestigious moral authority of the religion to advocate behaviour such as fidelity or abstinence (Green 2003:16). Green argues that based on research conducted in countries like Uganda and Senegal, FBOs have a natural ability to promote behaviour change because abstinence and marital fidelity are central to the values of virtually all religions (Ibid: 17).

## **Chapter three: Methodology**

### **3.1 Country profile: Kenya**

The study was conducted in Kibera slums in Kenya. Since Kibera's HIV response is guided by Kenya National AIDS' - strategic plan, it is important to present Kenya's profile before entering the study area.

Kenya is a country with a varied landscape and wildlife. Kenya lies along the equator in Eastern Africa, bordering the Indian Ocean and sharing borders with Uganda, Tanzania, Sudan, Ethiopia and Somalia. Kenya covers an area of 582,646 square kilometers with 536 kilometers of coastline.

The terrain of Kenya is very diverse, comprising mountain ranges (most notable Mount Kenya Africa's second highest peak), a series of plateaus in the low belt of inland Kenya, the cool and agriculturally rich Kenyan highlands of the western and central part of the country and the Great Rift Valley. Kenya has eight counties, with a total of 72 districts. The capital Nairobi is its own administrative district.

Kenya has a variety of climate throughout its territory. The southern coastal region is very tropical, experiencing substantial rainfall throughout the year and is known for having high rates of humidity. The north and eastern part of the country is arid and very dry. Nairobi and most of south-western Kenya have temperate climates receiving moderate to high rainfalls throughout the year.

According to the World Vision country report (2012) the life expectancy is 57 years. The main religion is Christianity with Islam being second and mainly concentrated along the coastal regions of the country. The report puts the current population of Kenya at 40,153,000. There are over 40 different ethnic groups within the country.

Historically the main groups (or tribes) are of Bantu descent that migrated from western Africa. The main ethnic groups in Kenya are the Kikuyu, Luhya, Luo, Kalenjin, Kamba, Kisii, and Meru. Ethnic affiliation is a very important part of Kenyan life and culture, as one's identity and customs are directly linked to ethnic identity (World Vision Kenya report 2012).

### **3.1.1 Education and literacy**

Estimates of the Kenyan literacy rate are 90 percent for males and 83 percent for females (World Bank, 2010). The education system offers eight years of free primary education, beginning at age six, four years in primary secondary education and four years university education. Primary school enrolment has increased since the introduction of free primary education in 2003 and currently stands at 83 percent according to World Vision country report (2012).

### **3.1.2 Economy**

In the 1990's Kenya's economy experienced modest growth. The country's economic performance has improved in the last decade, with an average annual increase in the gross domestic product of 4.5 percent (Kenya Institute for public policy Research, 2009). According to the institute report the post-election violence of 2008-2007 interrupted the economic growth although it has subsequently gone up again.

According to the World Bank report 46.6 percent of the Kenyan population live below the poverty line (almost half of the population), and 40 percent live on less than US\$2 a day (World Bank, 2010). The Kenyan economy is predominantly agricultural with a strong industrial base. The agricultural sector contributes 25 percent of the gross domestic product (GDP) with coffee, tea and flowers being the main export products. The currency used in Kenya is Kenya shilling (1 NKR=14 Kenya shillings (2013)).

The poor growth of the economy has contributed to the deterioration in the overall welfare of the Kenyan population. Furthermore the economy has been unable to create jobs at a rate to match the rising labor force. Kenya is ranked among the most economically inequitable societies, the gap between the rich and the poor is wide, and the poorest 20 percent accounts for only 4.7 percent of the national wealth, and by contrast, the richest 20 percent claims 53 percent of the national income (World Bank, 2010). Poverty continues to be a problem. The HIV/AIDS pandemic has also had a devastating impact on all sectors of the economy, through loss of production and labor force. HIV has resulted in severe consequences in households, one out of nine households in Kenya is affected by AIDS, with the head of the household having HIV in more than three out four of AIDS-affected households (NASCOP& NACC, 2012).

### **3.2 HIV/AIDS Incidences and Pervasiveness in Kenya**

The first reported case of HIV/AIDS in Kenya was in 1984 (NASCOP 2012). Since then the epidemic has continued to be a household name in the country. In 1997 the Ministry of Health instituted an AIDS Control Committee and developed the first five-year strategic plan for AIDS control (NASCOP 2005:11).

The sessional paper no 4 of 1997 on AIDS which was approved by the government in 1999 marked an important milestone on the political front and gave an outline of a new institutional framework (NASCOP 2005:11). According to the report, the goal of the sessional paper was to provide a policy framework within which AIDS prevention and control efforts will be undertaken for the next 15 years and beyond.

This was a sign of the clear intent of the Government of Kenya to support effective programs, to control the spread of HIV/AIDS and to promote care for those who are affected. The sessional paper recognizes that responding effectively to the HIV/AIDS crisis will require a strong political commitment at the highest level, implementation of a multi-sectorial prevention and control strategy with priority focus on young people (Ministry of Health Sessional Paper no 4 1997).

In the same year (1999) the Government of Kenya declared HIV/AIDS a national disaster and established the National AIDS Control Council (NACC) to coordinate a multi- sectorial national response and to seek to forge a stronger response in the coming years (NACC &NASCOP, 2012).

A declaration on “total war on AIDS” in 2003 by former President Kibaki and the bringing together of an ecumenical group of religious leaders have been important steps in the HIV/AIDS prevention, care and support efforts (NASCOP, 2005).

According to the Kenya National AIDS Control Council, as of December 2011, 1.6 million people in Kenya were living with HIV, with HIV-infected individuals living longer due to an increased treatment access. An estimated 49,126 people died of HIV/AIDS related causes in 2011. Kenya projects that the number of people living with HIV will continue to grow, placing continuing demands on the health and social service systems (NACC&NASCOP 2012).

The same report puts adult prevalence rate in 2010 at 6.2 percent. Among adults living with HIV, women represent 58 percent; the large number of sexually acquired HIV infections

among women has resulted in a substantial transmission to new born babies, with an estimated 12,894 children in Kenya becoming infected in 2011.

Most new infections occur in couples who engage in heterosexual activity within a union or regular partnership according to the Kenya National AIDS strategic plan. The Kenya National AIDS strategic plan indicates that men and women who engage in casual sex contribute 20 percent of new infections, while sex workers and their clients contribute 14 percent. Men who have sex with men and prison populations contribute 15 percent of new infections, and injecting drug use accounts for 3.8 while health facility related infections contributed 2.5 percent of new cases (KNASP III, 2009).

Awareness of the HIV status is the cornerstone of Kenya's response to the epidemic. In 2010 more than 5.7 million people were tested for HIV through a combination of channels, including counseling and testing in health settings, time limited campaigns and testing centers (NACC & NASCOP, 2012). Currently the country has in place a framework to combat the epidemic.

### **3.2.1 Strategic framework to combat the HIV/AIDS in Kenya**

Kenya's response to HIV is guided by a strategic plan that aims at harmonizing and aligning the HIV-related activities of diverse partners and stakeholders and is coordinated by the National AIDS Control Council. The response builds on robust engagement of civil society and people living with HIV/AIDS (NACC&NASCOP, 2012).

To date NACC has led the national response by coordinating three five-year Kenya national AIDS strategic plans (KNASP), covering the periods 2000-2005 (KNASP I), 2005-2009/10 (KNASP II) and 2009/10-2012/13(KNASP III). The three year plan's emphasis is on effectively responding to the evidence and providing coordinated, compressive and high services (KNASP III; 2009).

In order to provide universal access to essential services, the three strategic plans are organized around three main channels to support their implementation. These are health sector and community based HIV programming, and in addition a new streamlined robust national management and accountability governance and strategic information was created within the National AIDS Control Council (KNASP II, 2005). The first Kenya National strategic plan 2000-2005 basically was a pace setter for the alignment and harmonization of the related activities of diverse partners and stakeholders.

The development of the second Kenya National Strategic Plan of 2005-2009/10 (KNASP II,2005), the theme of which was “a call to action”, followed a participatory process in which all stakeholders, drawn from a cross section of public, private, civil society and faith-based organization and international institutions, were involved (KNASP II, 2005).

According to the plan its goal was to reduce the spread of HIV, improve the quality of life of those infected and affected and mitigate socio-economic impact of the epidemic in Kenya. Following emerging evidence of new infections the third national strategic plan of 2009-2010/13 (KNASP III) was developed.

The Kenya National Strategic Plan of 2009/10- 2012/13(KNASP III), and the last in that series, was developed in 2009 and built on its predecessor’s (KNASP II) key gaps and challenges that led to non achievement of its established targets. Under the KNASP III ending in 2013 with its vision “An HIV-free society in Kenya”, the following impact results are expected to be achieved by 2013; they include the number of new infections to be reduced by at least 50 percent, AIDS related mortality reduced by 25 percent and reduction in HIV-related morbidity and reduced socio-economic impact of HIV and AIDS at household and community level (KNASP III, 2009).

According to the plan this will be achieved by the provision of cost effective prevention, treatment and support services which are informed by an engendered rights-based approach to realize universal access. Secondly by mainstreaming HIV in key sectors through long term programming addressing both the root causes and effects of the epidemic. Another way will be by targeting community-based programs supporting achievement of universal access and social transformation for an AIDS competent society, and lastly by ensuring that all stakeholders are coordinated and operate within a nationally owned strategy and aligned results framework that is grounded in mutual accountability, gender, equality and human rights.

In addition to offering essential care and treatment to people who are living with HIV/AIDS the country has prioritized efforts to mitigate the epidemic’s impact on household and communities. An estimated 1.1 million children in Kenya lost one or both parents to AIDS (NASCOP, 2012). Most children orphaned or made vulnerable by HIV receive no free assistance, which prompted Kenya to call for increasing funding for children-focused support services under the current national AIDS strategy(KNASP III,2009)

The future of the epidemic in Kenya, according to Kenya AIDS Control program report (2012), will be determined in large measure by the country's success in attracting the resources needed for scaling up services. According to the report, the continued Kenyan push to achieve universal access to HIV prevention, care and support would result in 57 percent fewer new infections in 2030. Were AIDS funding to stagnate in the coming years, it's projected that the annual number of new infections and AIDS deaths would be substantially higher in 2030 than it is today.

Despite the major strides that have been made in prevention and control of HIV/AIDS in Kenya, the pandemic still has a solid grip on the country and continues to reverse the gains made in key health programs and the initiatives put in place by various sectors in society. Knowing very well that the war against HIV/AIDS pandemic is yet to be won, the country is still in dire need of more initiatives in response to the epidemic.

In response to the AIDS epidemic, several organizations in Kenya, like in most developing countries, have invested millions of dollars over the past three decades in programs that focus on prevention through behavioral change; many of these prevention programs focus on sexual practices. Key investments have been allocated toward increasing awareness and knowledge, reinforcing attitudes and maintaining interests, motivating people living with HIV/AIDS and demonstrating simple skills, increasing demand for health services and reinforcing behaviors, as well as building social norms (UNAIDS 2009). However not all these programs have proven successful, and sometimes they fail to realize appropriate behavioral change.

Some researchers suggest changing the communication approaches to incorporate other strategies that seek to increase understanding and therefore motivate compliance (Martin 2007:177-178, Ndlovu 2005:36). Others recommend communicating with social, political and cultural contexts and the incorporation of spiritual values for behavioral change (Haynes 2007:163-168, Green 2003:16).

### **3.3 Study area**

The study was conducted in Kibera slum, Nairobi. The Kibera slum is one of the largest slums in Africa with an average population of approximately one million people; it takes up 2.5 square kilometers of land according to UK Kibera. The slum is roughly five kilometers away from the Nairobi city centre.

Many residents of Kibera come from rural areas all over the country with chronic underdevelopment and overpopulation related issues in search of employment in Nairobi city. This multi-ethnic nature of the Kibera population combined with the tribalism that pervades Kenyan politics, has led to Kibera hosting a number of small ethnic conflicts, especially during and after general elections.

The Kenyan government owns all the land upon which Kibera stands, though it continues not to officially acknowledge the settlements (Bodowes 2005:56). No basic services, such as running water or lavatories, are provided by the government but the government has provided a few schools and health facilities though there is still a high demand. There are also private services within the slum. Most houses in Kibera are one room structures made by polythene bags or mud walls with iron sheet roofs.

Daily life in the slum is filled with many challenges and is characterized by the presence of garbage, open sewers that run throughout the entirety of Kibera slum, overflowing with human feces due to lack of proper drainage system. Lack of adequate toilets has led to some residents resorting to “flying toilets” - plastic bags used as toilets and thrown into the streets.

The Kibera settlement is located in two administrative areas, Dagoreti and Langata divisions. The slum is divided into 13 villages with varying populations - Kianda, Olympic, Soweto West, Gatwekera, Raila, Karanja, Kisumu Ndogo, Makina, Kambi Muru, Mashimoni, Lindi, Laini Saba and Soweto.

The accurate measures of the impact of HIV/AIDS in Kibera are difficult to make, but most analysts suggest that the percentage of Kibera population that is living with HIV/AIDS is above the Kenya national average (Bodowes 2005:195). The UN-Habitat report (2010) on HIV/AIDS in informal settlements puts HIV prevalence rate in Kibera at 12-17 percent and Nairobi at 10 percent while in other parts of rural Kenya it is 7.4 percent.

### **3.4 Study design**

This is a qualitative study that has sought to gather information on the current faith-based HIV/AIDS initiatives in Kibera slums through data that was gathered by qualitative interviews with FBO members and people living with HIV/AIDS.

Information was gathered through focus groups and in-depth interviews with FBOs, support groups for persons living with HIV/AIDS (PLWHA), and health professionals who practice within faith-based initiatives and are directly involved in HIV/AIDS interventions. Data was

gathered from five focus groups, three with FBOs and two with people living with HIV/AIDS (PLWHA).

The PLWHA were recruited through the support offices and were mixed groups of men and women. Twelve in-depth interviews were conducted, eight of them with FBO leaders, leaders from selected PLWHA organizations, and with two medical professionals who are affiliated with religious organizations and are playing a role in their HIV/AIDS initiatives and four with PLWHA.

