

THE CHALLENGES OF HIV/AIDS EPIDEMIC:

A CASE STUDY OF NAMIREMBE DIOCESE,
CHURCH OF UGANDA, 1992 – 2012

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DECLARATION:

I, Kabanda Paul Richard, do hereby declare that this research is my own presentation and also to the best of my knowledge has never been presented to any institutions for any awards and it should not be reproduced without my consent.

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Dedication:

The researcher has dedicated this report to members of the Namirembe Diocese Post Test Clubs' Network including; Namirembe Day Care Post Test Club , Masulitta Post Club , Gombe Post Test Club , Kyampisi Post Test Club , Kireka Post Test Club , Kasekulo Post Test Club, Bulega Post Test Club and Bwaise Post Test Club who have taken the courage to test their blood to establish their sero status, which they use to join in the struggle against HIV/AIDS.

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“Ebenezer” To the Glory of God. That seems to be impossible with man is possible with God.

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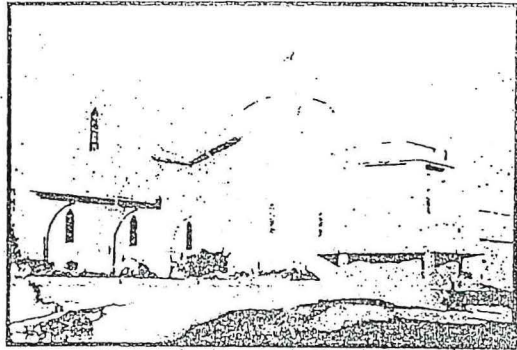
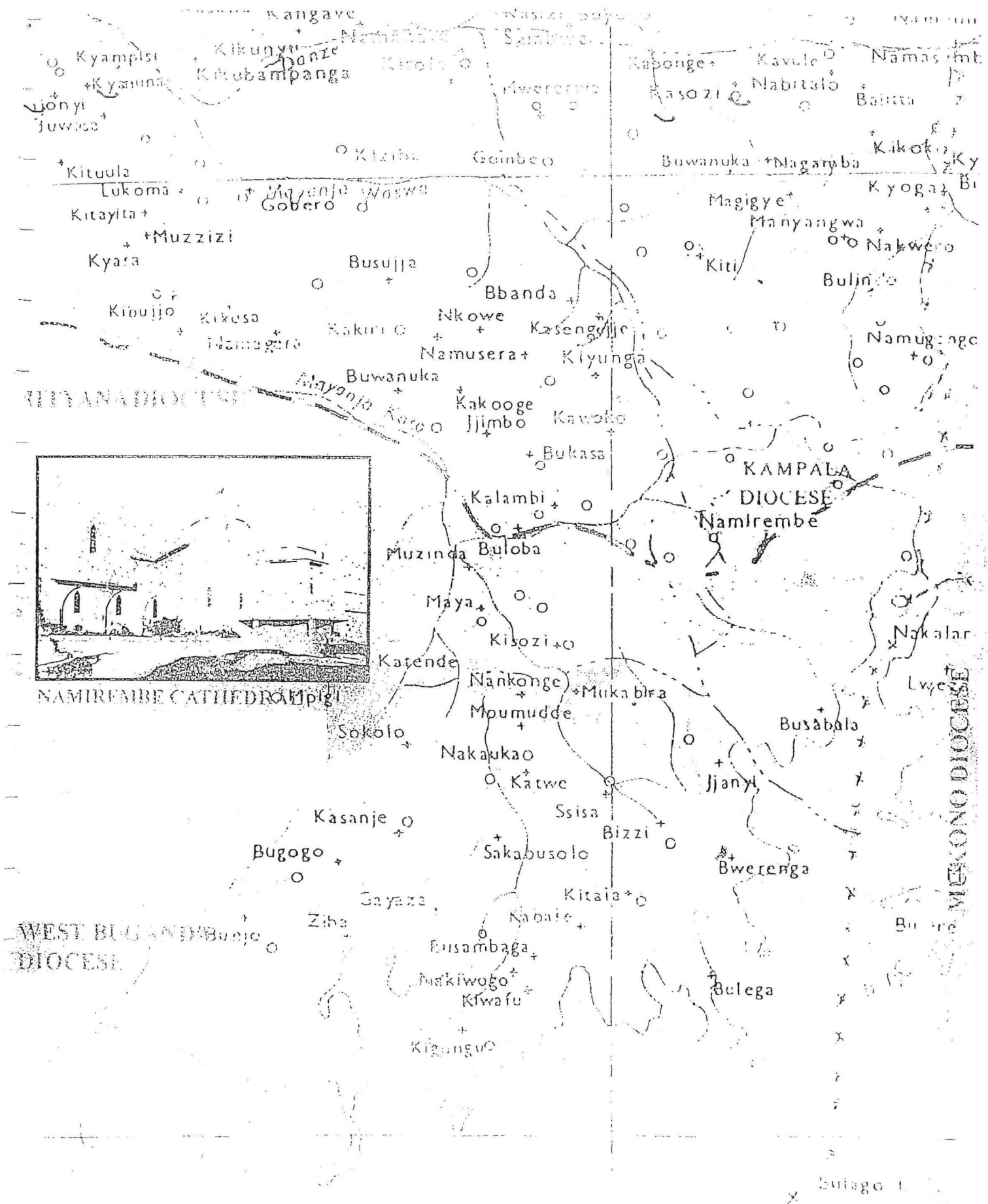
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Map of Namirembe Diocese.



NAMIREMBE CATHEDRAL Mpigi

Abstract

An investigation of the Challenges of HIV and AIDS was conducted in Namirembe Diocese - church of Uganda. The Diocese of Namirembe is the oldest Diocese in the Anglican Church of the Province of Uganda. It covers the districts of Wakiso, Kalangala (Ssesse Islands) and most parts of Kampala, with 6 Archdeaconries & one Deanery, 57 Parishes, and 342 local congregations (churches). Namirembe Diocese shares boundaries with Luweero Diocese in the North, Mukono Diocese in the East and South East, in the South; it is bordered by West Buganda and Central Buganda Dioceses, in the West it is bordered by Mityana Diocese.

The major Variables in the study included; Diocesan responses in terms of caring for People Living With AIDS , Support offered to HIV and AIDS Carriers in the Diocese, Church activities that PLWA are engaged in and the Diocesan involvement in HIV and AIDS activities. In order to investigate a descriptive research design was used. Methods of data Collection included; Discussions, Questionnaires and interviews as primary sources of data Collection. Documentary method and Observation methods were the ones used as secondary sources.

Results indicated that HIV and AIDS awareness and Prevention strategies are very much promoted by Namirembe Diocese through various activities, 42% are health Centers that offer services on behalf of the Diocese, 18% are activities promoting Abstinence, Behavioral Change, being faithful to one trusted partner. 12% are activities promoted through Music, Dance and Drama, 4% use Sports as a medium, and 24% through training and educative seminars.

Activities done in relation to HIV and AIDS programs were noted at 42% as prevention (Behavioral Change Communication, Peer education, promotion of ABC). 17.8% as Awareness through various activities like, Information Education and Communication tools distribution, Drama, Music, Sports and Dance. Voluntary Counseling and testing was at 14.1% this involves Voluntary Testing, and Counseling of people.

Acronyms:

ACCREC: Archbishop Carey Regional Resource Center

ACP: Aids Control Program

AIDS: Acquired Immune Deficiency Syndrome

AIM: The Aids Integrated Model District Program

AIC: Aids Information Center

ANERELA: Africa Network of Religious Leaders living with or Affected by HIV/ AIDS.

ART: Antiretroviral therapy

ARVs: Antiretroviral drugs.

C.o.U: Church of Uganda

CAPA: Council of Anglican Provinces of Africa

OVC: Orphans and Vulnerable Children

HIV: Human Immune Virus

MoH : Ministry of Health

PTC: Post Test Clubs

PLWA: People Living with HIV and AIDS

STD: Sexually Transmitted Disease

TASO: The AIDS Support organisation

VCT: Voluntary Counseling and Testing

CHAPTER ONE

INTRODUCTION AND GENERAL BACKGROUND

1.1 Introduction

HIV/AIDS is the most devastating epidemic in human history. HIV has reduced life expectancy by more than 20 years, slowed economic growth, and deepened household poverty. In Sub – Saharan Africa alone, the epidemic has orphaned nearly 12 million children aged under 18 years.¹ With an estimate of 25 million deaths worldwide. Countries, Governments and Organizations are working diligently to identify effective mechanisms to prevent HIV transmission and provide care, support and treatment for those affected by and living with the virus. Human and financial resources are still considerably inadequate to meet the overwhelming level of existing need. It is, therefore, imperative that existing resources be used wisely, based on the best available evidence of what works.

Portray

HIV and AIDS cases were first identified in USA between 1980 and 1981 among gay men. In 1982, Dr. Anthony Lwegaba then a medical officer at Kalisizo – Rakai District, revealed the 1st case of AIDS disease along the shores of Lake Victoria in Uganda.² The identified case was from the fishing village of Kasensero in Rakai District, South Western Uganda, and then it was not long before it spread to the entire country. A lot of effort has been put into the work of fighting the HIV and AIDS epidemic. Uganda has been frequently cited as a success story in HIV and AIDS prevention, due to the large declines in HIV prevalence that occurred during the

¹UNAIDS, *Report on Global AIDS epidemic* (Switzerland : PTY, 2008) p.13

² TASO , *Workshop for religious leaders* (Namirembe Diocese: Fountain, 5th April, 2008)

1990's due to the intensified prevention awareness campaigns by both the political, civil and religious leadership. After the first cases of AIDS were identified in 1982, the number of HIV infections increased rapidly throughout the country as a result of wide ignorance to the infection risk factors. By 1988, an estimated 1 million Ugandans were thought to be infected and Uganda had one of the highest rates of HIV infection in Africa³. For two decades, Uganda's population has experienced an HIV/AIDS epidemic. In response, the Government of Uganda set up the Uganda Aids Commission to coordinate all the programs that were being implemented in the fight against the epidemic in the country. HIV/AIDS still remains a global challenge that demands scaled and sustained prevention and impact mitigation interventions. Uganda's success story of the late 1990's evidenced by declining national sero-prevalence rates from around 18.5% in 1993 to 6.2% by 2000 has put the country in the limelight of global efforts.⁴

The Bishops, Clergy and Laity of the Church of Uganda under the leadership of His Grace the Late Most. Rev. Dr. Yona Okoth Archbishop of the Church of Uganda constituted a seventy eight (78) delegates conference from 26th-30th August 1991 representing the twenty two Dioceses at Bishop Tucker Theological College, Mukono, Uganda for the Church of Uganda HIV and AIDS Prevention leadership Conference. Delegates acknowledged that every person was created in the image of God and that was the purpose of God's love and care; and that the church was a channel of this love and care on earth, and recognizing the gravity and scourge of the AIDS epidemic and the rate at which it was claiming the lives of both Young and old in the church and

³Uganda HIV and AIDS Partnership, *Uganda Ministry of Health, Uganda AIDS Commission, and Measure Evaluation project, AIDS in Africa during the Nineties: Uganda young people, sex and AIDS in Uganda* (Chapel Hill, Inc. Measure Evaluation, Carolina Population Centre:University of North Carolina at Chapel Hill , 2004) p.1

⁴Ministry of Health – STD/ACP , *Surveillance Report* (Kampala : STD/ACP June 2003)

the nation at large are being ill equipped with knowledge, skills and logistics for the effective guidance, prevention, care and treatment of the HIV infected and people with AIDS⁵.