The FBOs that were interviewed were World Vision, Kibera Corp and Community Centre, Toi Mosque, Kenya Mission Trust, Pillars of Kibera, Lindi Mosque, Life Evangelical Church for Community self-help Group, Catholic Relief Services, Ujuzi Anglican Church Youth Group, Pentecostal Church of East Africa (PCEA) HIV/AIDS project, Orthodox's Church Kibera project and New Life Revival Church.

### **3.4.1 Surveys**

Qualitative interviews entail a high level participation on behalf of the informants. In depth interviews seek to encourage free and open responses. Follow up questions provide a chance to clarify and expand on what has been said, and they also indicate to the informant that the researcher is listening. Allan Bryman states that an interview strategy should be characterized by the interviewer clarifying meaning of interview statements but without imposing meaning of interviewer's statements on them. Bryman states that an interview should be ethically sensitive, should be sensitive to the ethical dimension of interviewing, ensuring that the interviewee appreciates what the research is all about, its purposes and that his or her answers will be treated confidentially (Bryman 2012:470-475). The interviews were face to face and characterized by extensive probing and open ended questions. This was to allow the respondents to provide sufficiently complete information.

Qualitative research is also viewed as a means for a dialogue and community engagement on serious health issues. Guba and Lincoln refer to qualitative research both as a set of interpreting research techniques and a discursive space or meta-theoretical discourse (Guba&Lincoln 1994:105-117). They also emphasize the role of qualitative research in a culture centered approach where the researcher becomes "a listener and a participant, who engages in a dialogue with members of the community".

An interview guide with a list of questions that were to be explored was used. The guide helped pace the interview and made the interview flow systematically. Bryman argues that qualitative methods are recommended for complex subject matters where detailed information is sought and where the subject for research is highly sensitive (Bryman 2012:479). This is especially true in issues of sexuality which this research sought to explore. The privacy and confidence provided by face to face interview allowed respondents to reveal more information during the research. The respondent's confidentiality was maintained throughout the interview. The respondents were more likely to report their inner stories during the face to face interview than when given questionnaires.

The advantage of interviews was that it yielded rich data and a lot of new insights. It also provided an opportunity to explore topics in depth. It allowed for clarification of questions increasing the likelihood of useful responses. It further allowed for flexibility in administering interviews to particular individuals or circumstances. The respondents were free to choose where they wanted the interviews to be held and also the timing. The disadvantage of this method is that fewer people are usually studied and it is less easy to aggregate data and makes systematic comparisons (Bryman 470-473).

During the research period, I also experienced disadvantages while interviewing the respondents. Since this is a sensitive topic touching on sexuality; some were not honest and some answered according to what they think is correct and recommended. This was revealed by the inconsistency with which they answered questions, especially those that were touching on individual needs. However, the strong rapport built with the participants prior to the interview, with the aim of building trust and confidence between the researcher and the participants, made the participants relaxed.

In most instances they answered the questions according to my expectations due to the earlier assurance that confidentiality would be maintained during the interviewing and after having signed an agreement form to confirm that.

### **3.5 The target groups**

The study targets are faith-based organizations and PLWHA in the slum of Kibera. Inclusion criteria for PLWHA were that they were of reproductive age, were residents of Kibera, that they were living with HIV/AIDS and must have lived in Kibera for at least one year prior to the interview. The inclusion criteria for faith-based organisations were that should be based in Kibera or having their project in Kibera. Their program must be on HIV/AIDS prevention,

care and support and they should have had a running program in Kibera for at least one year prior to the interview date.

### **3.6 Data Analysis**

A qualitative analysis using descriptive and interpretive techniques followed the transcription of the interviews; an analysis of participants' responses was done thematically. This was by identifying the themes that emerged from the responses, creating a running list of repetitions and metaphors that were repeated across the texts while keeping in mind the original research questions. This type of analysis involves focusing on the general agreement among participants in each group. It requires the researcher to gain a sense of the continuities and linkages between them (Bryman 2012:578-80).

For validity and reliability of study findings, I used a member-checking method. Bryman Allan notes that member checking which consists of the researcher restating, summarizing or paraphrasing the information received from respondents, ensures that what was heard or written was in fact correct. Checking was done continuously during and after each focus group, through repeating respondents' statements and prompting for clarification where necessary. Validity pertains to whether a method investigates what it purports to investigate (Kvale 2009:246). Reliability pertains to the consistency of the research findings ensuring there is consistency throughout the research to counteract haphazard subjectivity (Bryman 2012:46). Probing during the interview was also used to ensure clarity on issues mentioned and to avoid ambiguity and inconsistencies in the reporting.

### **3.7 Ethical considerations**

This study obtained ethical approval from Kenya Research Ethical Clearance Committee. A copy of the research proposal was submitted to the above officials for assessment to verify if the proposed study is in line with the international and national guidelines protecting any human subjects in any research. Clearance was also given by the local provincial administrators in the slum areas (local chiefs). The ethical standards were adhered to. Participation was completely voluntary and participants were free to leave the project at any time, for any reason, without inducement or penalty. Informed consent was obtained before participation and confidentiality and anonymity of data guaranteed by signing consent form and not including the names in the recordings of data and in the final report.

### **3.8 Limitations of the study**

The study experienced several limitations. Qualitative study design which was used provides rich data and specific examples pertaining to the issues that the study sought to explore as I have indicated above. However, as is common with most qualitative study designs, I did not try to obtain a statistically representative sample of the population; in preference a purposive sampling was used. This method does not allow more generalized and quantifiable results on how frequently FBOs engage in particular HIV/AIDS activities and barriers to these activities. Rather, the study results contribute towards establishing the range of ways that FBOs address HIV/AIDS and range of barriers to these activities which can set the stage for further research.

Despite the strides that have been made to create HIV/AIDS awareness, many people living positively with HIV/AIDS are not willing to discuss it openly. This was no different in the Kibera slum. It was difficult convincing the participants that it's true their identity will be sealed and that the research was not connected with any financial or material gain.

As many respondents that accepted the interview, just as many declined. The majority of those who refused cited so many people interviewing them and giving them promises that they had never fulfilled. They felt that they were being used to gain money from donors while themselves they gain nothing, a statement I could not verify since I was also conducting research in Kibera and bringing the data to Norway. Maybe another researcher will be told the same about me. I explained to them the purpose of my research and those who understood my purpose accepted and those who found it unconvincing refused to be interviewed.

#### **3.8.1 Insecurity**

Insecurity in Kibera is an issue of concern. Like any other slum in the world, harsh economic conditions and a high rate of unemployment make robbery a day to day activity in the slum. I was warned that I should never walk alone with a laptop after an interview because they would think that I'm carrying money with me or it might simply attract them.

I found it was also dangerous to venture into some parts of the slum so I had to make appointments with one of the persons I was assigned to by the FBO leaders and at the same time book an appointment with my respondents. In most cases it was time wasting as both could not meet on time as per our schedule.

### **3.8.2 Privacy of the respondents and the environment**

As much as the researcher and the respondents try to find the most secure environment where PLWHA could share their experiences, this was not an easy task in the slum of Kibera. The temporary structures close to each other with cracks in the mud walls made it easy for a neighbour to follow word by word whatever was going on in the next house. This did not allow for full privacy and the noises that sometimes came from the neighbor's house. In some cases we had to move out to look for a different place either under a tree or in the restaurants; a lot of time and efforts was spent trying to find suitable environment where we could share freely. Even inside the restaurants passers-by were curious to know what was going on.

### **3.8.3 Finance and time.**

Poor time management coupled by demands for money resulted in a lot of time negotiating with PLWHA. I had to explain each and every time before the interviews the purpose of the research and that it carried no economic benefits to either of us. A lot of time was also spent on preparations for the interview. Many respondents who were running their small scale income projects had to finish with their business before they could spare me some time even though an appointment had been booked prior.

In light of these problems, it is important to note that this does not invalidate the findings. In cases of lack of privacy we wasted time but in the end we found a place where we felt we were free to conduct the interview. In cases of people who never turned up, a representative sample was drawn from the population from different areas of the slum.

### **3.9 My role as a researcher**

One of the dilemmas of a student researcher studying in Europe and collecting his data in a developing country is to balance the expectation of the participants who feel that the research will benefit them economically, the participants who in most cases live in contexts characterized by deprivation, marginalization and lack of power. They always complained of researchers giving them false promises and according to them using the data gained from them to get money once back in Europe.

I attempted to communicate openly and respectfully and to be honest about my research intentions. I did not want to create an image of a savior. I was there mainly because I wanted data for my master's thesis, and I was there on moral and ideological grounds. I also wanted to learn more about the daily lives of PLWHA and the faith based organizations' activities. Yet I had to draw personal limits in order not to be engulfed in the perception of being a

helper without boundaries drowning in requests and needs. Even though I did not feel particularly rich, to them I was. Requests for money, transport fares and other favors were endless. Turning down all requests would have been hypocrisy, after all I needed them. Communication and exchange of different views and opinions in a supportive environment were instrumental in establishing a good partnership.

In most cases the PLWHA and I entered into continuous negotiations about all aspects of the projects and our relationship, and often settled on compromises. For example, the participants wanted me to sponsor them with lunch and fare after each interview. I could not offer both. We decided lunch was most important, and so we implemented that decision. In all negotiations, I emphasized that I could not promise more than I could keep, but that I would keep the promises that I made, for I was also looking for my life as a student at the end of the data collection.

Occasionally I took the role of a counselor having been born and brought up in Kenya under almost the same grinding poverty, and having lived in Europe for six years gave me the opportunity to understand both situations and expectations. Being with the PLWHA every day during my research gave me a better picture of how religious organizations interact with PLWHA in the campaign against HIV/AIDS. Time spent with the FBO leaders in the slum was equally rewarding. The responses from all the categories of my respondents were a good foundation for unearthing the response of faith-based initiatives in response to HIV and AIDS in Kibera slum.

## **Chapter Four: Findings**

### **4.1 Introduction**

The study with FBO leaders and PLWHA not only described the range of HIV/AIDS related activities in which FBOs were involved in Kibera slums but also provided insights into ways in which FBOs are suited to get involved as well as challenges and barriers that can hinder their effective involvement.

These insights are important considerations when examining the role of FBOs in the HIV/AIDS response since they point to areas of particular strength and how their involvement could be improved as well as how these challenges experienced by faith-based organisations in Kibera need to be addressed to enhance effectiveness.

This chapter reports on these key findings, by describing the FBOs initiatives towards HIV/AIDS within Kibera slum, their communication strategies, why respondents prefer FBOs services and then pointing at the challenges experienced by FBOs in the wider Kibera slum; these include some of the things that the study noted that FBOs were not doing well or what was not within their reach but necessary in the HIV/AIDS prevention.

The study came up with several key findings, identified on the basis of the recurring themes from the focus groups' discussions and in-depth interviews, guided by the research questions that helped focus on the study. I started with the respondents' background knowledge of impact of the epidemic in the community and the role of faith-based leaders and members in preventing the widespread epidemic within the slums.

Based on their responses, the initiatives ranged from prevention measures, provision of care and support for people living with HIV/AIDS, through meeting their basic needs - food, clothing and care for orphaned children to social and psychological support. Prayer and faith healing notably were used in conjunction with medical interventions in some cases while in some cases it stood alone.

Their communication strategies included among others, support groups and peer educator forums, FBOs awareness meetings and counselling strategies. The study confirmed the relationship between the participant and faith-based organisations. Participants were then asked the role of the faith-based leaders in HIV/AIDS prevention.

A common response was that faith-based leaders are responsible for giving spiritual guidance, communicating with the public, and giving guidelines on how to improve lives and about issues affecting their society such as HIV/AIDS and other risky behaviours contributing to its infection. This is based on their social status and the trust they command in people's lives as emphasized in the following comment:

*When our pastors tell us to pray for somebody daily we make it a responsibility, when he says we meet for prayers we do exactly that. We always do what our leaders tell us to do with lots of respect since they represent our saviour (Female PLWHA).*

And another respondent noted that in the situations requiring personal attention,

*They give personal visits at any time when they need us we always avail ourselves without hesitation". Many participants gave instances where they had consulted with faith based leaders about their problems whom they felt were more capable of helping than anyone else including close family members (Female PLWHA).*

When asked the same question, faith-based leaders also acknowledged that HIV/AIDS was an issue that required their complete dedication, and many of them indicated their involvement either directly or indirectly in addressing the HIV/AIDS epidemic. The extent of their involvement varied, but in general, all FBOs indicated some form of initiative to address the epidemic within Kibera slums.

#### **4.1.1 Spiritual healing**

Spiritual healing is one of the FBOs initiatives for Kibera slum and valued by most respondents who are attached to a particular religion. Spiritual practices such as prayer, meditation and laying on of hands can contribute to healing according to the respondents. It was evident that the role spirituality plays in people's health is widely appreciated within FBOs. As one FBO leader indicated in an interview:

*In my work as a pastor, I see that religious people tend to come out strongly in times of illness as a result of spiritual interventions. I believe that spiritual forces can enhance the healing process (Male FBO leader).*

Having realised a general consensus that people's faith and spirituality contribute to healing of various illness, I asked participants about their views on HIV/AIDS healing given the fact that there is no conventional cure for the disease at present. Again a majority of the

respondents emphasized the power of spiritual forces such as prayer, meditation and laying on of hands in healing, regardless of the nature of the disease. Demonstrating the role of prayer, meditation and laying on of hands in HIV/ AIDs cure, one focus group participant amid support from others indicated:

*Doctors treat but God heals and he does that through prayers. I believe in prayer and anointing which is a healing power (Male respondent).*

Many respondents share this opinion in all group discussions, giving numerous examples where they believe people with HIV/AIDS need prayer for relaxation of mind and healing of the mind created by the fear of the disease. It was acknowledged that PLWHA rely on prayer and spiritual healing by anointed leaders. The FBO leader's role in healing was confirmed by several respondents; even though none among the respondents interviewed claimed to have that power, they indicated the existence of that power to cure several illnesses, showing strong belief in the role spirituality plays in healing. The general view was that faith-based leaders play a significant role in the healing process.

*Since I tested positive it has not been easy for me, I could not believe it, I lost weight but upon talking to my leader in the congregation I turned to prayer as I take my drugs. I now feel relieved, I believe we can't ignore the spiritual part of our lives; we have to take drugs, pray and follow our doctors' advice (Female PLWHA).*

#### **4.1.2 Spiritual support and psycho-social support**

FBOs in Kibera have been concerned with the provision of social and psychological support to PLWHA and the affected members of the family. In all the focus group discussions, members indicated a strong link between them and their FBO leaders. They talked of constantly going to their religious leaders for prayer and meditation. They recognized the role of counselling in their lives both and after testing by their FBO leaders. The majority admitted most counselling had taken place after testing HIV positive.

*At first I did not know what it was all about, how to approach it, so I went to my church leader. He talked to me, encouraged me that God is in control just play your part and take the drugs as per doctor's instructions. I now feel better and ready to handle my situation (Female PLWHA).*

Throughout the study, PLWHA emphasized the role their faith-based organizations have played to improve their lives especially after they tested HIV positive. This is a time when,

without the spiritual support, some respondents in the slums indicated experiencing difficulties in life, giving up in life and in some cases contemplating suicide or ending up getting some diseases that are associated with stress which worsens their conditions.

*It was the most trying moments in my life, I had warned my husband against that woman, it was rumoured here in Kibera that he was HIV positive, so when I tested positive I knew it was my husband who infected me, I felt betrayed and felt life was worthless, I felt I should end my life. After a thought I decided to go to see my church leader because I had no one else to talk to. He talked to me and I told him what I had (Female, PLWHA).*

Faith-based leaders during the study indicated there was a need to give PLWHA psychological support, counsel them, meditate and pray with them as well as their close relatives. As was indicated by one FBO leader:

*The prayer and spiritual counselling we give to PLWHA will always give a sigh of relief to them as they suffer to gain back confidence in their lives, by expressing their pain, anger, guilt, despair and hope in the presence of their leaders they get relieved and find refuge in their leaders (Female FBO leader).*

According to another FBO leader,

*The role of FBO counsellor in the counselling process is to listen, spiritually guide the dialogue, confront PLWHA with reality of living a meaningful life with pardon and reconciliation to make better adjustments and decisions concerning their new way of life by providing them with information about HIV/AIDS relevant to their current and future needs (FBO leader).*

#### **4.1.3 Alternative employment or income generating projects**

Due to the nature of life in the Kibera slum characterized by poverty and unemployment, poverty in some cases has caused many people especially women to have unsafe sexual relations for monetary gain and as a consequence contract HIV/AIDS. Poverty has intensified the struggle as many people lose their ability to earn an income, especially when bedridden since the majority in this area rely on manual jobs for their living. Though in most cases antiretroviral drugs are given free of charge, the same FBOs in their awareness campaigns have always preached good diet to accompany the antiretroviral for better living. Given that most PLWHA in Kibera are poor and vulnerable, FBOs in some cases have started small

scale businesses or income generating projects to engage them and enable them earn something for their daily livelihood. As one FBO leader commented,

*As a person continues to live with HIV/AIDS he/ she suffers from opportunistic infections for which he/she seeks treatment. In the process they spend a lot of money on medical care as well as on nutrition and supplements to help them remain healthier for a longer period of time. Though we provide some drugs and food this can't sustain for long and hence the need to empower them to have some small scale projects to sustain them (Male FBO leader).*

Giving economic capital to PLWHA has been an incredible source of strength, courage and hope to them, as was stated by one respondent:

*Since we started our basket weaving and car washing businesses, I can say life has been better, at least I can take with me something home for my family; besides I find that I'm occupied most of the day (Male PLWHA).*

The above statements indicate that the FBOs have a long term strategy to offer a long term solution to PLWHA so that in the future they can continue supporting themselves without the support of FBOs or other secular organisations.

#### **4.1.4 Support programmes for vulnerable and orphaned children**

In the African set up it has been argued that there exist nothing like an orphan. Children belong to the community. Children who lost their parents were being adopted by their relatives or close members of the community. In most cases, these adopted children would enjoy the same treatment their relatives gave to their children including basic needs. But with increased number of orphans and decreased number of potential caregivers, and willing relatives to take up the challenge, orphans have faced many challenges due to the loss of their parents thus calling for new ways of helping them cope with demanding situations they have found themselves in.

In most cases HIV/AIDS attack people of child bearing age. As a result its impact on children is another matter of concern in the Kibera slum, and the FBOs interviewed had a general consensus of the need to address the issue. It was revealed during the study that vulnerable children, whose parents are ill, are coping with the psychological burden of watching their parents lose strength and the economic burden of reduced productivity and income.

These children also face stigmatization and lack of love and care. They always suffer from external emotional distress, lack of food, lack of health care and no access to school or drop out of school as a result of lack of support from the sick parents. Within the Kibera slum, the HIV/AIDS orphans too are at risk for exploitation such as sex trafficking, homelessness and exposure to HIV/AIDS. These children most of whom reside with one of the parents after the death of the other or in some cases live with relatives in case of the death of both parents have little to count on in terms of basic needs.

Increasingly extended families of the orphans and vulnerable children (OVC) within the Kibera slum find their resources inadequate to provide the basic needs for their children. FBOs within Kibera have organised lunch programmes in schools to save these children from the burden of walking home from school over lunch breaks, only to find nothing on the table. According to one FBO leader these children used to sit inside the classrooms as they waited for the lunch break to end so that they can resume their afternoon lessons. The programmes have been of great help to them as was noted by one leader:

*The feeding programme has been useful to them; we can see significant improvements in their academic performance. We ensure continuous monitoring of the children's wellbeing (Male FBO leader).*

In addition they provide basic school necessities for school going children like uniforms and stationeries. The Kibera slum is hit by a double hammer of HIV/AIDS and poverty, there are many vulnerable children, those whose parents are ill and may not receive the support they require from parents and in extreme cases, the roles in the households have been reversed and the children have become their parents care givers.

The FBOs in some cases arrange for members of the congregations to visit and help with household chores and give them necessary psychological support even though they admitted that this is not offering a permanent solution. It helps the family feel loved and cared for. One respondent was quick to note this:

*When I was down, my congregation members were coming in turns to have a conversation with me and my children and assist them in household chores (Female PLWHA).*

Children affected by HIV/AIDS suffer anxiety and fear during years of parental illness. In some cases they just suspect or are totally ignorant of what kind of disease their parents are suffering from. This only adds to the stress they undergo since it's hard to find laughing

moments within such homes. The worst scenario of their parents' death comes with grief and trauma for the children. Cultural taboos surrounding the discussion of HIV/ AIDS and death in the African set up often fuels this problem. Children and their care givers need love, psychological and material support to express their feelings without fear or stigma and discrimination. In some cases FBOs organise counselling sessions to assist ill parents in disclosing their HIV status to children and other family members, where desired and appropriate. One responded noted:

*.... It was good that we sat down and I explain to my children what was happening with assistance of my pastor. It brought an end to my days of hiding with my anti-retroviral drugs, nowadays; they even remind me when time comes for me to take drugs (Female PLWHA).*

#### **4.1.5 Di-stigmatising HIV/AIDS**

There was an agreement among respondents that language in some cases had been used by FBOs leadership, supported and propagated discriminatory views towards PLWHA within their religious communities, even though they admitted that the cases of stigmatisation have gone down. The study revealed that it still exists in the community.

*In the beginning it was rather not very kind because whoever declared her HIV status in the church was looked at as a sinner and I think our congregations have played a role in enhancing stigma which was very bad. Today at least you can have some who will understand your situation (Female PLWHA).*

Respondents cited some leaders making use of religious teachings to ascribe blame without regard for a deeply HIV/AIDS polarised society that needs to be met with lots of care. According to the respondents, many of the traditional religious solutions offered by our congregations sometimes did not address the significant acquisition risks faced by vulnerable groups, such as women in the Kibera slum. One leader commented:

*Not all men and women who get infected in this slum have had sex with more than one partner. They are faithful but infected so to argue that if one wants to escape HIV/AIDS he should come to Jesus and get married in church and things will be fine without proper education to both parties throws the whole congregation in disarray (Male FBO leader).*

However, the respondents noted the about turn that the FBO leaders have made in reducing this stigma that hinders people from being open about their status in the congregations, by involving PLWHA in the activities of the congregations. This involvement has made it

possible for PLWHA to break the silence about their status as one respondent indicated in an interview:

*When I was appointed to lead the choir, members were a bit reluctant to accept me since I had declared I was living positively with the HIV/AIDS but after a meeting with my pastor and the choir members, I now enjoy support of every member of the team (Female PLWHA).*

On the other hand, changing attitude has been attributed to increased knowledge among congregants through FBO leaders. The respondents applauded FBOs for accepting HIV/AIDS as a problem without borders and for sharing this message in their faith groups:

*.....Today our leaders are emphasizing that HIV/AIDS can get me but it can also get you, so we should support PLWHA in the community because it is our collective responsibility to keep them feel loved and cared for (Male PLWHA).*

Though the respondents indicated that FBOs are armed with better information to fight discrimination and stigma within their religious institutions, they admitted it still exists but with fewer incidences. The respondents also indicated that FBOs are better placed to reduce stigma and discrimination due to their social influence in society and the availability of religious resources as one leader noted:

*When teaching about stigma reduction, sometimes we use biblically related materials such as the stigma of leprosy, Jesus healing lepers and showing them love. We refer them to go and read these stories and they come back inspired by them (Male FBO leader).*

The respondents also acknowledged the community mobilisation efforts by FBOs that have led to increased engagement in prevention services such as voluntary counselling and testing. Through these efforts as well as educational and outreach programs, FBOs were observed to contribute to reducing stigma and discrimination in the community. FBOs have continued to educate people about HIV/AIDS and the more you educate, the more you change their minds and perceptions about the disease.

#### **4.1.6 Mobile clinics**

Some FBOs in the Kibera slum also provide medical assistance and support for physical needs. The Life Evangelistic for Community Self Help project runs a health clinic within the church compound that provides care and treatment for all illnesses within their reach, including those that are AIDS-related. In complicated cases they do referrals to better

equipped hospitals. The mobile clinic has an office within the church compound and usually goes round in congregations to offer medical services and offer voluntary counselling and testing services. The FBOs are assisted by professional medical personnel, in most cases nurses or clinical officers, and congregations members who are living positively are sometimes used in counselling sessions. One respondent noted:

*There are so many people who get tested and treatments for their HIV related illness whenever we visit their places of worship; though the number is big we are coping up with their demands (Female nurse).*

Many respondents stated preference for FBO clinics where according to them AIDS is treated like any other disease and they are handled in most cases by people they trust. The clinics are also affordable due to subsidies from the faith based organizations; respondents also noted that their focus on prayer in addition to treatment puts them in favour of the people of Kibera.

Notable was the Toi Mosque youth centre which promotes healthy lifestyles and integrates HIV/AIDS issues within its programs. They had a discussion group called ‘*Bunge la Afya*’, the Kiswahili words for health parliament. Though it was just picking up, they had involved a clinical officer who is sponsored by a secular organisation who meets with the youths in the mosque compound to attend to all illnesses within their scoop and gives references in other cases. The programme was targeting youths to come forward and be tested to know their HIV status. The health official had this to say about the programmes:

*Though our targets are the youths, we welcome everybody to come forward and have HIV test since this is the cornerstone to HIV/AIDS prevention. All our initiatives start by one knowing his or her HIV status (Male health official).*

#### **4.2 Communication strategies by FBOs in the Kibera slum**

Participants stressed the need for FBO leaders to be in the forefront in the HIV/AIDS prevention campaigns given the benefit of the relationship of trust and openness with the people of Kibera. When asked about the appropriate ways they consider suitable for FBOs to communicate their messages to the people of Kibera, participants came up with several ways they consider appropriate within the slums. Some participants were comfortable with information communicated to them by their peer educators and in support groups, others preferred FBOs organizing awareness campaigns while to some counselling by FBO leaders and peer counselling meant a lot.

The study revealed a consensus that open talk about the epidemic was a cornerstone in creating awareness of HIV/AIDS and understanding how it can be transmitted and the perception of individual risk.

#### **4.2.1 Support groups and peer educator programmes.**

This is a means by which people who find themselves in a similar situation can meet others in the same situation so they can encourage each other and share their experiences. One respondent had this to say about her experience with the support group meetings:

*It came with confusion, I could not see any meaningful life after receiving my results, but through support group meetings I found that I'm not alone, I got encouraged by other peoples' experiences and gained more knowledge on how to maintain the disease.*

It was also revealed that apart from meeting people they trust in the support groups, it gives them the opportunity to learn more from people who have lived with HIV/AIDS for a longer period and are more knowledgeable.

The study shows that meeting others with the same problems is a great way to encourage PLWHA since there is no fear, embarrassment or stigma about the disease. Good support groups are characterised by openness, courage and honesty which they bestow in their FBO leaders. From her experience of facilitating such groups one participant responded by saying:

*In some cases, members of a support group will even make fun of their situations; they appear as if they are in another world that nobody but them understands. They feel relaxed and ready to share and learn (FBO leader).*

The peer educators in most cases are more influential within such groupings than people from outside and as a result, it may have greater potential to effect behaviour change. Within the Kibera slum support groups are used by the FBOs to foster specific behaviour practices among PLWHA, affected families and the community they are working with; they are also used within the slum to complement, not to replace, the work of professionals.

#### **4.2.3 FBOs awareness and swop meetings.**

In the Kibera slum many FBOs organize regular awareness meetings that address the various issues related to HIV/AIDS. These seminars are organised separately for the youths, women and men and are highly motivating and interactive. It was noted that some FBOs have health professionals who take the initiative to implement such programmes with the support of their

religious leaders. Some of them collaborated with secular organisations that also operate within the slum, such as Medicines Sans Frontieres, but they are conducted mainly within religious contexts. In some cases they take part immediately after a worship service or a special date is organised. Leaders give relevant information on HIV/AIDS as per the theme of the day and participate in prevention programmes. One respondent noted about the meetings:

*The ever changing scene of HIV/AIDS epidemic requires everybody to have accurate knowledge and be updated with latest information about the disease for any meaningful gain to occur in its prevention efforts (Male FBO leader).*

According to the respondents, small group meetings are effective in HIV/AIDS education. They are also considered effective when addressing the acceptance that they are living with HIV/AIDS, particularly when PLWHA are involved in the process. Through small group seminars and workshops, participants get the opportunity to gather information on various AIDS related issues, but also the opportunity to meet and share experiences as well as receiving a fresh look of life knowing that one is not alone.