It was decided to increase the awareness of the HIV and AIDS epidemic. Thus, the first Sunday of November of every year was declared a National Day of Prayer and Fasting for the end of the scourge. Every Bishop in every Diocese was urged to strengthen and expand the existing HIV and AIDS education and prevention programs. The month of January 1992 was declared an HIV and AIDS awareness month throughout the length and breadth of the Church of Uganda and this saw the establishment of the Namirembe Diocesan HIV and AIDS care and prevention program with the creation of the Post test clubs , Under the leadership of the late Rt. Rev. Misaeri Kauma Bishop of Namirembe Diocese.

A study conducted by the Diocese of Namirembe , Health Department among adolescents in sampled parishes , revealed that there was high sexual activity among the respondents accounting for 54% , out of which 71% having had unprotected sex , 84% not in marriage.⁶

1.1 Statement of Problem

Since the proclamation of the HIV/AIDS Awareness program in January 1992, Namirembe Diocese of the Church of Uganda has been at the forefront of implementing HIV/AIDS Education, prevention and care programs which have seen religious leaders and the church share an important responsibility of advocating for behavior change , reducing on stigma and discrimination , care for orphans and vulnerable children , opening up church doors for people living with HIV/AIDS through Post test Club formation. However, HIV/AIDS remains a

⁵Church of Uganda, *HIV and AIDS Prevention Leadership Conference*, held at Bishop Tucker Theological College, Mukono (26th-30th Aug 1991)

⁶Byamugisha Gideon , *Sexual Behaviors Survey in Namirembe Diocese* , (Kampala: Fountain , 2008)

significant health problem in Kampala , Wakiso and Kalangala Districts covered by the Diocese. The researcher's aim is to assess the Diocesan contributions to the HIV/AIDS Epidemic challenges.

1.2 Hypothesis

HIV and AIDS prevention programs implemented by Namirembe Diocese have significantly addressed the challenges of HIV/AIDS with regard to people and families affected by it.

1.3 Objectives of the study

General Objective

The researcher is studying the contribution of Namirembe Diocese to the Challenges posed by HIV/AIDS.

Specific Objectives

The Specific objectives of the study are to:

1. discover the challenges of HIV/AIDS epidemic in Namirembe Diocese.
2. discover the HIV/AIDS programs conducted in Namirembe Diocese
3. find out solutions and recommendations as regards the challenges.

1.4 Scope and Purpose of the Study

Conceptual Scope:

The study covered the Diocesan responses in caring for people living with AIDS , Support offered to HIV and AIDS Carriers in the Diocese, Church activities that PLWA are engaged in and the Diocesan involvement in .HIV and AIDS activities.

Geographical Scope:

The study area was Namirembe Diocese, the first Diocese to respond proactively to the challenges of HIV/AIDS in Uganda. After the proclamation in January 1992 as a Church of Uganda Provincial HIV/AIDS Awareness month, Namirembe Diocese has been involved in a National Multi-sectoral effort to control HIV/AIDS up to date. The HIV and AIDS programs in the Diocese have been implemented in 23 Parishes with almost 30,000 people reached. The study focused specifically on a cross section of 5 parishes representing the whole Diocese Each Parish covers a vast area equivalent to a government sub county with a number of local churches (Sub Parishes) Data was got from 140 people who were the researchers sample size and this target was composed of people who are leaders in the different parishes that have participated in the implementation of HIV and AIDS programs in Namirembe Diocese during the period between 1992 and 2012.

Time Scope:

The researcher studied the contribution of Namirembe Diocese to the challenges of HIV/AIDS from 1992 because this is the year when Church of Uganda declared start of the

campaign to address the challenges of HIV/AIDS to 2012 the time the researcher is accomplishing his study.

1.5 Significance of the Study

1.5.1 Guide to Faith-based Organizations:

The study will be used as a guide to faith based institutions in integrating HIV/AIDS campaign in their Church Programs.

1.5.2 Performance Appraisal:

The study will assist the Diocese of Namirembe in appraising its performance in the struggle to fight HIV/AIDS epidemic.

1.5.3 Attract Funding:

The study will be used as an avenue to attract funding from the government and other AIDS actors to faith based organizations to support them in implementing programs aimed at eradication of the HIV/AIDS epidemic. The funding organizations will have access to the faith based constituencies, thus promoting their organizational values and programs.

1.5.4 Guide to HIV Programming

The study will equip the church leadership with knowledge, skills and logistics for the effective guidance, prevention, care and treatment of the HIV infected and affected people with AIDS.

1.5.5 Basis to further research

The study is likely to serve as a reference document to the faith based actors in HIV/AIDS and be useful to other researchers having interest in the same study.

1.6 Literature review

HIV remains a global health problem of unprecedented dimensions.⁷ More than 40 million people around the world live with HIV and each year millions more become infected. Around half of all who become infected with HIV, do so before they are 25 and are killed by AIDS before they are 35. This leaves communities without a vital part of their population - the parents, bread-winners, farmers, and professionals. Sub-Saharan Africa is the worst affected region. It holds just 10% of the world's population but is home to more than 60% of AIDS cases.⁸ Eastern Europe, Asia, and Latin America have also seen recent spikes in HIV infection. This is especially true in poor communities where poverty contributes to risky behaviors such as prostitution, selling children, and migrating to urban areas to find work.

Therefore strategies which address poverty have to be emphasized as this will enable the population prone to practice activities which may put them at risk of infection stay safe.

Thinking about this crisis reminds me of the lament psalms. For example, listen to this prayer:

"My life is consumed by anguish and my years by groaning; my strength fails because of my affliction, and my bones grow weak. Because of all my enemies, I am the utter contempt of my

⁷ UNAIDS, *Report on the Global AIDS epidemic* (Geneva: 2008) p.30

⁸ Ibid.

neighbors; I am a dread to my friends - those who see me on the street flee from me. I am forgotten by them as though I were dead; I have become like a broken pottery. For I hear the slander of many; there is terror on every side; they conspire against me and plot to take my life”⁹

It is easy for me to imagine that this prayer is being said by someone infected by HIV. If we are honest, we can see how the church has contributed to this lament. AIDS has carried a sexual stigma for churches that we did not want to deal with. The early perceptions of the disease were mostly associated with homosexuality, another topic that the church wanted to avoid. Today, however, the majority of AIDS victims are women and children, infected by the promiscuity of men and exacerbated by poverty. Therefore programs which address the plight of women and children have to be designed by religious organizations.

Some have likened HIV/AIDS to modern-day leprosy, the terrible scourge of Jesus’ day. The gospels note that lepers were isolated and abandoned by society - especially the religious people. They also point out that Jesus went out of his way to embrace these outsiders. Shouldn’t we do the same? Therefore programs which embrace a caring church free from isolation and pointing fingers have to be intensified and promote a brotherly attitude.

Although there is a substantial amount of literature around the issue of a Christian response to HIV/AIDS and the role of faith-based organizations in the prevention and mitigation of the pandemic, there is still little clarity as to a unified Christian theological response. Nearly ten years ago, Nicolson wrote comprehensively on the theological and ethical imperative for

⁹ International Society, *New International Version* (England: 1984) Psalms 31:10-13

churches to respond to the pandemic and join in what he hoped then would become a national multi-sectoral approach around AIDS. He emphasized the considerable role that churches play “as centers for community engagement and as providers of education and medical care in rural South Africa”¹⁰.

Liebowitz writes that often people consider the actions of religious leaders to be less politically motivated and selfish than the initiatives of government leaders, and thus their messages are received with respect and trust that is highly valuable in a setting like South Africa where people are still suspicious of the intentions of government¹¹. However, this greatly increases the responsibility of church leadership at every level to be consistent, and clear about the basis and possible impact of their messages. This example puts religious leaders in our own set up at a strategic position of being at the fore front of HIV/AIDS advocacy.

Analysts have spoken of the effects of attitudes of church leaders towards HIV/AIDS and those infected and affected. These often relate to church attitudes to sexuality, the history of which often militates against clear and helpful teachings. Messages from churches that speak of sex primarily as sin and abstinence before marriage as the only option, as well as AIDS being God’s punishment for sin, have resulted in strong stigmatization in churches in South Africa. It has also been noted that when information is delivered in an arrogant or judgmental way by religious leaders, it encourages blame to be placed on individuals and leaves them feeling “disempowered and uninvolved” in HIV/AIDS interventions⁴. Assessing the prevalence of these sorts of attitudes

¹⁰ Nicolson, R, . *AIDS: A Christian Response*. Cluster ((Pietermaritzburg : 1995)

¹¹ Liebowitz, J, *The Impact of Faith-Based Organizations on HIV/AIDS Prevention and Mitigation in Africa : Paper prepared for the Health Economics and HIV/AIDS Research Division* (University of Natal: October 2002) pp. 11, 13, 31.

and messages in churches will help in assessing the impact they have on People With HIV and AIDS' ability to disclose in their churches and the level of support they receive. As Mtetwa has written, "The Church is one of the best placed sites of the struggle to deliberately, aggressively, and comprehensively engage destigmatization in a sustainable manner and with a programme that the entire community can identify with and support."¹²

Conversely, this also means that the Church might be held accountable for fuelling the HIV/AIDS epidemic with teachings that increase stigmatization and drive People Living With HIV/ AIDS 'underground' as it were. There have been reports of PWHAs in churches in Africa being the victims of discrimination. These have included PWHAs being summoned for special prayers or confessional sessions in front of congregations, often based on claims about miracle cures for HIV/AIDS¹³. Fears of contagion have caused some churches to order that PWHAs receive Holy Communion last or that they be excluded from religious rites entirely¹⁴. Church leaders at the Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS in Africa admitted that "Today, churches are being obliged to acknowledge that we have- however unwittingly- contributed both actively and passively to the spread of the virus. Our difficulty in addressing issues of sex and sexuality has often made it painful for us to engage, in any honest and realistic way, with issues of sex education and prevention"¹⁵.

Therefore churches should be opened up for People living with AIDS. They should turn out to be the caring venues where PWHAs seek care and love. This will enable them come out which will

¹² Mtetwa, S, "HIV and AIDS" : *A New Kairos for the Church* (Unpublished paper given at the SACC Triennial Conference: July 2004) p. 4.

¹³ UNAIDS , *A Conceptual Framework and Basis for Action: HIV/AIDS, Stigma, and Discrimination.*(Geneva : 2002)

¹⁴ Campbell, I.D. and A. Rader eds. *HIV/AIDS, Stigma and Religious Responses: an overview of issues related to stigma and the religious sector in Africa*,2002

¹⁵ World Council of Churches,*Plan of Action: The Ecumenical Response to HIV/AIDS in Africa*,(Geneva :2001)

spearhead the campaign of prevention. Through the HIV/AIDS prevention campaign re-infection and new infections will be prevented, thus contribute to the falling rates of the HIV/AIDS scourge.

Directly linked to the problem of stigmatization is discrimination. These two terms seem to be inseparable from each other¹⁶. So serious is the problem of stigmatization and discrimination, that it has even been described as a second epidemic, next to HIV/AIDS¹⁷. Stigma and discrimination supplies the fuel for HIV/AIDS, as it hampers prevention and care efforts through silence and denial about HIV/AIDS, as well as marginalizing those who are affected by HIV/AIDS¹⁸. This fear of stigmatization and discrimination leads to an endless circle of denial and silence: “Fear of stigma makes people afraid to reveal their positive status by changing their behavior. This means that men and women continue to have unprotected sex. intravenous drug users continue to share needles, and HIV spreads faster than ever”¹⁹. In a Theology of HIV/AIDS stigmatization and discrimination will have to be exposed for what it really is, which is: “sinful, in that they deprive HIV-positive people of the freedom to live openly, seek treatment and enjoy a normal life”²⁰

Though many Christians have simply regarded the HIV/AIDS pandemic as a tragedy, it has been suggested that they also begin to see it as an opportunity and a challenge. The crisis is a “new opportunity for Christians to bring Christ to a world that is increasingly being forced to

¹⁶ Chitando Ezra, *Living with Hope : African Churches and HIV/AIDS*, (WCC Publications , Geneva: 2007)

¹⁷ Dube W. Musa , *HIV/AIDS and the Curriculum*, (WCC Publications, Geneva: 2003) viii

¹⁸ UNAIDS, *A Report of a Theological Workshop Focusing on HIV and AIDS related Stigma*,(Windhoek: 2005)

¹⁹ Chitando2007

²⁰ Chitando 2007

recognize its brokenness and need for God. And in this lies the challenge: to rethink how to bring Jesus' unconditional love, healing, wholeness, and hope to this broken world"²¹. Jesus Christ has demonstrated that God loves his people to such an extent that he was willing to become a human being in order to experience our humanity and to bring redemption to the world²². Following after Christ's example of incarnation, the church's mission must be to demonstrate the unconditional love of God to the hurting, broken, sick, poor, and marginalized. To fail to respond to an issue of such great magnitude as HIV/AIDS would be to imply that God, Jesus, and Christianity are irrelevant to contemporary society²³.

Furthermore, the church is the Body of Christ with many parts²⁴. If one part of the Body is infected or affected, then the whole Body is infected and affected. On the basis of unity within the Body, no church can claim that HIV/AIDS is not a relevant issue for its congregation, because "if one part suffers, all suffer together with it"²⁵. Thus, many have reflected on the need for developing a theology of a caring community. Mtetwa suggests that the building blocks of such a community would include prayer with and for the infected and affected, care for households of the infected and affected, grieving with those who have experienced loss, supporting and assisting those on antiretroviral treatment, encouraging members to go for, or providing voluntary counseling and testing, and making available a "sacred space" for those

²¹ Gennrich, D, *The Church in an HIV+ World: A Practical Handbook* (Cluster: Pietermaritzburg 2004)

²² John 3:16, All scripture references are taken from the *New Revised Standard Version*.

²³ Nicolson, R, *AIDS: A Christian Response* (Cluster: Pietermaritzburg 1995)

²⁴ 1 Cor 12:12, All scripture references are taken from the *New Revised Standard Version*.

²⁵ 1 Cor 12:26, All scripture references are taken from the *New Revised Standard Version*.

who are infected to disclose their status and be embraced, and other symbolic practices²⁶. The psychosocial ministry has been strengthened.

1.7 Research constraints

In the course of the study, the researcher encountered a number of challenges that however were able to be solved, so they did not hinder him from carrying out the research conclusively.

1.7.1 Lack of cooperation

There was lack of cooperation from some of the respondents who viewed the exercise as a waste of time, arguing that they had spent few months in office and that they were not involved in the program implementation. This did not hinder the research as there was a wider scope of respondent selection. This substituted those who did not cooperate thus enabling the researcher to have the required targeted number.

1.7.2 People's attitudes

The respondents thought that the data was not worth collecting since they had not seen the programs in their parish churches or that the programs had collapsed some years back. People interacted with in some parishes were new in those areas , thus they were urged to make recommendations for future programming.

²⁶ Mtetwa, S. July 2004. "HIV and AIDS": *A New Kairos for the Church*. (Unpublished paper given at the SACC Triennial Conference, 2004) p. 4.

1.7.3 Weather Changes

There were disturbances from the rain, which used to fall while the researcher was in the field collecting data and the roads could hardly be used to access some of the areas where the respondents gathered. The priests in the field enabled the researcher to meet the respondents in church halls and a vehicle was acquired to ease the transport.

1.7.4 Wide scope of the study

The factor of vast place is another constraint encountered by the researcher. The Diocese covers a wide place with 58 parishes. The researcher sampled 5 parishes with intensified activities addressing HIV and AIDS.

1.7.5 Appointments delayed the study

The researcher had to make appointments to meet most of the respondents this delayed the whole process of interviews.

1.8 Methodology

1.8.1 Research Design

The study followed a general Survey research design in which the researcher studied the contribution of Namirembe Diocese to the challenges of HIV/AIDS from 1992 to 2010. The

variables included; strength, weaknesses, Opportunities and Threats that the health department has faced since until today.

1.8.2 Sampling Framework and sample size

The study focused specifically on a cross section of 5 parishes representing a wider area where HIV/AIDS programs are implemented in the Diocese. People were selected to the tune of 140 people from an estimated population of 30,000 people who have benefited on the program. Information was got from 140 people who are key in the leadership and implementation of the HIV/AIDS activities. The researcher has applied both the quantitative and the analytical design - qualitative method of research using Primary and Secondary sources.

Need to justify 140 as number in details. Explain in details. Governance , beneficiaries .

1.10.3 Data Collection Methods

Primary Sources

Interviews

This was administered to respondents who did not have quite ample time to answer all the questions in the questionnaire. The interview schedules were agreed upon at the respondents' convenience and locality. The questions were summarized to capture the gist of the study using the variables of the study.

Questionnaires

This was administered to all the selected respondents from organized groups of 3 Post test Clubs, 10 Parish priests, 6 heads of Laity, 15 Heads of departments for the purpose of guiding

the study. The questionnaires were designed in consistency with the study objectives. The questionnaires were composed of open ended questions that helped the researcher to collect qualitative data on the strength, weaknesses, Opportunities and threats, Consequences and strategies advanced to improve service delivery.

Discussion

Small focus group discussions were met composed of organized members of the post test clubs. 4 Post Test Clubs and one Youth group were engaged in small focus group discussions each targeting 10. They were interviewed about the SWOT of Namirembe Diocese health department. Later they raised some solutions and strategies to be advanced to improve service delivery within the department of Health of Namirembe diocese.

Observation

The researcher visited various HIV and AIDS projects being implemented by Namirembe Diocese in order to have firsthand experience and observe the lessons from a range of different projects. On the visits the researcher aimed at getting information on the background of the projects, goals, and beneficiaries of the project, results of the project work and lessons drawn from the work. The results were observed basing on the attitude of people in that community in regard to HIV/AIDS and the results of the projects implemented.

Secondary Sources

Documentary

To supplement the primary data got from interviews and questionnaires, the researcher visited libraries, consulted books, policies on AIDS, journals, surfed information from the internet.

Specify libraries (CD-ROMS) in details.

1.11 : Definition of terms

Advocacy: Organized efforts to influence policy, leadership and opinion at various levels of action in the national response.

AIDS Competence: The ability of all elements of society to recognize the reality of HIV/AIDS, to analyze how it affects life at home and at work, and action to prevent its spread, maintain and improve the quality of life of PHA's, families affected by AIDS and the community at large.

Care Giver: A person, who attends to the needs of (a) PLWHA, be they physical, emotional, spiritual, financial, or related to childcare or household chores. Half of the caregivers in this study care for PWHAs as hospice employees or in a similar professional capacity, and the other half informally care for PWHAs who are family members or friends in their homes.

Child will refer to all persons under the age of 18 in agreement with the U.N. Convention on the Rights of the Child. However, it should not be forgotten that life is continuous and conditions and events that impact the life of a person as a child also have an impact on the life of that same person as an adult.

Church: The use of this term has become increasingly problematical, and as a result we have used it in a very restricted sense, to mean a local Christian church community – its leadership,

members and teachings. This is also because it is at this level that most ordinary people experience the reality of the church.

Health Worker: Any provider of health related services, regardless of level of training or location of work.

Home Based Care: Any form of care given to sick people in their homes, which includes physical, psychosocial, palliative and spiritual activities.

HIV/AIDS refers to the Human Immunodeficiency Virus, and its inextricable link to its symptomatic consequences in the human body: an Acquired Immune Deficiency Syndrome. We use this term for ease of reference, although we recognize that not all people living with the HI Virus have AIDS.

Lay Reader: A person in a leadership position in the church but who is not ordained, inducted or appointed as a senior leader, including Elders, Lay Ministers, Sunday school teachers, Women's Group leaders, etc.

Minister: An ordained, inducted or appointed person on the senior leadership staff of a church, including priests, pastors, reverends, (and in one Protestant Independent Church – apostles), etc.

PLWHA: Person living with HIV and/or AIDS.