The whole community engagement and education that bring behaviour change on the HIV/AIDS epidemic was mentioned as a key prevention strategy. FBO leaders noted that given the widespread epidemic, there is a need to address it openly and create awareness of the disease not only for educational purposes but as a way of addressing HIV/AIDS related stigma within our religious institutions. From the focus group discussions, one male participant noted, amid support of others:

*There has always been something new to learn about every time we meet, it gives us an opportunity to learn and get more updates about the disease (Female PLWHA).*

FBOs in Kibera also occasionally organise ‘swop meetings’ where members bring goods they have at home and are not using them currently or simply want to help others with; they might be clothes, furniture, utensils etc. Such meetings are organised so that members can get something they need and can’t afford to buy. The study revealed that such meetings have proved helpful as in some cases outsiders came with things they donate to the congregants. Even though the whole congregations are involved the leaders ensure that PLWHA and vulnerable children get first priority. Since the material aspect of it attracts many, FBO leaders use the platform to pass across information to the public.

#### **4.2.4 FBO leaders and counselling**

The study reveals that most PLWHA find it appropriate to discuss their personal problems with their leaders with a view of getting a solution. The participants found counselling a suitable way of communicating information since apart from sharing their problems together it gives them the assurance of privacy from their religious leaders. As one leader indicated:

*At first they will always come up with phrases similar to this..... I have thought about who I can share with this problem and finally you came to my mind (Female FBO leader).*

The leaders indicated that the counselling strategy works within the slum given that many have reported back to ask for information they did not get clearly, a sign of follow up on the part of PLWHA. However, the leaders stressed the need for more FBO leaders to be trained in counselling to enable them to handle the complex situations.

#### **4.2.5 Sports and recreation**

Kibera slum is known for producing young talented sportsmen. FBOs have put in place a sports programme targeting the youths. Congregations through the support of their leaders have put in place a series of football tournament for the youths. The tournaments are arranged over the weekends and various youth teams meet in their various training grounds for practice before the day of the tournaments. Sports facilities like trophies, balls and uniforms are donated by church members and well-wishers.

This is a behavioural change intervention that involves using football for both boys and girls to keep them healthy and keep them off from destructive behaviours. Before the beginning of such tournaments, the participants assemble in a football field where they are served with snacks and information about HIV/AIDS delivered to them. Some of the uniforms that the players use in the tournament carry HIV/AIDS messages such as “people living with HIV/AIDS need love and care”. I know my HIV status and you? Such occasions are sometimes used to inform the youth on importance of HIV testing.

Religious leaders and sometimes health professional used these forums to educate and encourage them to go for HIV/AIDS testing. The leaders emphasized the need for a development of manuals for such activities by religious organisations to enhance their effectiveness.

### **4.3 Respondents' choice of FBOs**

The study also sought to establish what encourages the respondents to continue visiting various faith-based organisations for their care and support. The study revealed that PLWHA are mostly associated with the FBOs due to their deep roots within the community and hence easy to access anytime.

*One thing I like about our centre is that we can pop in anytime to talk to our pastor on what to do in case of a problem. She is always available to assist (Female PLWHA).*

Their community based response takes faith-based organisations services closer to the people, hence their popularity with most respondents. Due to the availability of a ready audience in the places of worship, they are in a unique position to raise awareness and diffuse potential prevention messages.

Further response indicated that FBOs had wider approaches in terms of reaching out for support and care. Given the diverse nature of HIV/AIDS as both a medical and a social problem, the epidemic not only requires medical solutions but also other aspects of interventions, including spiritual intervention require that FBOs have various ways of tackling the epidemic from all fronts.

The FBOs' background of having a faith component or using faith as their backbone in all operations was another reason for most respondents being comfortable with them, as one participant noted.

*Faith-based organisations are governed by some principles of the faith they associate themselves with, the background of faith lays the foundation for what they do and in most religion it calls for values of compassion, love and care, which is instrumental in HIV/AIDS prevention, care and support (Male PLWHA).*

The most significant asset of FBOs is addressing the need of people living with HIV/AIDS in a holistic way meeting the physical, spiritual and emotional concerns of the individual and community as a whole.

The respondents also mentioned hospitality among FBO workers whom they considered friendly and understanding and ready to listen. On further probing, the respondents also indicated free medical services or in some cases subsidised costs for those opportunistic

ailments that are within the FBOs' reach and free antiretroviral drugs as one of the reasons for sticking with their FBOs.

#### **4.4 Challenges faced by FBOs in their response to HIV/AIDS**

FBOs have made contributions to HIV/AIDS control and prevention globally. They have been present at the frontiers of behaviour change. At the same time they have been accused of standing in the way of the campaign to prevent the HIV epidemic. In Kibera as the study has indicated, FBOs have much potential based on their grass roots connections, trust and availability of their leaders to the people. There are however several criticisms of their approach in some of the touchy issues of sexuality. They also face some challenges in administering their services to the people.

It was evident that the majority of the FBOs that participated in the study had a program in place as it was indicated when identifying the FBOs. However, there are several FBOs in Kibera with no proper HIV/AIDS response policies to guide their activities. Some FBO leaders lacked commitment to the HIV prevention efforts. Respondents associated lack of involvement of some FBO leaders with lack of knowledge and the capacity of the FBOs to deal with the epidemic, as well as the general view of looking at HIV/AIDS as a sinner's disease, a view which to some extent still exists within the FBO bodies.

##### **4.4.1 Problems of addressing sexuality openly**

In the African societies open talk discussion on sexuality is socially discouraged, especially between the elderly and the youths. Indigenous religions too tend to link it to the spiritual world. The linkage between sexuality and privacy in the African setting can have a negative impact on the spread of HIV/AIDS given that so far the major mode of HIV transmission in sub-Saharan Africa has been heterosexual activities.

In spite of their role as behaviour change facilitators, addressing the issue of HIV/AIDS epidemic comes with some challenges to the FBOs and their leaders. The nature of the disease involving sexuality represents a hurdle for addressing the issue effectively. Sexuality and sexual orientation are not openly discussed in Kibera slum and the Kenyan society as a whole. This limits FBO leaders in discussing HIV/AIDS related topics with the people involved.

Some people consider it a taboo to openly talk about it while others simply think it's a shame to talk about it openly in religious forums. Throughout the study there was concern about lack

of open talk on sexuality related issues even among people in sexual relationships. As one leader commented:

*It's almost a normal thing here that sex related issues are forbidden to talk about in the open; even people in relationships admit that they find it hard to have an open discussion about sex. Others consider it a taboo (Male leader).*

Such beliefs put FBO leaders in difficult situations in addressing HIV/AIDS related topics. Many are still struggling with the challenge in the Kibera slum on how to effectively discuss such topics freely, while some FBOs deny their existence in their communities. The majority has accepted treating sexuality as a private issue and therefore not talking about it which contributes to the spread of HIV/AIDS epidemic. This is reflected when one partner sneaks and goes for testing and then, after finding out his or her status, he or she hides it from the partner and starts taking antiretroviral drugs secretly without informing the other partner. Another instance is where sexual partners fail to discuss and reach an agreement on whether to use protection during sexual intercourse just because of shyness or mere embarrassment over discussing the issue of sexuality.

#### **4.4.2 Sustainability of programmes**

The study revealed that FBOs rely mostly on donor budgets and face uncertainty for their programmes when the donors withdraw their support. Even though the study indicated that some FBOs have started some initiatives that will ensure continuity of the programmes, like soap making, car washing and basket weaving, respondents indicated uncertainty and insecurity of these programmes at the end of donor support. The study indicated that the respondents had their own fears or compared what had happened to other similar programmes:

*I can't conclude that our program will fail because other programmes have failed after the donors withdraw their support but we are sure of some challenges (Female FBO leader).*

Sustainability of these programmes remains a cornerstone of the programmes since the improvement of the lives of PLWHA rests on the success of these programmes.

#### **4.4.3 Challenge of condom promotion.**

The study revealed an ambivalent stand on the use of condoms among the faith communities. Several leaders were concerned about promoting condom use within their faith communities

due to their stand and belief about contraceptives. Some FBO leaders consider condom to be encouraging people to engage in extra marital affairs, while others worry about exposing the young generation to have sex at an early stage. However it was noted that some FBO leaders leave it up to the user to decide. One respondent had this to say;

*The idea of condom promotion implies a dilemma because we cannot preach about abstinence only while we know some can't maintain that. At the same time we can't openly stand and tell the youth to use a condom in the pulpit because we will be licensing sex before marriage (Male FBO leader).*

It was also noted that not all FBO leaders are opposed to the use of condoms or protected sex. Some respondents agreed that it is necessary to allow use of condoms since the epidemic is spreading, and trusting everybody with abstinence alone puts them at risk as some can't abstain and they are sexually active. Some respondents admitted that they still find it hard to discuss it with their children since they consider it a shame. One health professional had this to say about condom use:

*Some of these people have lost one partner; some are in a relationship and are living with HIV/AIDS. They need to use condoms to reduce cases of re- infections. The issue of condom should be treated with a lot of care when dealing with issues of HIV/AIDS (Male clinical officer).*

The condom controversy seemed a difficult code to unlock within the FBOs since they have taken different stands as regards their personal beliefs or their organization's policies. But the health officials emphasized that it's important to give the correct information about preventive measures, including condom use.

#### **4.4.4 Personal attitudes and beliefs.**

The inadequate knowledge, personal attitudes and beliefs that some leaders and some faith community members hold about the disease are major obstacles in the efforts of prevention, care and support of HIV/AIDS in the Kibera slum. In some cases FBO leaders who are expected to be the role models, have not provided a proper road map in addressing the HIV/AIDS epidemic, partly because of their attitudes, as discussed in one group:

*In some cases, we see our leaders not comfortable with those of us who declare our status; they seem to be reluctant to allow us give testimonies about the disease (Female leader PLWHA support group).*

One FBO leader who took most of his time taking me around in the Kibera slum whenever I needed help, also admitted to me towards the end of my study that he is also living with HIV and has decided not to reveal his status because he knows some of his colleagues will think that he is not a worthy leader and does not command societal expectations of being a role model. However he admitted that this attitude is slowly changing in Kibera but still exists among some individuals.

Many PLWHA cited some faith leaders building unnecessary fear and mistrust based on their negative attitude towards them. There was a general consensus that some FBO leaders need to re-examine their own behaviours and values. This will create the love and empathy needed by PLWHA to give them hope and determination to move forward in their new conditions. The study shows that the personal attitudes of FBO leaders determine their relationship with PLWHA. Poor relationships will deter people from having confidence and trust in their FBO leaders and as a result they will not be able to reveal their HIV status which might result in the denial of the existence of HIV/AIDS in their respective faith communities.

While recognising that there has been a considerable progress in the FBOs efforts in HIV prevention care and support programmes, it remains a long journey that is yet to be completed. The challenge of such a journey is that not all passengers are headed to the same destination. Another challenge that hinders effective contribution of FBOs is the rigidity of some of its leaders. This includes some cases where a leader who was heading a congregation is transferred. His successor might not fit in his place and might not resume his roles as the programme demands. These in most cases have led to slowed programmes activities or in some cases collapse of such programmes. Such occurrences are not new with religious organisations when dealing with HIV/AIDS. It has been attributed to leaders not being 'competent' to handle other demanding tasks of the organisations combined with the demands of HIV/AIDS programmes. In some cases it's just rigidity of the leaders. Some leaders were trained long before HIV/AIDS became a critical issue and have yet to come to terms with the fact that it has become part of the church, mosque or other religious organisation. This calls for a need for FBOs to continue training and updating their leaders on the value of mainstreaming HIV/AIDS in their theological programmes.

#### **4.4.5 Stigma and discrimination.**

From the discussions, it was evident that one obstacle to effective HIV prevention is stigma. The participants admitted that they not only face the challenges of the epidemic but also discrimination. Even though participants stated that FBOs have done a lot to eradicate stigma and discrimination. There was a general consensus that they still exist. It was attributed mainly to the lack of adequate knowledge about the disease and to the rigid theologies that they preach in some instances. This has weakened the efforts in HIV/AIDS prevention as it leads to loss of dignity and even loss of self-esteem in some cases as indicated by the study.

The study revealed that HIV/AIDS is sometimes treated by the religious communities as punishment for violating community norms, where stigmatized persons are held responsible for what is considered their own ills within the community. In such cases PLWHA feel sidelined and rejected. Participants faulted some FBO leaders for their moralistic and judgmental attitude and for discouraging people from coming forward and openly speak about the disease. One of the respondents had this to say:

*As long as we still stand before our faith communities and give the perception that HIV/AIDS is a punishment from God, and that God always punish sinners, we will still be sending a message that PLWHA are not morally upright and HIV/AIDS is a curse (Male FBO leader).*

During the discussion respondents emphasized the need for leaders to have proper knowledge about HIV/AIDS to help them address the epidemic adequately. Such knowledge will equip them with skills as well as enhance their understanding about the disease to help them lead the community in addressing the HIV/AIDS epidemic and reducing stigma and discrimination.

The associations of HIV infection with immorality and the failure to openly discuss the root causes of HIV transmission have contributed to stigmatisation and discrimination of PLWHA within the religious communities. This fear continues to accelerate infection rates as people are not willing to go for HIV/AIDS test for fear of being rejected and exposed if found living with the virus.

#### **4.4.6 Lack of documentation or inadequate documentation**

Given that HIV/AIDS prevention, care and support are not a day's work but require consistency that involves monitoring over time, good documentation is absolutely necessary. The study revealed that one of the challenges facing most of the FBOs in Kibera is failure to

document their work or in some cases poor documentation that creates a lot of gaps in accountability. The study indicated that FBOs have put a lot of efforts in HIV/AIDS prevention but little of this work has been documented. In some cases the FBO leaders talked of what they have done in their prevention, care and support which was confirmed by PLWHA associated with them, but there was lack of proper documentation or none at all.