CHAPTER TWO

2 Challenges of HIV and AIDS epidemic in Uganda

2.0 Introduction

Sub-Saharan Africa remains the region most heavily affected by HIV, accounting for 67% of all people living with HIV and 75% of AIDS deaths in 2007.²⁷ Women and children are the most affected with an ever-increasing rate of infection. This is the most vulnerable category prone to societal factors that increase HIV risk and vulnerability. There is a change in family demographics and social set-up of family units. The terminology of care and prevention once miles apart, are seemingly so intertwined as the links between HIV/AIDS and poverty follow a similar pattern. In the midst of all this there is hope. There always is hope. This research looks at a historical approach in this journey to hope. The role of the Church cannot be underestimated. It is imperative and this is the premise of the entire presentation.

2.1 HIV reality in Uganda

Uganda, in the late 80's & early 90's was for long synonymous with HIV. Just when it had been known for the dictators before, it came to light that there was a silent Holocaust that was consuming the people, AIDS - or slim as it was called - because of the loss of weight it caused in its 'victims'.²⁸ The country, as many others have done since, went into denial for fear of being discriminated by the international community.

²⁷ UNAIDS, *Report on the Global AIDS epidemic* (Geneva: 2008) p.30

²⁸ Uganda AIDS Commission, *The Revised National strategic framework for HIV/AIDS Activities in Uganda*, Kampala : Pine Enterprises, 2004

2.2 Responses and Impact of Programs in Addressing HIV and AIDS

It is almost three decades since the first AIDS case was diagnosed in Uganda in 1982.²⁹ Over the last 30 years, the HIV/AIDS epidemic has had a devastating impact on Uganda. Since 2000, the country's response has been guided by the National Strategic Framework for HIV/AIDS and the National strategic plan. The interventions that guide the responses in addressing HIV/AIDS challenges are guided at three levels:

GOVERNMENT ACTION,

The Government has supported in addressing the campaign by leveling an enabling environment which saw an establishment of a number of initiatives that address the challenge.

This involves the establishment of the AIDS Control program under the Ministry of Health in 1986.

The AIDS support Organisation formed in 1987 as a support organization for people living with AIDS³⁰.

The conducting of the National sero – survey in 1988 to assess the magnitude of HIV/AIDS.

The establishment of the Joint clinical Research center in 1990 to conduct clinical research on HIV/AIDS and additionally care and treatment in 1992³¹ and The AIDS information center was formed to provide voluntary counseling and testing services.

Uganda AIDS Commission was formed in 1992 to coordinate the multi sectoral approach to AIDS control and the operational plan and HIV/AIDS policy guidelines.³²

²⁹ Yoweri K. Museveni , Foreward , *National HIV/AIDS Strategic Plan 2011/12 – 2014/15* , December 2011.

³⁰ *The AIDS Support Organisation brochure* .

³¹ *Joint Clinical Research Center brochure* .

³² *Uganda AIDS Commission brochure* .

Amidst a number of strategies set up by the Government, still HIV/AIDS remains a big challenge in the country. Poverty has been often cited as a being among the major factor that drive people to engage in activities that put them at risk of contracting HIV. Poverty should be seen as both a driver of HIV transmission, and also a consequence of HIV. Strategies for effective stewardship of resource need to be designed as often when resources are available, they are not always used as efficiently as they could be thus sustaining the challenge of HIV/AIDS.

COMMUNITY ACTION

Some of the challenges identified relate to the inequalities in society and to cultures in a number of communities. There may be limited contact with people affected by the epidemic, so the decisions about resource distribution are taken without their input.³³ This spearheaded the increase in the vulnerability of the very people whose voices are least audible in society and may also be those at risk of contracting HIV. In responding to the above, the affected have mobilized themselves into establishing community support groups, post test clubs . These are constituted by people who have undergone through Voluntary testing .

Focus on prevention programs for youth by Religious and cultural institutions. These have focused;

On increasing knowledge about HIV and how it is transmitted and can be prevented.

Encouraging young people to delay the age at which they first have sex

Encouraging young people to abstain from sex

Encouraging those who are sexually active to have just one partner

³³ Gillian Paterson ed. , *HIV Prevention A global theological Conversation* (Geneva : Ecumenical Advocacy Alliance , 2009)

Encouraging use of condoms if having sex with someone other than a spouse. This is in general , however in this paper i encourage the condom use to be practiced in discordant couples and also as a family planning method for married people.

JOINT GOVERNMENT AND CIVIL SOCIETY ACTION .

Partnerships in service delivery has been instrumental in the implementation of activities addressing HIV/AIDS challenges. The government has networked with civil society and international organizations in responding to HIV/AIDS in the country by raising financial aid to the civil society organizations. The joint action has scaled up support which involves capacity enhancement programs to prevent the spread of HIV. Support and care for those infected and ease the impact of HIV on families and communities.

Support from the Global Fund, the Global Fund to Fight AIDS, Tuberculosis and Malaria was created to significantly increase resources to fight three of the World's most devastating diseases, and to direct those resources to areas of greatest need. As a partnership between government, civil society, the private sector and affected communities, the Global Fund represents an innovative approach to international health financing.

Although there is evidence of collaboration between the Government and Civil Society there is still need to strengthen their roles according to their mandate and comparative advantage to support expanded prevention initiatives.

2.3 Effects of HIV AND AIDS epidemic on Church

2.3.1 Dissolving families

When a parent dies the house hold may dissolve and the children are sent to live with relatives or left to fend for themselves³⁴, this is a great effect on the church, the church is basically built up by family units, so when it is dissolved and the children are scattered to other places the church is greatly affected. Therefore this is one of the main challenge of HIV/AIDS which calls for a Church's response in building programs that will enable to keep families together amidst the loss of their parents.

2.3.2 Reduction in Christians tithing

The number of Christians tithing is greatly reduced when a staunch Christian dies, and the amount of money that could be given by a couple as tithes is spent on Medical bills in cases where the couple is infected.³⁵ Therefore the dwindling income of the church has brought up under development in the institution and the capacity to work on the establishment of self reliant projects is hampered with.

2.4 Effects of HIV and AIDS epidemic on the family

2.4.1 Social Stigma

It is common knowledge that people react differently to the threat or confirmation of illness. What is striking about families affected by HIV/AIDS is that, among many of the issues that most families face in dealing with an ill member, the additional issue of social stigma associated

³⁴ Data source: *Researcher in the Field* 2010.

³⁵ Kakooza Wilson (Rev), *interview* , Namirembe 29/09/2010.

with the diagnosis will also arise. The marginalization of people with HIV disease is as a direct consequence of their sexual orientation, sexual behavior or drug use, fear of an infectious disease, as well as social unease with death and dying. Some people view infection with HIV as the fault of the individual and AIDS as punishment for immoral or offensive behavior.

Disclosure of the diagnosis in the family may confront its members with revelations about lifestyle or behavior, such as homosexuality, infidelity or intravenous drug use. Even though there is some evidence of more enlightened views towards this stigmatized population, on a global scale there is increasing discrimination against people with HIV infection. Family members are also affected by social stigma and may experience rejection from friends³⁶, loss of jobs and harassment as well as more subtle gestures such as neighbors not visiting and children not being invited to parties.

Therefore the increased discrimination against people with HIV infection has to greatly be handled as there is a great need to eliminate it completely. People Infected and affected need care and love and a need to be part of the entire community and thus contributing to its development.

2.4.2 Isolation and Secrecy

Social isolation resulting from a fear of stigma is one of the most challenging problems faced by these families. On the one hand family members may draw a boundary between the family and others outside this system by not disclosing the diagnosis to more distant relatives, friends, close colleagues and others who comprise the social support system. There may also be secrets within the family unit where children are not told the diagnosis or elderly parents are protected from the

³⁶ Respondent , Masulitta 21/09/2010.

news where there is a belief or myth that this would compromise their health.³⁷ Sharing should always be encouraged as people that might be chose not to disclose results , may turn out to be helpful as they might act as a link in accessing health care.

2.4.3 Social Support

Studies of social support and emotional well-being have demonstrated that people with AIDS report fewer feelings of depression and helplessness if they have close friends or relatives to talk to about emotional and illness-related problems. People with HIV who fear disclosing their diagnosis to others and who are socially isolated may be at increased risk for psychological problems. Many PLWA are dependent on Institutional support networks (NGO's, FBO's & CBO's) rather than on parents or siblings³⁸. In some urban centers where there are large concentrations of people infected with HIV, an increasing number of PLWA suffer multiple losses in their social support networks. The number of losses experienced is positively correlated with sedative use, traumatic stress responses and uptake of psychological services.

2.4.4 Stress and Coping

Stress is commonly seen in family members who may react to news of the diagnosis with disbelief, shock and confusion.³⁹ The feelings experienced by family members where someone is dying may include guilt, helplessness, depression, anger, confusion and despair. There may be more rules prohibiting emotional expression, greater anxiety about illness and less trust in families affected by HIV/AIDS. This may be a further manifestation of preexisting relationship problems in the family in addition to the stress arising from illness in the family and a fear of social stigma. For this reason, it is reasonable to conclude that families affected by HIV/AIDS

³⁷ Focus Group Discussion ,Gombe , 21/09/2010

³⁸ Robert Igo, *Listening with Love : Pastoral Counseling* , (France :WCC Publications , 2005)

³⁹ Dixon Patrick , *AIDS and YOU* (India: OM Books, Secunderabad, 2004)

may face more complex problems in their adjustment to, and coping with, illness than other families having to deal with death and dying. Therefore these families should be assisted to access psychosocial services as this will enable them cope easily with the condition and be supportive to the patient. This can be done by promoting team counseling, attaching the patient to a qualified trained counselor, having home outreaches which promotes active community participation in offering care and also arrange trainings for the catechists and Christian lay leaders to be counselors as part of the pastoral ministry.

2.4.5 Communication and Disclosure between parents and their Children

The dynamics of relationships between parents and their children and disclosure of HIV/AIDS to them is a more complex matter. Infants and children may be either infected with HIV or affected by other family members who are themselves infected. Most children worldwide who have been diagnosed with HIV infection were infected by parents and for this reason the mother and possibly other family members will also be infected.⁴⁰ Parents face the difficult task of achieving some balance in the child's life between normal routines and the added demands placed on all spheres of life brought on by illness. Whether or not the child has been infected with HIV, there is a chance that children in the family will become orphans, which may lead to social and emotional deprivation. It is always important to encourage expecting couples both the Father and mother to be to attend antenatal clinics. These will enable the Mother access prevention of mother to child treatment, thus reducing the risks of giving birth to the sick child. And in cases where parents have died and children are orphaned⁴¹, support networks in the community should

⁴⁰ Peter Piot, *Report on the Global AIDS Epidemic*, UNAIDS, 2004

⁴¹ Gillian Paterson ed., *HIV Prevention A global theological Conversation* (Geneva : Ecumenical Advocacy Alliance, 2009)

be established by both the church, Local councils, clans, professional bodies, learning institutions, places of work and other welfare organizations to take care of the social and psychological needs of the orphans.