#### **4.4.7 Perceptions about HIV/AIDS**

In their attempt to have a fresh resolve in addressing HIV/AIDS, FBOs undergo a series of challenges. The realisation of behavioural changes is the main target of FBOs in the wider Kibera slum. During the interviews it was noted that FBOs should put more focus on cultural and social contexts in which the individuals experience illness and in which illness is managed.

In order to grasp such cultural and social contexts, knowledge of the epidemic becomes a crucial component in effective HIV/AIDS prevention. FBO leaders need to have the understanding of the disease and its impact in order to pass accurate information to the people entrusted to them.

It was evident a few leaders indicated lack of proper understanding and comfort about educating others. Even though they talk about it they lack deeper knowledge to address the epidemic in a relevant way. Some respondents indicated lack of general understanding on critical issues that concern HIV/AIDS. Discussions in the focus groups indicated concerns about the ability of some religious leaders to have power to cure HIV/AIDS.

*One thing we can't ignore is that miracles still happen and if you have faith, you can test HIV negative as a result of consistent prayers, we have seen people testify to this in crusades and confirmed with medical experts (Leader, PLWHA support Group).*

Such statements indicate lack of knowledge on HIV/AIDS and the faith healing process. Notably, some respondents indicated that even though HIV/AIDS has no conventional cure it can be treated with African traditional medicine. As was expressed by this statement:

*I know it's impossible in hospitals as they say to get complete cure but traditional medicine clears the signs within weeks ((Female PLWHA).*

These statements indicated respondents' perceptions and their limited understanding about HIV/AIDS. There was a demonstration of some knowledge gaps that needed the work of

FBO leaders. It was also noted during the study that most PLWHA had a better knowledge about the disease apart from a few cases. Participants mentioned some religious leaders' ignorance in spite of the fact that they viewed them as credible sources of information. Participants indicated the need for more awareness building and openness in acknowledging and discussing sensitive issues related to the pandemic. The study indicated lack of enough information on medically healing in HIV/AIDS and the whole healing process.

#### **4.4.8 Resource barriers**

The study noted the lack of sufficient resources for HIV prevention, care and support activities. First, the FBO leaders emphasized that many faith communities are small in nature and do not have resources. Many of them have modest resources. Most faith-based organisations emphasized the challenge of having so many dependants to cater for, as was indicated by this respondent;

*As a pastor so many people visit us and they require basic needs, which we can't satisfy fully due to their large numbers and many visits (Male FBO leader)*

It was also noted that some PLWHA are registered with more than one organisation for assistance, hence making it difficult for all to get what they rightfully deserve. The health professionals, however, noted that this problem mainly occurs with denominations. According to one of them well established FBOs have a well-connected access to resources which act as their strengths rather than a challenge. FBOs receive many financial donations and are strong in human resources due to many volunteers. Above all, there was the consensus that resource barrier is a factor that hinders FBOs efforts in realizing a HIV free society.

#### **4.4.9 Differences and tensions between FBO leaders and people living with HIV/AIDS**

The study revealed fundamental differences in the way these programmes are run, whom to involve in what activities and how to implement them. The participants indicated some lack of agreement between PLWHA and their FBO leaders. FBO leaders attributed the disagreement to poverty that comes with the disease rather than trust. According to them, PLWHA in some cases become very curious and want to be involved in every meeting and decision making. He gave an example of when donors donate to faith communities:

*In some cases they become curious on what we receive from donors in the form of donations. The donations can be just what we give them but some will always think that their appointed leaders have used part of it for their personal gains (Male FBO leader).*

However the FBO leaders did not attribute this to lack of trust, but to poverty. The demand to attend all meetings with their leaders and the donors was attributed to ignorance; since the FBO leaders emphasized that it was impossible for everybody to attend all meetings; instead leaders would relay to them information as the protocol demands.

It was also noted that some PLWHA are not honest enough to stick to one organisation and in some cases register in more than one organisation for material gains, for example they would register in two organisations to get two bars of soap just in case each organisation was giving one or to grab an opportunity that one of them was not offering, Such incidences when discovered cause tension between FBOs and PLWHA with some of them threatening to pull out of the organisations and be left to face death. It was noted during the interview that such differences and tensions are caused by lack of enough resources and by poverty.

#### **4.5 Challenges faced by the beneficiaries (PLWHA)**

Having looked at challenges facing FBOs and their leaders, the study also sought to find out challenges faced by the beneficiaries in accessing the HIV/AIDS prevention, care and support services provided by the FBOs; The respondents identified some of the challenges which included, lack of clear programmes at meetings; as a result they take a lot of time since some religious leaders do not prepare in advance for the talks. One respondent said:

*Sometimes the line is too long. We spend a lot of time standing in the sun to be served, what encourages is that we get what we want eventually (Female PLWHA).*

They pointed to long queues when distributing resources like food, antiretroviral drugs and clothing. FBO leaders however attributed this to the overwhelming number of clients that they have to deal with on such occasions in Kibera.

The respondents also indicated financial burdens in case they develop complications that the FBO clinics can't handle and they are referred by these clinics to government hospitals or private health facilities that demand that they make some payments before they are attended to.

Interviewees drew attention to lack of confidentiality on personal information that in some cases arises since FBOs are closely knitted communities where there was a possibility of this information leaking to other people, some of whom would not treat it as confidential, thus fuelling the stigma if counselling is not done in time. Because of this perceived lack of confidentiality and the stigma that might come as a result, people may shy away from seeking voluntary testing services offered by FBOs, hindering the FBOs HIV/AIDS prevention efforts.

Another challenge that PLWHA faces is disclosing their HIV positive status. Anxiety and reluctance to disclose their status for fear of being discriminated and rejected and in some cases divorce, keep them from revealing their status. AIDS related stigma remains one of the barriers to eradicate the spread of the disease among people who are aware of their status. Thus in Kibera slum HIV/AIDS related stigma poses a challenge in the prevention efforts by faith-based organisations.

Related to stigma is the extent of giving the disease some other names meant to ridicule PLWHA. In some cases the respondents talked about people using phrases like:

*“You know he has been caught by the lion, he can’t escape”*

According to the health professionals and religious leaders decisions about disclosure are dependent on perceived AIDS-related stigma. PLWHA identified additional problems for women who keep quiet about their status to their spouses and family members since they could face divorce or even being subjected to violence.

In the view of the above mentioned challenges, the findings revealed that PLWHA have access to the FBO leaders and the services offered by FBOs, and that the services have impacted positively on improving the quality of life for the beneficiaries. The next chapter will try to explore the connection between the findings in this study and what other researchers have found.

## **Chapter Five: Discussions**

### **5.1 Roles of FBOs**

The point of departure in analysing FBOs initiatives in response to HIV/AIDS in the Kibera slum is to explore the range of activities that they have set in progress as described in the last chapter. These are initiatives that FBOs have considered as consistent with their mission and have the ability to undertake in the best way possible. The analysis of the findings will discuss the initiatives in response to HIV prevention, care and support.

Findings from this study reveal that FBOs in Kibera have responded to the HIV/AIDS epidemic in a variety of ways and with diverse approaches. The Faith-based organizations displayed a wide range of programmes and approaches towards promoting behaviour change. As the study revealed, these diverse approaches, if well executed, can in a unique way contribute to the realisation of a HIV free society depending on availability of resources.

Faith-based organisations focused on prevention strategies, care and support services, while also prayer and spirituality remain valuable resources in the response to HIV/AIDS in Kibera. The study shows the importance of prayer in building hope and help in resisting PLWHA from harmful behaviours. The role of prayer in bringing hope to the sick continues to receive attention among FBOs not only in Kibera, but throughout the African culture, given the demanding nature of chronic illnesses such as HIV/AIDS. Igo argues that “the word of God is another crucial weapon in building hope and faith in the fight against a deadly virus of despair and depression as it helps focus our thoughts and challenge when some of our more negative and destructive ways of thinking” (Igo 2005:117). The study reveals however that spiritual healing of HIV/AIDS, though central, remains a contentious issue among FBOs in the wider Kibera. It was evident that healing in HIV when one is confirmed to be HIV negative would mean something different from the process of healing where one can be helped to come to terms with the new reality that has dawned in his/her life

Among the wide range of approaches and attitudes displayed by FBOs in Kibera towards the realisation of behavioural risk reduction, the most common was abstinence and being faithful. Here the aim was prevention while there was also a range of programmes aimed at care and support. Although some FBOs maintained a strong anti-condom stands for the unmarried people, especially the youth, others chose a ‘silent mode’, and thereby leaving an open option for the target groups. Yet other FBOs gave condom use a green light under limited circumstances but this was done with low tones.

The study finds that faith-based Organisations are ideally placed to handle the HIV/AIDS and its devastating effects. FBOs promote values of compassion, love, tolerance and care for those in need, the sick included. FBOs in Kibera have relied on their relationship with the locals; the trust people have in them to communicate their prevention, care and support messages. As was revealed by the study HIV prevention is not just a matter of finding the appropriate technical interventions; it has to do with the values people hold. Faith-based organisations are embedded within the communities as a result they understand local needs of the people, by virtue of their long standing, multifaceted presence religious organisations have a great potential of supporting its people in matters that are of critical to them such as life and death (Orkalet 2001:83).

## **5.2 Evaluation of FBOs prevention Initiatives**

One of the interventions of FBOs in Kibera is in prevention; the prevention consists of two categories, promotion of behavioural risk (reduction (e.g. abstinence, being faithful and condom use) and impacting knowledge regarding HIV/AIDS. The study showed that there is a link between faith-based organisation`s involvement and behaviour change in the Kibera slum. This was indicated by respondent`s testimonies of improved health as a result of new lifestyle influenced by FBO`s initiatives. This finding corresponds with the association of religious leaders and faith-based organisations in HIV/AIDS prevention in the Caribbean and Latin America where they have sought to focus upon and address the issue of HIV/AIDS by influencing behaviour change (Haynes 2007:171).

The study also showed that FBOs initiatives in response to HIV/AIDS in Kibera focused on prevention among the youths and on men and women of childbearing age. However, FBOs in Kibera did not give much attention to high risk groups and highly stigmatised groups, such as commercial sex workers and men having sex with men (MSM). The lack of attention to the high risk groups is attributed to the FBOs unwillingness to associate with them. In some cases they were by and large absent from the scene as stigma and discrimination kept them off.

The theme for leadership in the response to HIV/AIDS is recurrent with FBO leaders in Kibera. Effective leadership at various levels does and can make a significant difference. Just as open and honest discussion among Muslims and Christians organisations combined with national leadership about HIV/AIDS helped in achieving a decline or stability as regards HIV prevalence rates in Senegal and Uganda (Green 2003:6-10). So the study revealed a

remarkable step towards better health in the lives of the PLWHA as a result of the initiatives by FBOs.

The study demonstrated that, relying on their religious teaching that forbids high risk behaviours, FBOs are suited to help in reducing the rate of HIV infection, but leaders need to reinforce them with constant information and follow up. Basing his argument on religious teachings effectiveness in HIV prevention, Ragab concludes his essay on a faith-based approach to HIV prevention and care from the perspective of a Muslim writes “Faith-based approach has all the potentials for success in the Muslim countries, if it is presented and handled appropriately with the use of the sources of Sharia’s at its ideal level. Since Islam forbids all acts which are believed to be harmful to sexual health like, sex out of wedlock, homosexuality, sex during menstruation and sex with animals. Applying this will help in maintaining sexual health and prevent sexually transmitted diseases including HIV/AIDS (Ragab 2010:101).

The study showed that, abstinence from sexual relationships is a primary method of preventing HIV/AIDS. The respondents agreed that this was the best method to stay away from infecting others, but some FBO leaders suggested it should be left to people who can manage it while those who can’t manage it should be allowed to explore other alternatives, a suggestion pointing at the possibility of giving room to condom use where deemed necessary. After all, the primary enemy is HIV/AIDS not condoms.

The study further revealed a need for the right information from the leaders to the right people and ensuring the information is adopted. For such information adequately given combined with training both faith-based organisation leaders and PLWHA on how to handle HIV/AIDS, faith-based organisation prevention strategies will undoubtedly bring about positive changes.

Further developments in religions and HIV/AIDS call for commitment to the training of leaders and the people involved. “And given the character of HIV/AIDS which interweaves with various social categories and permeates almost all departments of life, future approaches to religion and theology should be both socially engaged and interdisciplinary” (Dube 2012). Leaders need to be equipped with knowledge and competency of analyzing, addressing and engaging the epidemic as a medical problem as well as social factors such as poverty, violence and discriminations of all forms which are associated with the spread of the epidemic.

On the same note, while recognising that adequate knowledge is of great significance, it is not enough to rely exclusively on public campaigns and occasional educational programmes organised by FBOs. A thorough and consistent follow up on the programmes is needed. Leonard M. Martin stresses that giving the right information to the right people at the right time remains a cornerstone in HIV prevention since it appeal to the rationale side of people, to their intelligence and to their prudence, while its weakness is that it fails to take into account the fact that people do not always do what they know is best, nor what they know is right (Martin 2007:78-79).

He further argues that the obligation is not only to teach, but also to learn and knowing is not enough since prevention is about choosing behaviour patterns and implementing them. This is affirmed by the Kenya National AIDS Control Programme report (2012) that finds awareness of HIV and understanding of how HIV/AIDS is transmitted a vital point for reducing infections, but also emphasises that awareness and understanding are often insufficient on their own in preventing transmission. A consistent follow up should be done to ensure what is learnt is implemented.

The study finds that there exists a general obligation to religious leaders to inform people about AIDS and other health matters and educate them in humanizing values so that they can take measures to protect themselves and their loved ones. Even though most religions of the world stress abstinence and being faithful, the study revealed showed a need for FBO leaders to use their social influence in society to make a consistent follow up and ensure the knowledge is implemented for meaningful behaviour change.

### **5.2.1 Condom; a promoter of promiscuity or life saver.**

The promotion and use of the condom has raised alarming concern among faith- based organisations. Some have perceived this as contradicting the teaching that premarital abstinence and marital fidelity are the safest and morally correct methods of HIV prevention, others have also questioned the safety of condoms.

Ethical questions have been raised in connection with outcomes on behaviour of the use and promotion of condoms in HIV/AIDS prevention. Some have argued that promotion of condom promotes promiscuous sexual behaviour, while others argue that sexual behaviour is determined by other factors and condom is a suitable way for it prevention. A conflict arises between the desire to protect people's moral integrity and the desire to promote human life.

The study emphasized a uniform call for abstinence and being faithful as a strategy of prevention of HIV/AIDS while the condom issue received a mixed reaction among the FBO leaders and PLWHA in the Kibera slum.

Donald Messer in his book “Breaking the Conspiracy of Silence”, when explaining what he calls the ABCs of prevention, gives A for Abstinence, B for being faithful and C for condom - or to him it can stand for controversy since Christians seem hopelessly divided on the subject (Messer 2002:101).

During the study, FBO leaders gave a mixed message about the use of condoms; some maintained a firm anti-condom stand while others chose to be silent on the issue and thus leaving a gap for the people to decide. Others were comfortable promoting condoms for HIV/AIDS prevention for the whole community.

This diversity has deep theological roots, and has to do with, the society in which they live and how it views sexuality issues. The diverse positions of FBOs did not seem not to change, and the fact that different FBOs have different views should be respected. What should take centre stage according to the health professionals interviewed was that adequate information should be given to the public so that they would be left to choose which prevention methods to adopt.

This will cater for the needs of vulnerable groups who have no choice but to adopt condom use such as people living with HIV/AIDS who have been advised to use condoms to avoid re-infection .The study showed that the diverse positions of FBOs on condom use continue to give loopholes for the efforts of FBOs in HIV/AIDS prevention. The whole community is not prepared to tackle the issue of condom usage; this is not only treated as a private matter by FBOs but also the general public.

The mixed reaction to condom use by FBOs in Kibera is not unique. It is found in the entire Kenyan community. Just as the FBOs in the study showed diverse positions in the use of condom, so the whole country faces a similar situation which in turn influences the whole FBO fraternity, a recent Television advertisement promoting condom use in the country had to be withdrawn after an outcry by religious leaders according to health officials.

In the one minute government sponsored advert shown just some few minutes before the news to capture the attention of many and reach a wider audience with a view of educating the public, a woman in an extra marital affair is advised to use condoms for protection (BBC

News Africa, 2013). Below is how the religious communities reacted to the advert before it was finally withdrawn from the media: Christians and Muslims clerics said the advert encourages infidelity rather than safe sex to curb HIV/AIDS. The Kenyan Anglican church bishop said the advert has promoted extra marital affairs and sex among school going pupils. He argued that there are several ways of passing useful information to the society, but this one has failed. He further said that “it openly propagates immorality, especially when all family members are gathered before a television set” (BBC News Africa, 2013).

The Kenya Muslim religious body, the Council of Imams and Preachers of Kenya (CIPK) also condemned the advert in strong terms arguing that the advert depicts the nation as Sodom and Gomorra and not a nation that values the institution of marriage and family.

Another reaction came from the parents, who have children, friends and relatives living with HIV/AIDS. To them it was embarrassing to watch the advert together with children and they had to change the channel when it appeared. Some of the FBOs that were interviewed fall under the umbrella of organisations such as the Council of Imams and Preachers of Kenya. The Anglican bishops too have their say in their parishes in Kibera, and their stand on such issues of importance as condom use are adopted by their followers and brings more challenges in addressing HIV/AIDS prevention.

This is a reflection of the diverse stands FBOs within Kibera slum have. The study revealed a dilemma faced by the whole community whether condoms protect life or just is a tool to allow room for promiscuity.

The youths, FBO leaders and health officials are locked in a standoff and as the standoff continues the epidemic continues eating into the community. The use of condom also shows a tension between some FBOs and health workers who recommended the use of condom and insisted on that the right information about condoms be given to the public. The same applied to the Kenya TV advert. Just after the advert had been withdrawn from the TV channels, the deputy director of Kenya National AIDS and STI control programme said he was not apologetic about its message and that it was essential for people to use condoms to prevent the spread of HIV/AIDS.

There is a similar tension in the Kibera slums among FBO leaders themselves, PLWHA and the health workers.

FBOs positions on condom use, though highly diverse, generally have deep theological roots. Arguing about those different positions stands to bring no gain. It will be more constructive to accept and appreciate that different organizations have an entirely different views in their behavioural risk reduction. Finding a common way of harmonizing their ways of working together in achieving a common goal will be more appropriate as they accept and respect these differences.

The study showed that some FBO leaders are reluctant to be seen as promoting the use of condoms in general. Others expressed frustration since FBOs' involvement in HIV/AIDS has always revolved around condom use, leaving out other areas of equal importance.

### **5.3 Care and support services**

Another area that FBOs were involved in Kibera slum was providing care and support services to PLWHA and their affected families. These services include, pastoral care, providing an alternative employment or income generation projects, support programmes for vulnerable and orphaned children and medical care. Caring is expressed in various places where people feel safe. People living with HIV/AIDS need care in their worshiping places, their homes, in the hospital and even in their support group meeting places.

The respondents' clear need for material and spiritual support is not surprising considering the conditions they live in. The majority of PLWHA in the Kibera slums is struggling to cope with the new lifestyle that they are facing after knowing their HIV status. They are also struggling with important life demands such as getting adequate financial resources and fulfilling their desire to live according to the will of God.

The need for companionship and care are well responded to by FBOs in Kibera, The study shows that care and companionship seek to enable PLWHA to accept their situations and enable them to care for themselves if need be. There are diverse kinds of care to cater for individual needs at different levels. Giving compassionate companionship that offers effective care to the suffering and encourages them, integrates them into the healing process (McDonough 2007:57).

Many FBOs are well suited for providing spiritual counselling services but some still need the help of health professionals to conduct HIV/AIDS testing. The testing opens the door for what kind of attention an individual needs. Those who test positive are prepared to live and cope with disease while those who test negative are given sufficient education on how to stay

healthy. The pastoral counselling becomes an important starting point when dealing with PLWHA since it helps them cope with the awareness that there is no cure for the disease but that it can be managed with proper care (Wittenberg 2006:152).

There is a strong connection between pastoral counselling and the improved health of the respondents and the ability to adjust to the new lifestyles. The study also revealed the role of spiritual counselling in diverting destructive behaviours if properly conducted. The findings indicate that PLWHA trust and find comfort and relief from FBO leaders who try to influence behaviour change.

Investing in some source of income generating projects was found appropriate for the PLWHA. Giving economic capital to PLWHA has been a source of strength, courage and hope within the slum. Creating hope for them helps them face the future with determination. In connection with the importance of FBOs creating hope for the community Chitando adds that “above all, competent churches must be ambassadors of hope amid, pain anxiety and death to improve lives” (Chitando 2007:92)

Swop meetings is another initiative that helped the respondents meet their basic needs. They create an occasion for the FBOs to extend their giving hand and exchange goods with each other since little exchange was done among. PLWHA The involvement of the community becomes handy since it widens the choice of goods and ensures that it is seen as a whole community’s project and not simply an activity for PLWHA. In some cases it attracted even politicians to come and share something.

The emphasis placed on group meetings showed a strong move by FBOs in Kibera to ensure that respondents get a psychological assurance that they are not alone. As regards sharing experiences and widening their knowledge on HIV/AIDS the whole community engagement is a vital way to gain meaningful behaviour change. The FBOs also used the swop meetings as a communication strategy to attract many people so that they could use such platforms to create awareness.

The devastating consequences of HIV/AIDS on African societies, and its particular impact on Children, is requiring every organisation involved in fighting the epidemic to find new strategies to adequately address both the scale of the problem and its duration ( UNICEF& WCRP 2003:3).

Inevitably, many family structures have collapsed because of the effects of the HIV/AIDS which has left many children orphans and many homes to be headed by children therefore the children undergo a severe psychological torture. They are stigmatised in the society, since they are associated with the disease, they drop in performance in schools and some even drop out of school. In response to this a number of FBOs in Kibera have started an initiative to help the children with material support to meet their daily needs.

Most of these initiatives were mainly to provide them with clothes, food and to integrate spiritual and psychological support, to help them deal and cope with daily psychological issues as well as helping them develop their potentials and personal characters which are under threat due to lack of parental guidance. In most cases religious leaders and organisations are representatives of their parents. Most of the FBOs lacked the capacity to organise homes to house these children and could only support them through their schools or visit them in their children's homes or where they stay with their relatives.

According to the respondents, getting to know that you are living with HIV virus triggers emotional fear. In most cases of spiritual and psychological counselling, acceptance is shown and in cases where there is poor or no counselling, revealing one's HIV positive status is still a worrying experience. The respondent's fear of rejection keeps them from accepting their new condition and from revealing their status. The respondents indicated that in some cases the FBO leaders contribute to this by the use of religious teaching to blame PLWHA for their situation.

### **5.3.1 Stigma reduction revisited.**

Stigma is that part of identity that has to do with prejudice- the setting apart of individuals or groups through the attachment of heightened negative perceptions and values (Birdsall and Parker 2005:5). Stigma can be defined from medical, anthropological, social, or religious perspectives. However, common to all of these perspectives, is the understanding that stigma is characterised by judgementalism, differentness, blame, devaluation, spoiled identity, fear, power, exclusion and discrimination (Munyika 2005:76).

There is a distinction between stigma and discrimination. Stigma is largely related to ideas about others, whilst discrimination involves some form of enactment of stigma which may be verbal or physical, and which is likely to be hurtful and/or harmful to the person to whom its addressed (Birdsall and Parker 2005:5).

It has been widely recognized that FBOs play significant role in relation to the HIV/AIDS epidemic. Elements of this include among other doctrinal positions and religious teachings on the meaning of HIV, how open the religious communities address HIV/AIDS and how religious communities handle the initiatives that they have put in place in response to HIV/AIDS.

FBOs have taken initiatives to reduce stigma and discrimination. They have done this through consistent public awareness and education on HIV/AIDS. This is being done mainly by the call for accepting HIV/AIDS as a problem without borders and that it can happen for anybody irrespective of social status. In this way the FBOs call for compassion, love and care for those infected and affected.

The study has shown that through community mobilisation and education within the slums, FBOs in Kibera have contributed to reducing stigma and discrimination. Through peer group educators and support groups FBOs have communicated prevention messages. Peer educators are more influential in HIV/AIDS communication than people from outside since the peers share common characteristics like belonging to a particular faith group and being in similar medical conditions. This has the potential to effect behaviour change and impact knowledge on the respondents. Support groups are used within the Kibera slum to complement and not to replace the work of professionals.

FBOs as behaviour change agents in their campaigns emphasize individual choice, such as the abstinence, being faithful and condom use. Individuals are given sufficient knowledge but the responsibility of implementing the knowledge given rest with them. Such emphasis might imply that people who become HIV positive have been irresponsible through their own actions and negligence or simply put carelessness. Such Emphasis on individual agency masks many of the underlying conditions that influence and fuel HIV risk, for example, economic conditions, disparities in power that are a product of gender imbalances, age differentials, abuse of authority, physical power and economic power ( Bisal and Waren 2005:7)

I would argue that even though it remains critical to highlight the role of poverty, gender inequality and many other factors cited by Bisal and Waren above, there is a danger of erasing and ignoring the aspects of individual responsibility in contexts of HIV/AIDS. However this should not fuel stigma and discrimination. FBO leaders and their members should not feel hopeless against HIV/AIDS it is possible to minimize vulnerability to HIV

AIDS. Faith-based organisation leaders in some cases focused on structural issues that increases vulnerability and downplays personal responsibility.

Without adequate knowledge about HIV/AIDS People living with HIV/AIDS are the objects of stigma and discrimination. The consequences of such stigma and discrimination maybe expressed through feeling of denial, guilt, loss of hope, depression withdrawal and in some cases suicidal thoughts and actions as indicated by PLWHA in Kibera slum.

The study demonstrated that stigma reduction still remains critical for realizing the full capacity of FBOs' response to the epidemic within the slum. FBOs showed a strong impact based on their principles of moral authority, the trust they receive and their ability to influence attitude.

This study also shows that religious leaders are among the few people that PLWHA would like to disclose their status to, and the church members are the people whom PLWHA want to hide their status to, depending on how the church handles such cases. Most FBOs find a biblical ground for stigma and discrimination against PLWHA. A number of FBO leaders interviewed gave instances of teaching which found parallels between the stigma of leprosy in the Bible and HIV/AIDS today. They also refer to how Jesus handled the lepers, mixing with them and treating them with love. These comparisons provide FBOs with a unique way to handle stigma and discrimination since they have a starting ground and available material to refer to. FBOs reported a number of activities aimed at stigma and discrimination reduction, which included most of all giving adequately information about HIV/AIDS to show that HIV/AIDS is a disease without borders and can strike any one of us and that it can be managed, for instance by talking more openly about it within religious gatherings.

Churches need to engage effectively with HIV/AIDS in order to realise excellent care, education and counselling rather than exposing their fault lines making them to be perceived as blocking ways for any meaningful gain in the epidemic eradication. HIV/AIDS stigma reduction should be considered a long term process that includes giving direct attention to the contexts within which they occur. Considering that degrees of stigma may vary, interventions should be oriented towards the goal of reducing stigma and mitigation effects, rather than attempting complete eradication (Parker and Birdsall 2005: 9).

Desmond Cox argues that today churches have been obliged to acknowledge that it has contributed both actively and passively to the spread of the virus because of its difficulty in

addressing issues of sex and sexuality making it painful for the church to engage in any honest and realistic way, with the issues of sex education and HIV prevention (Cox 2010:94).

It is therefore imperative for faith-based leaders to demystify human sexuality. They need to lift the lid off it and the hurdles of treating sexuality as a secret should be renegotiated if FBOs journey on HIV/AIDS is to be a successful one. In turn, open talk and sincerity on the matter would go a long way in addressing the issue as a result the community would be more empowered to fight HIV/AIDS epidemic. The central focus on the faith-based organisations prevention strategies has been focussed on effecting behaviour change, however in the absence of open discussion on sexuality which leads to among others, stigma reduction and disclosure of one's HIV infection such a goal remains a mere dream.