2.4.6 Family Responses to illness

Most families have to endure a long period of uncertainty about the course of illness. This is because the latent period before overt clinical symptoms of HIV disease are diagnosed can last a decade or more. The anticipation of a loss through physical illness in the family can disturb the current functioning of each family member who may be immobilized by the fear or dread of facing the loss. The shift from an asymptomatic to a symptomatic phase of illness may reactivate stress in the family system. Shock, fear, isolation, guilt, blame, feelings of being overwhelmed and psycho physiological distress may all resurface although this is commonly tempered by a measure of relief as the course of illness becomes clearer and more certain. Family members may be called on to provide greater material and emotional support at this stage. Changes in family relationships may be quite marked at this point of transition, sometimes punctuated by emotional tension, fighting or withdrawal. This stems from anxiety over people's needs not being met or an excess of support, both of which may become destructive to relationships.⁴²

Family members face a particular dilemma at the symptomatic phase of the disease. On the one hand there is a social expectation that they will offer hope and support to the member who is unwell, while at the same time they are faced with the reality that treatment and resources may be limited or ineffectual.⁴³ This can lead to secrets in the family as some members, including the infected family member who is unwell, are protected from the gravity of the situation. The

⁴² World Council of Churches, *Facing AIDS*, (France : Imprimerie Lienhart, 2002)

⁴³ Data source: *Researcher in the Field* 2010.

family looks inward as the illness progresses and death becomes imminent, and rivalry may surface between family members as they struggle to redefine their relationship with the dying person. At this stage, the parents, siblings and, where appropriate, the patient's partner, become the most important source of emotional support. A number of community based organizations have been established in the communities. In a way of meeting the basic needs for the unwell member of the family. Such opportunities have to be utilized to reduce the heavy load of meeting the financial costs of treatment.

2.4.7 Changing roles and structure in families

Deaths of parents in a home lead to change in family structure since the situation promotes child headed households⁴⁴. In addition to the profound psychological changes that a family may undergo when confronted with illness relating to HIV disease, important changes in the structure of families can also be observed. Illness almost always places a financial burden on families. This results from the direct costs of care and treatment and the disruption caused by loss of productivity. Where ill health interferes with the family breadwinner's mobility and employment, income may need to be replaced by other family members. In some cases, the role of the breadwinner cannot be substituted or replaced by others either because they are too ill themselves to work or they are fully committed to caring for other family members who may be unwell. This scenario is now all too common in parts of sub-Saharan Africa.⁴⁵ Changes in the structure of the family may become evident at different stages of illness or points of crisis. Assumptions may have been made about who is the next-of-kin, as this may not have been openly discussed in the family. There may be a need to clarify who has responsibility for making

⁴⁴ Robert Igo, *Listening with Love : Pastoral Counseling* , (France :WCC Publications , 2005)

⁴⁵ Gillian Paterson ed. , *HIV Prevention A global theological Conversation* (Geneva : Ecumenical Advocacy Alliance , 2009)

decisions on behalf of the patient if his or her health were to deteriorate. All people here should be encouraged to develop the culture of designing family memory books. These are different from Wills. They reflect the family hierarchy and in situations where the family head is bed ridden, it becomes easy to know the right person who has responsibility over the family and can make decisions on behalf of the ill head. However in situations where this does not work, the church to whom the patient belongs can take up the responsibility.

2.5 Effects of HIV AND AIDS epidemic on the economy

2.5.1 Reduction in life expectancy

At the current prevalence of 6% HIV and AIDS deny the country of some of its active population. According to the Uganda Human Development Report 2002, with over 1.7 million Orphans, Uganda becomes a country with one of the highest rates of orphan hood in the world⁴⁶ the dependency burden is high. In HIV and AIDS is affecting the great pillars of human development. Social economic empowerment programs have to be set up to target the orphans as this will build their capacities to meet their daily needs. Systems which support Clans, local councils, places of work face this challenge also have to be strengthened as they are more reliable and close to the affected.

2.5.2 Loss of productive Labour

A country's human and financial capital is deeply affected given that HIV and AIDS particularly affects the economically active, illness and deaths of household members lead to not only tragedy for the family and long term labour shortages in a country, but also life skills normally

⁴⁶ UNDP, *Uganda Human Development Report* ,(New York : 2002)

passed on to the future generation-the youth and other civil servants. Many skilled workers who have benefited from international scholarships have also been infected thus the country not benefiting from its investments.

2.5.3 The impact of bereavement on survivors

Research in social psychiatry has demonstrated that the death of a partner, spouse or other relative can affect the psychological and physical health of survivors or others who are bereaved. Furthermore, caregivers increasingly have to address the psychological needs of children and whose parents have died from AIDS. These findings have important implications for those affected by HIV as some of those who are bereaved may themselves be infected with HIV. Recent studies have sought to investigate whether bereavement has an adverse effect on the function of the immune system; whether survivors infected with HIV progress to AIDS more quickly than others who have not experienced bereavement; and whether social support buffers people infected with HIV from stress and the deleterious effects of adverse life events. Results of a recent study suggest that the survivor's immune system is not adversely affected by an AIDS-related bereavement. The effects of the death of a partner on depressive symptoms, anxiety and morale in both HIV-infected and non-infected gay care giving men were also investigated. Results of this prospective study revealed that prior to the death of the partner; HIV-infected caregivers were less distressed than those who were not infected. The profile was reversed after the death of the partner: HIV-infected partners displayed greater distress than the non-infected men. The latter may have experienced relief after the death of their partner, while HIV-infected men were left on their own to confront their disease.⁴⁷ In parts of Africa which have been heavily affected by deaths resulting from AIDS, rituals associated with funeral arrangements/and

⁴⁷ UNAIDS, Operational guide on GENDER AND HIV/AIDS : A rights based approach (New Delhi: Thompson Press, 2005)

mourning have had to be abandoned. Financial and other demands on kinsfolk and neighbours have become a significant burden as a result of multiple deaths. The survival of some clans in Africa could be threatened by a lack of available marriage partners for both young adults reaching maturity and those who have been widowed. A trend towards marrying very young women who are seemingly free from infection has also been noted. Therefore a wider campaign on HIV prevention should be strengthened in Schools.

2.6 Conclusion

In most societies, health and illness are at one level a private, individual matter, while at another, they have implications for relationships and social functioning. As with all illnesses, HIV disease affects the entire family system, the Church and the economy at large. Disruption in families affected by HIV may take many forms as relationships undergo change. While each family, Church and state has to process and adjust to these changes in its own way, we do not as yet have a clear view as to how culture, ethnicity or religion mediates this process, although the implications of HIV disease for an individual are inextricably linked to the social context where prevention, infection illness, treatment and care occur.⁴⁸ An understanding of the impact of HIV/AIDS on the family needs to be translated into supportive and therapeutic actions with individual family members and the family system as a whole. Approaches to counseling and support for people with HIV disease have tended to focus on the individual rather than on the family system. Therapeutic work with the family and the wider system has only recently been described. By studying the impact of HIV disease on the family, Church and Economy we come to understand, in part, the social context of HIV disease. At present, we lack extensive empirical

⁴⁸Gillian Paterson ed. , *HIV Prevention A global theological Conversation* (Geneva : Ecumenical Advocacy Alliance , 2009)

data that would yield important insights into how HIV/AIDS has affected families. As the focus for treatment in HIV care in the 1990s shifts from the individual to the family, we can anticipate a concomitant change in the focus of psychosocial research.

Conclusively one may ask that, “Will the church be able to make a difference”?

To answer this I would like to repeat the words used in Nairobi in 2001: “The churches have strengths, they have credibility, and they are grounded in communities”⁴⁹. This offers them the opportunity to make a real difference in combating HIV/AIDS. To respond to this challenge, the churches must be transformed in the face of the HIV/AIDS crisis, in order that they may become a force for transformation – bringing healing, hope, and accompaniment to all affected by HIV/AIDS.⁵⁰ Therefore the church has to put up strategies basing on family approach. This can be embedded in the house hold approach to HIV/AIDS care. The practical approach can be through the family life programs involving members of Mothers’ Union, Fathers’ Union, Christian women Fellowship, Christian Men fellowship and the Women’s Desk programs. These will strengthen the family approach to HIV/AIDS care.

⁴⁹ Ecumenical Pharmaceutical Network , *HIV/AIDS workshop for Church Leaders* , (Nairobi : 2001).

⁵⁰ World Council of Churches, *Responses of the Faith Based Organisations to HIV/AIDS in sub saharan Africa* (Geneva : 2003) . P.3

CHAPTER THREE

3 PRESENTATION OF FINDINGS AND DISCUSSION

3.0 Introduction

In every research it is vital to look at the demographic characteristics like gender, age and responsibility of the respondents so as to obtain good statistics from which conclusive facts about the entire population can be obtained. Therefore in this research, most of those demographic characteristics were looked at to come up with good information about the entire population. Strongly note that some questionnaires were answered by more than two people and thus the great variance of most statistics.

3.1.1 Gender of the respondents

The study showed that out of the 140 respondents, there were more males (62percent) than females (38.8percent) considered in the study to come out with the aims and objectives of the targeted study (see table 3.1 below). On the other side, lay readers, Parish Priests, heads of laity registered 88.2percent males and 11.8percent were females.

3.1.2 Age Distribution

It is clearly observed from table 3.1 that majority of the respondents (38percent) were in the age group of 41-50 years of which, their responses are considered to significantly impact the study

because of the length of time they have been in the field of HIV/AIDS, as compared to the 12percent in the age bracket of 20-30years.

3.1.3 Marital status

The study which was carried out in the urban centre as well as the age group of the respondents is reflected by the skewed relatively marital status with the largest part of respondents (64percent) who were married, followed by 18percent were single. (See table 3.1 below). The least of the respondents (8percent) were widowed.

Table 3.1 Summary of the Percentage distribution of demographic Characteristics

Administrators			Lay readers, parish priests, heads of lay		
Gender	Frequency	Percentage		Frequency	Percentage
Male	33	62		15	88.2
Female	19	33		2	11.8
Total	50	100		17	100
Age					
21-30	6	12		-	-
31-40	14	28		2	22.2
41-50	19	38		2	22.2
51++	1	2		5	55.6
Total	40	100		9	100
Marital Status					
Married	32	64		14	73.7
Single	9	18		4	21.1
Widowed	4	8		1	5.3
Total	45	100		19	100
Responsibility of respondents					
Church Leader	10	20	Lay readers	11	68.8
Health coordinator	6	12	Social worker	2	12.5
M& E Officer	5	10		1	6.3
Heads of Organizations	19	38	Principal	2	12.5
Volunteer	2	4		-	-
Doctor	2	4		-	-
None response	6	12	None response	-	-
Total	50	100		16	100
On average 13.2% of the respondents (gender, Marital status, and responsibilities held)					

Data source: Researcher n the Field, 2010.

3.1.4 Responsibility of respondent

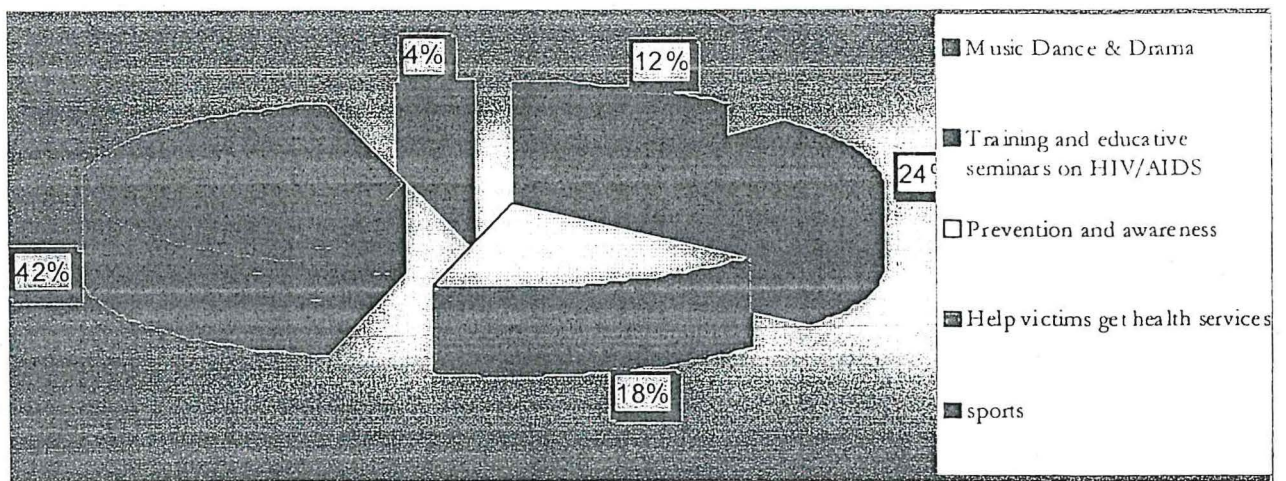
The responsibility of the respondent is a key factor in determining the respondents' obligation that is to say how far they are willing to sacrifice their services for the epidemic (HIV/AIDS). As shown in table.1 above, a large percentage (38percent) were heads of organizations, clubs, departments and centers with connection to HIV/AIDS closely followed by 20percent who were church leaders (4percent) doctors ; and volunteers at a draw Fear of responsibility disclosure was reflected by 12percent of the respondents that did not respond to what their jobs/ duties held.

3.2 BACKGROUND RESPONDANCE / DIOCESAN REPOSE

3.2.1 HIV/AIDS Awareness and Prevention Programs Promoted.

Given that 42percent of the respondents helped victims get health services, it's an indicator that majority of the HIV/AIDS victims were aware of the services offered and where to get them from. However, they were followed by 24percent who trained and held educative seminars on HIV/AIDS (See Fig3.1 below for details)

Fig 3.1: HIV/AIDS awareness and prevention programs that are promoted



Data source: Researcher in the Field, 2010.

As shown in fig 3.1 above, the study showed that many awareness and prevention activities were carried out, including 18percent involved in prevention and awareness (promoting abstinence, being faithful to one partner and a few encouraged use of condoms). Others included dramatizing the aspect of HIV/AIDS (12percent of the respondents) so as to pass on the message to the public. The least number (4percent) carried out sports events like football, netball, indoor game with an aim of congregating numerous people to the awareness and prevention messages that were passed across

3.3 Activities Done in Relation to HIV/AIDS Programs

Table 3.2 below summarizes responses showing activities done by the Diocese in its response to HIV/AIDS challenges. Majority of the respondents 40.7% had HIV prevention as one of the foremost activity, given on the list of their programs. In the field of HIV prevention, numerous activities were done, including promotion of being faithful to one partner, Peer education with a focus on abstinence, Community sensitization, preaching against HIV/AIDS but not

stigmatizing, collaborating with other organizations where necessary and many other activities. In this regard, HIV prevention was spearheaded by heads of organizations/institutions and clubs constituting a17.8% that is to say directors, heads of department, chairpersons and principles. With 14.1percent accruing to Voluntary Counseling and Training , this was courtesy of the heads of the organizations.

Table 3.2 Responsibility of Respondents by activities done in relation to HIV/AIDS

Responsibility of respondent	HIV Prevention	Care & Support	VCT
Church Leaders	3.7	4.4	3.6
Health Coordinator	2.9	0	8.1
M&E officer	0	0	0.9
Head of Organization	17.8	15	14.1
Volunteer	3.7	0	1.3
Doctor	5.6	3	1.8
None Response	7.0	4	3.1
Total	40.7	26.4	32.9

Source: Researcher in the field, 2010.

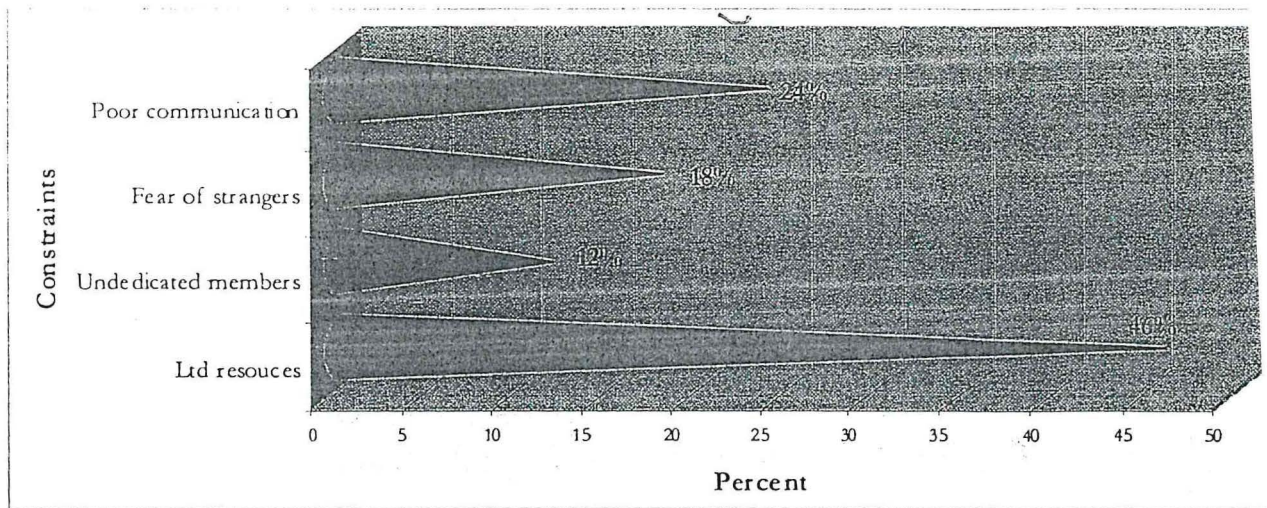
The study highlighted 26.4% of activities under the care and support category. These mainly focused on care of orphans and vulnerable children. 4.4% of the respondents who were church leaders had provided care and support to orphans and vulnerable children. 32.9% of the respondents mentioned activities relating to voluntary counseling and testing. These were mainly working with the HIV/AIDS support groups, the post test clubs.

3.4 CHALLENGES OF HIV/AIDS EPIDEMIC IN UGANDA

3.4.1 Organizational constraints

This sub-chapter investigates the objective of studying and discovering the challenges of HIV/AIDS epidemic in Uganda. The questionnaire was designed capturing the respondents' expressed scrutiny on the challenges of HIV/AIDS in Uganda. Several challenges are faced by the infected and the affected. In this study, emphasis is put on those involved in the process of awareness, prevention and treatment of the infected. The major constraint that they faced incorporated limited resources (46percent) in terms material items, funds, infrastructure, solidarity support from all parties involved and or knowledge on how to entice people into voluntary testing and disclosure. It was thus followed by poor communication within the organizational staff and to the beneficiaries

Figure 3.2. Constraints/challenges experienced in the organizations.



Source: *Researcher in the field, 2010.*

3.4.2 Priority issues addressed by the organizations/institutions, highlighting the weaknesses faced that hinder the progress institutions and organizations.

Table 3.3 Weaknesses Encountered by Priority Issues Addressed in the Institution.

	Accountability	Inadequate funding	Lack of enough Logistics	Wrong perceptions	Poor Planning	No follow-ups.
1.	HIV Prevention awareness	5.1	4.8	5.3	4	4.2
2.	Logistical Support	5.8	4.3	3.3	6	6.3
3.	VCT	2.2	3.2	2	3.3	-
4.	Moral rehabilitation	0.7	1.6	2	0.7	2.1
5.	Capacity Building	2.2	2.2	4	2	4.2
6.	MDD	0.7	0.5	-	0.7	-
	Total	16.7	16.8	16.7	16.7	16.8
NB: An Asterisk (*) indicates that the percentage is zero						

Data source: Researcher in the Field, 2010

On average, all the weaknesses faced had the same rating with correspondence to the priority issues addressed in the institutions and organizations. A total of 5.8percent of the respondents who had logistical support as the highest priority issue rated agreed that accountability of funds was their main weakness. They were closely followed by those who addressed awareness and

prevention of HIV/AIDS issue, with lack of enough logistics which entails drugs, communication aids, travel support and office utilities being their major weakness (5.3percent). Still in unison the two factors further did posses inadequate funding as a remarkable hindrance for the progress of their institutions. The least was Music, Dance and Drama with a major constraint of inadequate funding (0.5percent). See table 4.3below for details.