### **5.3.2 The dilemma of spiritual healing**

Issues of spirituality and religion have had a hard time trying to influence development theory and practice. Religious traditions carry many tried tested insights into the reality of the sacred, and it would be irresponsible to ignore them. At the same time, all traditions have been called in question by two great global currents of thought. The rise of natural sciences changes our view of the universe, and so of the context within which religious belief are to be interpreted.

Many world religions have a holistic perspective of the human life; hence health and healings have always been central to the belief and practices of religions. Religions in general deal with what causes diseases, how they can be healed or how it can be prevented. In this attempt the answers usually include a supernatural or transcendental being or aspect of human life. But with the advent and development of science, explanations about diseases and their diagnoses have gradually shifted from supernatural to a more rational and scientific basis.

For most people of the 'South', Spirituality is integral to their understanding of the world and their place in it, and is central to the decisions they make about their own and their communities development ( Beek 2002:60). Their spirituality affects decisions on who should treat their sick children, when and how they will plant their fields, and whether or not to participate in risky but potential beneficial social action (Ibid).

In the contemporary world addressing the issue of spirituality and health is not without conflict and dilemmas. Spirituality and religion have been treated as sources of conflicts and oppression as well as source of liberation and development on health issues. According to

Reverend Happonen Hannu the issue of HIV/AIDS is difficult to write about. He argues that even though we see a miracle working God in the bible, there are many cases of persons claiming to be healed to only succumb to the ravages of the HIV virus (Happonen 2005:118). There are those who have been influenced by “Healers” giving false hope only to be brought back to the grim reality of the destruction of the virus.

Most religions make strong claims about healing. The popularity of healing in many African churches is due to the centrality of healing in African cultures where the traditional healer/diviner/medicine woman is an important sacred practitioner who defeats illness and misfortune (Chitando 2007:67). It’s claimed within African traditional practices that the healers have spiritual powers that qualify them to tackle any form of illness. In the contemporary period, some traditional healers have claimed to have healed some people with HIV/AIDS. Scientifically a person is free of the virus if he or she tests HIV negative. Given the general agreement that people’s faith and spirituality contributes to healing of various diseases, spiritual healing in HIV/AIDS healing raises challenging issues.

According to Fraser spiritual practices such as prayer, medication and laying of hands can contribute to spiritual healing that parallels how psychotherapy can contribute to psychological healing (Fraser 2011:39). He goes on to argue that current concepts of spiritual healing in religious contexts have often contrasted it with the methods of modern medicine.

According to him spiritual healing has often been practiced in conjunction with modern medicine, and there has often been harmonious coexistence between them. Nevertheless, it remains the case that faith based communities have seen spiritual healing as something radically different from the methods of modern medicine (Ibid: 178).

This is the true reflection of how spiritual healing is viewed in the Kibera slum, even though none of the faith leaders owned up to heal HIV/AIDS. They indicated a strong belief that many have been cured of the epidemic through faith healing. Some respondents hinted at a spiritual cure to the epidemic having taken place in the slum by a known prophet.

It did not take long before the claims of HIV/AIDS healing were spread in the local dailies and television channels that a PhD holder in genetics turned preacher. He is now a famous prophet in Kenya and claims set afire the medical and religious grounds. Though he agrees that there is no conventional cure for HIV/AIDS, he was preaching to all that, through a series of prayers and intercessory grunts one can turn HIV negative (Daily Nation Kenya,

2013). This time what was raising eyebrows was the corroboration of his claims by some medics who said they have several cases of these faith healings, and one Rift valley, Kenya National AIDs and STI control programme (NAS COP) provincial coordinator confirmed having encountered several cases of this “faith healings” where individuals who were HIV positive turned negative.

Given the vulnerability of PLWHA, their struggle with a new kind of life, their diminishing hopes that need to be revived and their trust in their FBO leaders, such contradicting statements of whether or not HIV/AIDS can be cured presents the whole FBO fraternity with the big dilemma of what to believe and what not to believe, Kibera residents included.

Just as some respondents had little doubt that spiritual practices can at least facilitate healing, it remains a contentious question whether spiritual healing in a strong sense actually occurs, even more so in connection HIV/AIDS. Fraser asserts that it really does, though he admits that supporting evidence is admittedly of poor quality (Fraser 2011:168). To Levin there is more possibility, that there is a divine presence or God that can choose to bless us in ways that may violate the apparent physical laws of the universe (Levin 2001:183).

While the majority of FBO leaders showed a commitment to using both spiritual healing and conventional medicine, the dilemma was evident in some PLWHA who have dropped taking their antiretroviral drugs in the hope having been healed by the power of spiritual practices, only to resume treatment later when their condition worsens, FBO leaders attributed this to many religious voices, some of which endorse some spiritual practices in preference to conventional medicine.

According to Battin it is morally wrong to encourage people, either the current church members or prospective converts to claim that prayer is a more “dependable form of healing if you cannot actually establish that this is the case (Battin 1999:54). To her the church attempts to present its views, for example by providing videos for paramedics that might come in contact with Christian scientists, but this is a long way from providing testable, scientifically confirmed results.

Chitando, in his input to the dilemma of spiritual healing has a suggestion to the African churches that can be adopted to solve this puzzle; he sees the urgent need to develop an African theology of healing in the context of HIV/AIDS. Such a theology should synthesize the different therapeutic systems operating in most African countries: traditional healing,

Christian faith healing and biomedicine, and it should begin with the acknowledgement that God wills that all humanity enjoys health and well-being (Chitando 2007:70). According to him the African theology of healing requires that scientific progress in the development of antiretroviral drugs can be embraced as a miracle that God has worked in the contemporary period (Ibid 2007 :70).

Despite the dilemma that FBOs face in spiritual healing the study revealed that spirituality and prayer remain central in the FBOs response to HIV/AIDS in the slum.

Faith-based organisations are called upon to provide love, hope and compassionate care for the people infected with HIV/AIDS and their affected families, which is a reasonable expectation. But more is required if religious organisations are to remain relevant to the people they serve. They are called upon to address cultural norms and practices, socio-economic conditions and other factors that make people vulnerable to HIV/AIDS. Their work will be incomplete if they:

- Welcome people to church, but fail to understand the misery attached to their life and health.
- Pray for people living with HIV/ADS, but fail to put a strong emphasis on the importance of medication together with prayer.
- Develop active support groups, but fail to address human sexuality in sound, forthright and scientific manner.
- Organise seminars, workshops but fail to reach to those who are vulnerable in their communities such as commercial sex workers and men who have sex with men.
- Organise congregations to worship but fails to incorporate people living with HIV/AIDS in their services and listen to their voices as a means of reducing stigma and discrimination.

Faith-based organisations leaders find themselves in the challenging context of HIV/AIDS, not by accident, but by divine design for a purpose. Expectations are high. Just as much is entrusted to them, much is required. The general rise in prominence of faith-based organisations in relation to development in recent years tells it all. People everywhere are looking forward to faith -based organisations leaders, either alone or in collaborations with

other secular organisations for guidance. They need to know how to manage themselves in the ever changing face of HIV and AIDS pandemic. With their credibility, spiritual strength, authority, theological knowledge faith-based organisations can help change totally the course of the epidemic.

#### **5.4 Suggestions on areas of improvements by FBOs in Kibera**

The study revealed some areas where the FBOs need to expand their work and do some adjustments to meet their desired goals. These areas include the following:

##### **5.4.1 Expanding and strengthening partnerships**

According to the respondents, one of the benefits of FBOs is there free medical assistance or subsidized costs. In cases of complications the respondents are referred to secular organisations or government sponsored hospitals for advance treatments. This was a clear indication of a need for cooperation with other organisations to improve the quality of their services. Faith-based organisations' partnerships with secular organisation have in some cases been controversial, such as the condom issue above but the working together is necessary.

According to John K.Guiney the role of faith based organisations is frequently controversial in secular development organisations because both parties in the field are often hypercritical of one another, maintaining the higher moral ground rather than sharing the common ground of their work, but the faith and development worlds need one another and they need to network and act together in creating ways, both locally and internationally (Guiney 2012:110).

To Nussbaum religious organisations and secular organisations need to work alongside each other. He warns that "Let neither side go it alone, taking pot-shots at the flawed assumptions of other without recognising the flaws in its own assumptions". In describing how strongly they need each other he says "the two sides need each other like blades of a scissor or wings of a bird (Nussbaum 2007:136).

Faith-based organisations can collaborate with other organisations by complementing the work of other organisation by addressing the gaps that can't be filled by other organisations and FBOs are in a position to. They can as well reinforce the work of other organisations for example by reinforcing prevention messages like in the case where FBOs organise seminars and invite guest speakers. The leaders can later be used by the secular organisation to

reinforce their work. Faith based organisations can as well be used to facilitate the activities of others like making their congregations available for use by other organisations or giving their buildings for purposes of seminars.

FBOs in Kibera need to strengthen their work by co-operating with other secular organisations to more effectively provide what they are specially or uniquely positioned to contribute. Awareness meetings and education forums organised in Kibera in religious settings and secular organisations invited to educate people is but one of the many areas where they need to expand their work. The co-operation demands a more mutual responsibility and flexibility where both FBOs in Kibera and FBOS in general try to listen and accommodate each other's position on the contentious issues and advise each other accordingly.

#### **5.4.2 Improve their records/documentations**

Keeping accurate and consistent records is instrumental to the success of any organisations. Faith-based Organisations must realise that proper records kept will be one of the most important management tools within their organisations. Many management leaders of organisations invest a lot of time and efforts into the running of the organisations yet fail to realise that such importance of maintaining update documentation.

The study shows FBOs initiatives in their response towards the epidemic in the Kibera slum. In some instances both FBO leaders talked and demonstrated what activities they have been involved in towards realising their objectives; this was confirmed by PLWHA. And in some cases the documentation was not up to date and even lacking in some instances.

There was a clear need of improvement of records for purposes of accountability and evaluation. Faith-based organisations need proper documentation to provide management information that they can base their decisions on. It also helps organisations measure their performance against projections that they originally set down on their plans. This perhaps can be used to win donors confidence in providing more donor funds. The problems that arose during the study of double registration by some PLWHA straining the already scarce materials can also be avoided if proper records are kept.

#### **5.4.3 Improve management skills.**

HIV/AIDS is no longer a guest in our midst but one of us, we live with it, and it has become part of our life. FBOs have a beehive of activities to take care of in their daily programmes

and handling the epidemic might involve the availability of their FBOS leaders as one of their strengths. This calls for a balance between attending to other activities and being available for the PLWHA who need such help.

The study revealed the need for FBOs leaders to strengthen their management skills as this will enable them to serve their clients with confidence and professionalism. Managing the high number of clients that keep on rising, requires no mere miracle but professionalism blended with the calling they already have. Training more people within the congregation to help in the managerial positions is a necessity for effective results and sustainability of the programs.

#### **5.4.4 Development of a curriculum for religious leaders**

In view of FBOs' interest in expanding their programmes, it is recommended that training curriculum be developed or adapted for religious leaders and church members. Such curriculum should be designed to touch on the issues that affect the FBOs in dealing with questions that affect the church's ability to implement their initiatives in response to HIV/AIDS.

The curriculum needs to be designed to suit a particular need of the local residents. The curriculum should be dealing with the touchy issues such as human sexuality and other sexual related issues, how to handle stigma and discrimination, basic HIV/AIDS knowledge, and greater involvement of people living with HIV/AIDS as noted by Orkalet: "equipping would-be clergy and pastors in theological institutions with HIV/AIDS knowledge and skills prior to their posting and eventual work in their respective congregations and communities, is mandatory. This I believe will go a long way in shaping in shaping effective responses to the pandemic at grassroots level- and possible change of behaviour for the good of all" (Orkalet 2009:87).

The curriculum needs to be developed to meet the challenges posed by the fast- moving HIV/AIDS epidemic to ensure that FBOs take on board emerging issues that are critical in reducing HIV/AIDS infections.

According to Dube such curriculum transformation is needed from religion/theological institutions in the areas of social engagement. Given that Africa as a whole is saddled with numerous ills such as poverty, violence, corruption, patriarchy, dictatorships and HIV/AIDS,

it is important that religious leaders be equipped with tools to analyse, address and engage these challenges (Dube 2012:85).

#### **5.4.5 Make room for the voices of people living with HIV/AIDS**

No significant progress in the response to HIV/AIDS can be achieved if people living with HIV/AIDS remain invisible and inaudible. There is an urgent need to put a strong emphasis on the meaningful and greater participation of people living with HIV/AIDS in the faith-based organizations' prevention, care and support programmes. In the context of stigma and discrimination the contributions of people living with HIV/AIDS are critical. It starts with them building on their experiences of living with the disease.

Faith-based organisation leaders need to engage PLWHA more in religious worship, conferences, seminars and workshops. The FBOs need to take their views into considerations; if not the result will be that FBOs produce abstract materials that do not reflect the real experiences of people living with HIV/AIDS. According to the World Council of Churches, preventive work is indeed more effective when it engages persons who are living with HIV/AIDS. People listen and react when they hear the story of a person who is present among them, rather than merely seeing the words on a page or drawings on a poster (WCC 97:84).

## **Chapter six: Conclusions and Recommendations**

The study has sought to examine the initiatives by FBOs in response to HIV/AIDS in Kibera slums. This chapter will summarise the major findings, conclusions, and shortcomings of the study as well as recommendations for future researchers.

### **6.1 Summary of Findings**

Faith-based organisations work in prevention, care and support effort faces many challenges and much criticism, particularly in regard to their prevention strategies. The challenges include the use of condoms, the dilemma of spiritual healing and fuelling stigma and discrimination. However, faith-based organisations have increasingly been involved in developing initiatives in response to HIV/AIDS.

The criticism of those preventive strategies comes as a result of their emphasis on premarital abstinence and marriage fidelity which often clash with secular organisations' preference for safe sex. However, FBOs stand a unique ground to effectively contribute to HIV/AIDS prevention, care and support in Kibera because of their grass root influence and presence in all the thirteen villages of Kibera and because of their link to the cultural and social environment of the people. Since they meet frequently they have effective channels of communication. Faith-based organisations are regularly involved with people and meet them at key life events such as birth, initiation, marriage and death. Their diverse approach, such as home visits and care for orphans, makes them more effective in improving the lives of those who are infected or affected.