3.5 Assessment of the response and impact of Namirembe diocese in addressing the challenges of HIV/AIDS.

3.5.1 The concern of the church on the issue of HIV/AIDS

Table 3.4 Church's involvement on the issue of HIV/AIDS

	Ways in which the church has contributed in Supporting these activities.	Total
1.	VCT	28.6
2.	Sensitization about HIV/AIDS	20.0
3.	Logistical Support	18.1
4.	Provision of funds	9.5
5.	Others	23.8
	How the church has addressed the issue of preventing further Spread of HIV/AIDS.	
1.	Peer education	20
2.	Life skills	35
3.	Encourage VCT	35
4.	Music, Dance & Drama	10
	What the church has done to reach those infected.	
1	Good counseling and positive living	38.9
2	Peer education	27.8
3	Preach against stigma	22.2
4	Provision against of Logistics	11.1
	Total	100

Source: Researcher in the Field, 2010

The study showed that out of the 83.3percent percent that were in support the fact that the church was supportive in any of the HIV/AIDS programs, 23.8percent of them rendered that voluntary counseling and training was the most activity the church contributed in support to HIV/AIDS programs. 16.7percent of the respondents admitted that the church was not supportive in any HIV/AIDS activity. (See table 3.4 for details).

Most of the respondents (38.9percent) disclose that the church carried out good counseling and positive living to reach out to those infected. This means that in the process stigma was reduced, increase in disclosure of the peoples' status and increased on the level of confidence of those infected.

As observed from table 3.4 above, 83.3percent of the respondents revealed that the church was supportive in implementing HIV/AIDS programs. The church ought to be appreciated for the good work done so far in the fight against HIV/AIDS. Mutually the Church is also obliged to appreciate those who have performed well as this builds up motivation and strengthens partnerships and creativity amongst the actors.

Peer education (20percent), imparting life skills (25percent) and encouraging Voluntary Counseling and Training (30percent); as some of the ways the church had addressed the issue of preventing further spread of HIV/AIDS almost had the same share with respect to acceptance of the fact that the church supports programs relating to HIV/AIDS in Namirembe Diocese which has created impact. This strong input by the church is greatly

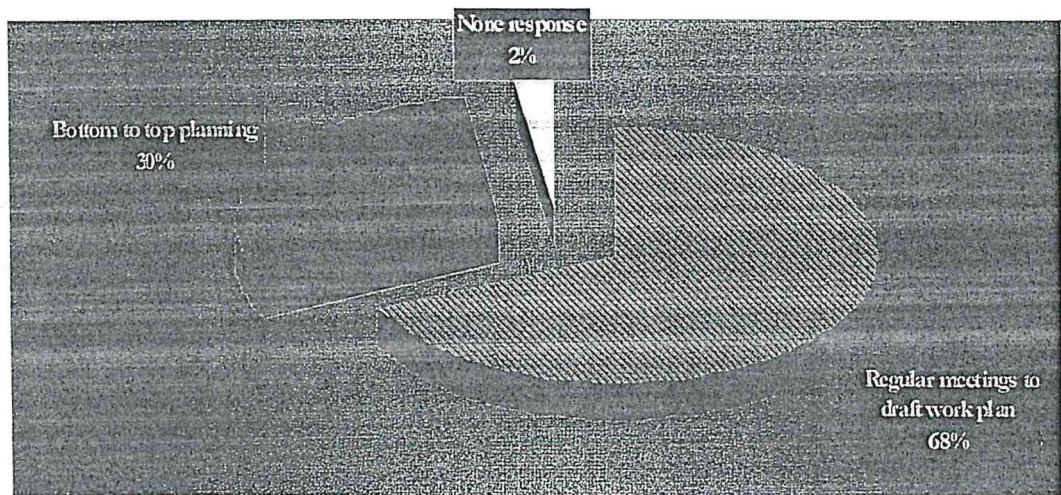
attributed its strict instinct of proper moral behavior and support for the community. (See table 3.4 for details)

3.5.2 Establish the sustainability of the HIV/AIDS work in Namirembe Diocese.

3.5.2.1 How planning is done in organizations/institutions

The highest percentage (68percent) of the respondents had regular meetings to draft work plans and to allocate duties and periods for their projects and activities. In some organizations, committees were set up for exactly planning for the programs, in others all the staff who were involved in the programme activities participated in the planning process.

Fig 3.3 How planning is done in the organizations/institutions



Source: Researcher in the field, 2010.

The least (30percent) did bottom to top planning, that s from the grass roots, involving all the stakeholders. This was done in such a way that committees would sit as well as plan

and then send the plans to the next level which was higher than the previous. (Refer to figure 3.3 above) None response (2percent) was attributed to ignorance of the particular respondents of the method their organization/institution used for planning. (See fig 4.3 above.) Therefore there is a need of having trainings for all stakeholders before the planning and strategic design process. This will enable the target beneficiaries to actively participate in the planning thus enable them track the programme progress.

Table 3.5 Activities done in the HIV/AIDS Programs

Table 3.5 Activities done in the HIV/AIDS Programs

Activities done in the HIV/AIDS Programs		Frequency	Percentage
	<i>HIV Prevention</i>	14	18.4
	<i>Care & Support for PHA, OVC</i>	12	15.8
	<i>Treatment and Medical Supplies</i>	10	13.2
	<i>Logistical Support</i>	14	18.4
	<i>VCT</i>	17	22.4
	<i>Initiate life skills</i>	9	11.8
	Total	76	100
<i>External factors that hinder the progress of institutions / Organizations</i>			
	<i>Local Administration</i>	10	21.3
	<i>Logistic Provision and distribution</i>	17	36.2
	<i>Collaboration from other institutions / organizations</i>	20	42.6
	Total	47	100

NB: The frequency Varies because some Questionnaires were answered in groups of more than three people

Data source: Researcher in the Field, 2010

CHAPTER FOUR

4 SUMMARY, CONCLUSION AND RECOMMENDATIONS

4.1 Summary

4.1.2 Challenges of HIV/AIDS Epidemic in Namirembe Diocese.

4.1.2.1 Inadequate funding

The Diocese mobilizes resources from its partners outside Uganda greatly and has dedicated one Sunday in the year known as a Good Samaritan Sunday where all Christians contribute towards the HIV/AIDS activities. These funds have not matched the magnitude of activities designed for implementation, thus standing as one of the major challenges encountered.

From the research findings, a total of 5.8percent of the respondents who had logistical support as the highest priority issue rated agreed that accountability of funds was their main weakness. They were closely followed by those who addressed awareness and prevention of HIV/AIDS issue, with lack of enough logistics being their major weakness (5.3percent). Still in unison the two factors further did possess inadequate funding as a remarkable hindrance for the progress of their institutions. The least was Music, Dance and Drama with a major constraint of inadequate funding (0.5percent).

4.1.2.2 Low Support offered to PLWA in the Diocese

The Diocese offers important support to the people living with HIV and AIDS in a way that; prevention efforts are given the highest support (40.7percent), these are followed by Voluntary counseling and testing (32.9percent) and care & Support is not strongly supported constituting 12.9percent, However, 13.5percent of the respondents didn't disclose their views on the sub

topic because they did not have any program for People Living with AIDS in there areas, so they did not have knowledge on what type of support that the Diocese offers to them.

4.1.2.3 Poor involvement of Communities.

The Diocese has a vast structure which exists in almost all parts of the community. This advantage puts it in a favorable position where it is effective with implementing activities that will impact on preventing the spread of HIV/AIDS and providing care for PWHAs. The challenge of poor involvement of communities has contributed to the lack of financial support, Lack of teams to strengthen home visits, weakened the relationship between the church and the local leaders. It has also brought the community not being sensitized to join hands with the church and resorted to viewing the Church as donors thus making the church efforts lukewarm to fight the monster.

This can be addressed by creating up community support teams at the various levels of the church. These teams will be charged with the responsibility of addressing the highlighted weaknesses independently, thus coming up with locally owned solutions.

4.1.2.4 Poor Financial system

The Diocese runs a consolidated financial system , which merges all financial resources for all departments together. From the study it was discovered that if the Diocese does not separate accounts for departments to run their own accounts and funds; lack of financial support together with dependence on outside support shall continue to be mega challenges in the fight against

AIDS. The separation of accounts will inspire the departments to raise resources to run departmental programs.

What is required from the Diocese is to build capacities of Departments in resource mobilization and corporate governance. This will build their capacities in mapping local resources and their effective usage, thus decreasing the dependence on the external resources.

4.1.3. Activities done in relation to HIV and AIDS programs

HIV and AIDS awareness & Prevention programs promoted given that 42 percent of the respondents who lived with the virus knew where to get health services, it's an indicator that majority of the PLWA were aware of the services offered and where to get them from. However, they were followed by 24 percent who trained and held educative seminars, the study showed that many awareness and prevention activities were carried out, including 18 percent involved in prevention and awareness (being faithful to one partner, promoting abstinence, and a few encouraged use of condoms). Others included dramatizing the aspect of HIV/AIDS (12percent of the respondents) so as to pass on the message to the public. The least number (4percent) carried out sports events like football, netball, indoor game with an aim of congregating numerous people to the awareness and prevention messages that were passed across.

The study also depict that about 4.4 percent of the respondents who are church leaders provided care and support for orphans and vulnerable children. The least were M&E officers who constituted for 0.9 percent for voluntary counseling and training. None response was mainly due to failure of disclosing responsibilities held by the respondent and as such could not tally with any activity.

4.2 Conclusion

4.2.1 Inadequate funding

There is need to do a resource mapping exercise which will enable the Diocesan Health programs in enlisting potential partners that will be able to finance a number of its programs. Funding HIV/AIDS activities is supporting development. HIV/AIDS has had a profound negative effect on development as it strikes mainly the sexually active, who are also economically active in society.

4.2.2. Low Support offered to PLWA in the Diocese

A church is ideally placed to make an important contribution to efforts to prevent the spread of HIV and to provide care and support for PLWAs. There is need to explore this potential as Churches represent a recognizable community that can be mobilized even in situations where perceptions of community based on geography are weak. They have access to substantial human resources with many skills in counseling , life skills education and a pool of voluntary financial contributors per Sunday . With this comparative advantage support to PLWAs should be scaled up.

4.2.3 Poor involvement of Communities

When people are fully involved, programs belong to the community that benefits the services, and not the aspirations of the institution. The community is not necessarily restricted to a geographical area, but rather the term community – based denotes that the local community owns it.⁵¹ This addresses the challenge of HIV/AIDS in a sustainable manner.

⁵¹ Dixon Patrick , *AIDS and YOU* (India: OM Books, Secunderabad, 2004)

4.2.4. Poor Financial system

The Diocese needs to develop a clear and open financial management system which empowers departments and programs. This also calls for a clearly defined organizational structure to be prepared and made known to all in the organization. People benefit from knowing who they are responsible to.