Faith-based organisations in Kibera are using unique communication strategies within the slum to educate people on HIV/AIDS prevention, care and support. These include; calling for swap meetings where people living with HIV/AIDS not only benefit from the goods given to them but also the information passed to them, the use of sports and recreation facilities to attract both general population and key populations at heightened risks among others.

The most significant asset of FBOs is the holistic approach to the PLWHA and their families, addressing the spiritual, physical and the emotional concerns of the individual and community as a whole. Their nature as value-based institutions with strong views on issues of personal behaviour, morality belief and family life gives them an advantage in tackling HIV/AIDS prevention measures.

The study revealed that the initiatives by FBOs in Kibera have changed the lives of the respondents in a positive direction. The respondents also testified to an improvement in their lives spiritually, physically and socially. The health officials and FBO leaders admitted experiencing some positive change with the PLWHA.

The respondents also indicated a change in their behaviour, such as avoiding multiple partners, being ready to share their experiences with others and openly talking about sexuality issues like condom use.

Faith-based organisations initiatives have realised an improvement in the situation of many orphans and vulnerable children together with their families within Kibera slum. The children and their families as a result have realised better services and socially active children, involved in social, cultural, educational and sporting activities.

Study findings revealed that faith-based organisations are popular among people living with HIV/AIDS in Kibera due to the availability of their leaders in times of need, their nature of being rooted in the community and hence familiarity with people's needs. The study also revealed that faith-based organisations are hospitable given their strong value base of concern for the poor and the sick. The study revealed further that spiritual counselling provides the people living with HIV/AIDS with hope, a valuable ingredient for them to help them adjust and face their new conditions with courage and determination.

The orphans within the slum have also realised a boosted morale as a result of provision of material, spiritual and psychological support. The faith-based organisations have also realised a noticeable number of children continue with school.

Though faith-based organisations initiatives are prevalent, it is likely that the support given to the affected children to enable them go to school and live adequately is still less. The desire by most faith-based organisations to improve their services is hampered by lack of enough resources.

Incorporating health professionals in some of their initiatives gives the FBOs and their beneficiaries an opportunity for a better understanding of the epidemic from diverse points of view, especially in regard to how leaders of faith-based organisations recognize challenges in their HIV/AIDS prevention, care and support initiatives that they need to improve. Even so there was an overall sense that faith-based organisations have made important contributions

by leveraging their capacity to motivate people to do exceptional things, and by their broad reach and influence to achieve behaviour change.

## **6.2 Conclusions**

The study findings show that FBOs in Kibera employ a multi-sectorial approach to HIV/AIDS prevention, care and support. In their comprehensive approach, the FBOs have not only geared their efforts towards behavioural change strategies but also tackle issues like poverty that predispose people to the epidemic. The multi-sectorial approach incorporates education for behaviour change and prevention as well as the psychological, social and physical support for the people living with HIV/AIDS and their families.

There was a strong emphasis on premarital abstinence and marital fidelity rather than on condom use. This is attributed to the fact that the organisations' religious principles and values are not always in line with condom use. However some organisations have incorporated other interventions due to the ever changing nature of the virus. Some leaders emphasized the need for providing all the necessary information about condom use for the beneficiaries to make informed choices.

The study also shows that spiritual practices such as prayer, meditation and laying on of hands are central to the FBO members and their leaders. These spiritual practices bring both FBO leaders and their members together and place the leaders at the centre of the members' daily lives and thus making them instrumental in motivating behavioural change. However, the study revealed that spiritual healing raises challenging issues as to whether spiritual healing can make somebody who is living with HIV test HIV negative. However, the study found that spiritual healing can enhance the healing process.

The involvement of PLWHA in the FBOs initiatives strengthens the FBOs efforts in impacting knowledge and addressing the issue of stigma and rejection. However, more needs to be done. The FBOs in Kibera have demonstrated that it is possible with limited resources to respond to the need of people living with HIV/AIDS and their affected families. Faith-based organisations have demonstrated that it is possible through faith, love of God and human commitment to tackle the issue of stigma and discrimination. Through their integrated approaches they have proved that it is possible to bring hope in situations which seem hopeless.

### **6.3 Recommendations**

This section suggests some recommendations to policy makers, secular and other government organisations, faith-based organisations and future researchers.

#### **To policy makers**

For policy makers, it will be worthwhile to offer positive criticism of the work of faith-based organisations and to appreciate their initiatives in response to HIV/AIDS. This will make them improve their prevention, care and support strategies and enhance the understanding of the role FBOs play in HIV/AIDS prevention, care and support.

#### **To secular and other government organisations**

Tensions and differences have emerged and continue to emerge between faith-based organisations and secular organisations concerning their stand on preventive methods. Cooperation of FBOs with secular organisation is needed where each organisation does what it is best suited for. In order to cooperate, both secular and religious actors need to show recognition of mutual goals and respect of the partners' ideological stand. There should be an emphasis on mutual understanding and a clarification of partner roles and responsibilities from the beginning.

Barriers to cooperation might be brought about by the perception that some groups either from the secular side or religious side use or exploit one another to accomplish their own goals, by assumptions by both secular and religious traditionalists that mutual understanding will lead to compromising values in order to work together, by disparities at the level of expertise and the tendency to be informed by negative stereotypes and in most cases mere ignorance. Bringing an end to such perceptions will harmonize these differences and be of great benefit. The challenge is, therefore, for the secular organizations and governments to see how partnerships with FBOs may be created.

#### **To the faith-based organizations**

The epidemic's future in Kenya will be determined, in large measure, by the country's success in attracting the resources needed to scale up essential services. Faith-based organisations need also to attract resources for effective services. To attract these resources,

FBOs need to have proper documentation of their work. There is a need for FBOs to provide adequate documentation for purposes of transparency and accountability. FBOs may also allow others to criticise and observe their programs with a view to improving quality and accountability.

There is need for FBOs in Kibera to direct their services towards other vulnerable populations like commercial sex workers and men who have sex with men. FBOs also need to strengthen their partnership with other secular organisations so that faith-based organisations may bring in their faith values as well as their capacity to motivate people towards worthy causes.

### **To donors**

Even though it has been mentioned that in general faith-based organisations can be credited for integrity, it should be noted that in some cases the temptation to divert designated donor funds to meet other genuine needs that were not planned for is not resisted. In some cases donor funds come with conditions and strategies that need to be followed by faith-based organisations before they are given financial support. When FBOs consider such strategies as going against their faith values they tend to keep off as well, resulting in donors withholding their support. Denying faith-based organisations funds on failure to comply with part of the requirement which they consider does not go well with their religious teaching will not help solve the problem. However, understanding what they can do best and maximizing them in areas where they act best is most suited if the realisation of an HIV/AIDS free society is to be achieved.

An effective solution to a problem must be based on good diagnosis. Faith-based organisations have proved that by being rooted in the community, by the trust they enjoy among their followers and their spiritual value as a platform for behaviour change, they are in a unique position to help reduce HIV/AIDS infections, more so with adequate funds. Allocating more resources to FBOs will strengthen and improve their services.

### **Suggestions for future researchers**

This study has looked at the FBOs' initiatives in response to HIV/AIDS in Kibera slum. However, it has some limitations, such as sample size and methods used in data collection. This could be improved if supplemented by other research methods or adopting completely new methods.

In view of the gaps shown by this study, the study recommends further research on the role of faith-based organisations in achieving behavioural change intended for the general population as well as focused interventions towards high risk populations. This could be realised by a combination of both qualitative and quantitative methodologies for an improved and better understanding of the initiatives of FBOs in response to HIV/AIDS.

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## **Appendices**

### **Appendix 1**

#### **Interview schedule (PLWHA)**

Participants must be over 18 years old, HIV positive, live in Kibera and attending FBO centre within Kibera slums.

1. Age
2. Gender
3. Time since diagnosis
4. Which FBO do you get your assistance from?
5. Do you go anywhere else apart from the named FBO for support?
6. How do you feel you are received and treated at the faith-based organisation centre you visit? Can you elaborate or tell me more about it
7. If you visit more than one place is there a difference between them from your experience? Can you tell me more about this?
8. What are the challenges and the encouragement you experience from FBO that supports you?
9. What are the challenges from living positively with the HIV virus?
10. Has the FBO centre you attend helped in overcoming these challenges?
11. What specific activities are you involved in during your visits and meetings with the above named FBOs
12. Do you pay for these services?
13. If yes, is it affordable for you?
14. Do you like the manner in which FBOs communicate to you concerning your status? Can you tell me more about this?
15. What do you enjoy about visiting your FBOs?

16. Do you experience a feeling of wellbeing when you visit your FBO centres?
17. What creates this feeling?
18. Do you ever feel anxious or afraid to visit your faith based organisation centre?
19. What contributes to these feelings?
20. Are there any factors about the FBO you visit that encourage you to continue using the services?
21. Are there factors about the FBOs that discourage you from using their services?
22. Which faith values do you meet during your visits?(faith values will be explained before this question)

## **Appendix 2**

### **Interview schedule for the faith-based organisation leaders (2)**

1. What is the name of your organisation?
2. How long has your organisation run its programmes in Kibera?
3. What are the main objectives of your organisation in dealing with HIV/AIDS pandemic?
4. Why did your organisation decide to offer services in Kibera?
5. How are faith values reflected in your work?
6. How do you identify your clients in this region?
7. What are some of the programmes that you involve your clients in?
8. What are some of the challenges you face with your campaigns in this area?
9. What are some of the significant achievements that you have realised in the region since you started working in Kibera?
10. What communication strategies do you use to pass you messages in the areas?

11. What feedback do you receive from PLWHS about the campaigns?
12. What is lacking in the HIV/AIDS campaigns among the residents of Kibera?
13. What would you recommend for future success in the fight against HIV/AIDS pandemic by FBOs?

### **Appendix 3**

#### **Focus group discussion with faith based organisations members.**

##### **Introduction**

1. Profession
2. Training.

##### **Services offered, strengths and weaknesses of the programmes**

1. What are the initiatives that you have put in place for your clients in the region?  
Knowledge about services, how clients use services, availability and accessibility.
2. What are your experiences of meeting with PLWHA?
3. As a team what are the strengths that you get when working on your goals?
4. What activities do you have that make your organisations different from secular organisations dealing with the same issues?
5. Describe your work day, how do you manage your activities
6. What is the importance of tackling the HIV/AIDS pandemic from the faith perspective and using it as a platform to put your message across
7. What are the challenges that you face in coordinating your programmes this way?
8. What is the feedback you get from PLWHA on the programme you run?
9. How often do you evaluate your programmes?
10. What are the areas that you feel need improvement, in order to achieve better results in the fight against HIV/AIDS in Kibera?
11. Do you think the communication strategies used are adequate?

## **Appendix 4**

### **Focus Group Discussion with people living with HIV/AIDS (PLWHA)**

1. Do you think the organisation that you attend is helping you cope with your situation?
2. What are the group activities that the organization is engaging you in?
3. What is importance of such activities in your opinion to the PLWHA?
4. What are the problems you encounter when accessing services from the organization you attend?
5. What are the activities that you are engaged in as a group during your visits?
6. How do you think the organization is dealing with the issue of your privacy?
7. Has working or discussing in groups strengthened your relationship with group members?
8. What do you like in the group discussion that the organization has initiated?
9. Do you like the ways the organization is handling your problems?
10. Do you think the involvement of fundamentals of faith as a basis of their work is of any help? Can you elaborate?
11. What do you like about the organizations initiatives towards the fight against HIV/AIDS pandemic in Kibera.
12. What don't you like about the organization initiatives towards the fight against the HIV/AIDS pandemic in Kibera?
13. Do you have any suggestions for the improvement of services by the organization?

## **Appendix 5**

### **Consent forms**

My names are Fredrick o. Ogango. I'm currently studying master of Philosophy in Religion, Society and Global issues at Norwegian school of theology. This research entitled Faith-Based Organisations initiatives in response to HIV/AIDS. A case study of Kibera slum in Nairobi, Kenya is partial fulfilment of the course at the institute. The information provided by you will be used for purposes of this research only. If you are willing to take part, you will be interviewed by me at a time and place that is easiest for you to get to.

The interview will last for about 40-60 minutes. With your permission this interview will be recorded so that I make sure I get the right information. Taking part in this interview is entirely voluntary and up to you and no person will receive any benefits or be disadvantaged in any way for choosing to participate or not to participate in the study. You may refuse to answer any questions you're not comfortable with and you may choose to pull out from this study at any point without any negative consequences.

Once the interview is finished all your answers will be kept confidential and private and no information that could easily identify you would be included in the research project. The interview material (recordings and transcripts) will not be seen or heard by any person besides myself and my supervisor. However, certain quotes from the interview might be used in the final report, but no names or other identifying information will be used.

Thanks in advance for your time.

### **Consent form (Interview)**

I----- agree/disagree to be interviewed by Fredrick ogango for his study in Faith based initiatives towards HIV pandemic, a case study of Kibera slums. Nairobi, Kenya.

I understand that:

- Taking part in this interview is voluntarily and is my own decision
- That I do not have to answer any questions I would prefer not to
- I may pull out of the study at any time
- Direct quotes or sayings maybe used in final report
- There will be no any personal benefits or draw backs for choosing to be involved in the study
- No information that will be included in the research report and my responses will remain confidential and private

### **Consent form (Recording)**

I..... Agree/disagree to my interview with Fredrick ogango for his studies in Faith based organisation initiatives towards H.I.V/AIDS pandemic. A case study of Kibera slums, Nairobi Kenya being recorded.

I understand that:

- The tapes and transcripts will not be seen or heard by any person in your organisation at any time and will only be worked with by the researcher and his supervisor
- All tapes will be under the custody of the researcher while the study is going on.
- No information that could reveal identity will be used in the transcripts of the research.

### **Consent form for focus group members**

This form is to ensure confidentiality of data obtained during the course of the study of faith based organisation initiatives towards H.I.V pandemic in the Kibera slum by Fredrick ogango. All members involved in this research including all focus groups members are asked to read the following statement and sign to indicate they are willing to comply.

I----- hereby affirm that I will not communicate or in any manner disclose publicly information discussed during the course of this focus group interview. I agree not to talk about material relating to this interview or study with anyone outside of my fellow focus groups members and the researcher