4.3 RECOMMENDATIONS

4.3.1 Resources

Developing relationships with funders is key ; the church should use its strength to lobby for more funds for program implementation. There should be the creation of an HIV/AIDS fund basket at all levels of the church. i.e Local church , Parish , Archdeaconry and Diocesan levels. Christians should be encouraged to contribute towards the HIV/AIDS fund basket at their church level so as to have local funds raised to support activities aimed by the church to carry out AIDS prevention, care and treatment programs among its congregation. A number of supporting mechanisms can be created which include monthly pledges or commitments by individuals towards this fund, income generation activities established to support the fund and also target local resources available at the Divisional, sub county and District administration levels.

4.3.2 Care and support

Holistic support be availed, Physical, Spiritual, Emotional, Economic support by non professional church members for all who are ill in the community, not only PLWA rather harmonize responses with existing medical support linked to counseling.

4.3.3 Community involvement

The church leadership should utilize the process approach to development at a means of having a Shared vision that is Community owned and serving the community then the people shall be part of the development process in the church programs hence their sustainability.

4.3.4 The work is for the whole church body:

Christians should be made aware that taking care of God's flock is work for the whole church not only local pastors. People must be Faithful, Able, Teachable, and Committed Christians with

concern for AIDS patients. Willing to work with all levels of the community; Parishes, community centers, Villages, schools, Universities, government and non Christian NGOs which include; AIDS Information Center, Uganda National AIDS Support organization , The AIDS support Organization and National network of people living with HIV/AIDS.

4.3.5 Organizational Management

Quality Christian leadership should be sought amidst the congregations to build on the Organizational capacity of the church– skill mix is evident, delegation of responsibilities to responsible Christians on a voluntary basis, using peoples skills to build Effective and efficient structures for Planning. A planning, Development and Advisory team designated in the church, utilizing other existing church structures; spiritual, education, welfare, and health Responsible to train, co-ordinate and support the growth and development of the church.

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Appendices

Appendix I: List of Informants

Name	Designation	Means	Date of Interview
Ajok Florence Adoch	TASO Mulago Centre Manager-	Interview	22/09/2010
Akisoferi Maguzi Rev. Canon	Archdeacon Kazo	Interview	20/09/2010
Angella Nambatya	Focus group member	FGD	21/09/2010
Annet Nanseera	Focus group member	FGD	21/09/2010
Bakisuula Paul	Youth Leader	FGD	24/09/2010
Beatrice Nakafeero	Focus group member	FGD	21/09/2010
Beatrice-Cashier & Store Keeper	Kisasi dispensary	Interview	20/09/2010
Benard Kityo	Head of Laity	Interview	21/09/2010
Bernard Kikomeko	Focus group member	FGD	21/09/2010
Buwembo Godfrey Rev.	Diocesan Youth Secretary	Interview	20/09/2010
Bwete Sendyowa Rev	Parish Priest – Masulita	Interview	21/09/2010
Catherine Kimanje	Diocesan Mothers Union Worker	Interview	23/09/2010
Charles Barungi	Laboratory Technician	Interview	20/09/2010
Charles Mawanda	Focus group member	FGD	21/09/2010
Christine Namuzibwa	Focus group member	FGD	21/09/2010
Christopher Mubiru	Peer Educator – Kyampisi	FGD	21/09/2010

Daniel Ddumba Ssentamu Rev	Priest – Mwererwe	Interview	21/09/2010
David Kabiswa	Director ACET	Interview	23/09/2010
David Lumala	Youth Leader	FGD	24/09/2010
Edith Nabawanuka	Focus group member	FGD	21/09/2010
Edward Gombe Rev.	Priest - Ssesse Parish	Interview	30/09/2010
Edward Sebuwufu Lubega.	Focus group member	FGD	21/09/2010
Edward Walakira	Lay reader	Questionnaire	23/09/2010
Elizabeth Ssemujju	Lay reader	Questionnaire	23/09/2010
Evatt Mugarura Rev	Director ALYED and Former Director CHUSA	Questionnaire	20/09/2010
Florence Kyambadde	Focus group member	FGD	21/09/2010
Florence Miiro-	Health Dept Staff	Interview	20/09/2010
Godfrey Mutyaba	Youth Leader	Questionnaire	24/09/2010
Grace Namuddu	Focus group member	FGD	21/09/2010
Harriet Nakakawa	Health Dept Office administrator	Questionnaire	20/09/2010
Harriet Segane	Head of Laity	Questionnaire	23/09/2010
Hasfa Nakakande	Focus group member	FGD	21/09/2010
Henry Ntulume Rev.	Can Archdeacon	Questionnaire	25/09/2010
Jackson Nsenga	Focus group member	FGD	21/09/2010
Jackson Ssekwazira	Lay reader	Questionnaire	30/09/2010

James Lubega Musisi	Lay reader	Questionnaire	23/09/2010
Jane Nakabonge	Focus group member	FGD	21/09/2010
Jessica Nakakande	Focus group member	FGD	21/09/2010
Joel Wakantuntu	Counseling Aide	Interview	20/09/2010
John Byansi	Focus group member	FGD	21/09/2010
Jonathan Ssevili	Focus group member	FGD	21/09/2010
Joshua Kitakule	Secretary General Inter-Religious Council of Uganda	Interview	20/09/2010
Joyce Nakayima	Focus group member	FGD	21/09/2010
Kamoga Stephen	Lay reader	Questionnaire	23/09/2010
Katumba Elizabeth Rev	Chaplain Mengo Senior School	Int/Questionnaire	24/09/2010
Kawooya Eriya Rev	Diocesan Planning & Dev't secretary	Int / Questionnaire	22/09/2010
Kezia Namutebi	Youth Leader	FGD	24/09/2010
Kitaka Gordon	Coordinator Health Units	Int/ Questionnaire	22/09/2010
Kyambadde Harriet	Incharge Nateete Dispensary	Interview	25/09/2010
Kyanda Rev	Priest Luzira	Int/ Questionnaire	22/09/2010
Kyobe James	site coordinator	Interview	30/09/2010
Lovincer Nabaaka	Focus group member	FGD	21/09/2010
Luboga Sam- Rev.Dr.Prof ,	Chairman Health Board	Interview	22/09/2010

Lumu Stephen	Youth Leader	FGD	24/09/2010
Lydia Kanyago	Nurse Kisasi dispensary	Interview	20/09/2010
Magdalena Nantume	Focus group member	FGD	21/09/2010
Male Bakka Patrick	Headmaster		
	Kings College Buddo	Interview	23/09/2010
Matovu Moses	Former Diocesan Health		
	Secretary	Interview	24/09/2010
Matseketse David Chrispus	Provincial Health Secretary	Interview	22/09/2010
Moses Batambuze	Health Department Staff	Interview	20/09/2010
Mukalazi Geoffrey	AIDS Officer –Uganda		
	Joint Christian Council	Questionnaire	23/09/2010
Mulondo Aloni Rev	Priest Kisaasi	Interview	20/09/2010
Musoke Silas Rev. Canon	Archdeacon	Interview	23/09/2010
Nakibuuka Milly	Focus group member	FGD	21/09/2010
Ndiwalana Rogers	Focus group member	FGD	21/09/2010
Nelson Balyeku	M&E Officer CHUSA	Interview	22/09/2010
Nelson Kaweesa Rev. Can	Diocesan Secretary.	Interview	20/09/2010
Noelina Nagayi	Focus group member	FGD	21/09/2010
Polly Musiime Rev.	Curate Namirembe	Interview	22/09/2010

Ponsiano Kalule	Focus group member	FGD	21/09/2010
Prossy Nabatanzi	Focus group member	FGD	21/09/2010
Racheal Nsangi Sebuwufu	Lay reader	Questionnaire	21/09/2010
Rebecca Mukasa Mutaawe	Program Officer		
	HIV/AIDS – IRCU	Questionnaire	20/09/2010
Rhoda Nakintu	Lay reader	Questionnaire	21/09/2010
Robinah Nakandi	Focus group member	FGD	21/09/2010
Ruth Nagawa	Focus group member	FGD	21/09/2010
Salasamba Joseph	Social worker	Interview / Questionnaire	24/09/2010
Sam Lwere Rev	Priest Mpererwe	Interview	22/09/2010
Sam Reteikara Rev	Former Director CHUSA	Interview	22/09/2010
Samuel Muwonge Rev	Chaplain Kings College Buddo	Interview	24/09/2010
Segawa Henry Rev Canon	Principal (UMSN)	Interview	25/09/2010
Solomon Lule Banabakintu	Head of Laity	Questionnaire	21/09/2010
Stephen Mugwanya	Focus group member	FGD	21/09/2010
Teo Nabadda	Peer Educator	FGD	21/09/2010
Teo Nabagala	Focus group member	FGD	21/09/2010
Twaha Sesanga	Focus group member	FGD	21/09/2010
Walusimbi Kezekia Rev	Diocesan Estates Secretary	Interview	24/09/2010

Wasswa Elly Rev. Diocesan Healing ministry Coordinator	Interview	25/09/201	
Wilberforce Kityo Luwalira	Bishop Namirembe Diocese. Interview	20/09/2010	
Willy Nsubuga	Focus group member	FGD	21/09/2010
Wilson Kakooza Rev. Vicar	St. Pauls' Cathedral Namirembe	Interview	22/09/2010

Questionnaire for people lay readers, Parish priests and Heads of laity.

SECTION A:RESPONDENTS BACKGROUND

1. Name of Respondent

.....

2. Responsibility of respondent

.....

3. Age completed:

4. Sex:(a) Male

(b) Female

5. Marital Status

(a) Married

(b) Single

(c) Divorced

(d) Widowed

MAGNITUDE OF HIV/AIDS.

- 6. Have you ever heard of an illness called AIDS ? Yes / No
- 7. Do you know if there is anything a person can do to avoid getting AIDS ?
Yes / No / I don't know
- 8. Do you know some one personally who has AIDS or the virus that causes AIDS or some one who died from AIDS ? Yes / No
- 9. Have you ever talked about HIV/AIDS with your spouse or regular sex partner?
Yes / No / Not married / No regular partner

SECTION B: GENERAL PARTICULARS

10. Has the Church been supportive to your kind of work?

1. Yes

2. No

11. If yes, state any way in which it has contributed in supporting your work.

1.

2.

3.

12. What activities do you conduct to support people living with HIV/AIDS

1.
2.
3.

13. How have you addressed the broader issue of preventing the further spread of HIV?

1.
2.
3.

14. How have you dealt with stigma, shame, discrimination and denial associated with HIV/AIDS?

1.
2.
3.

14. What are the effects of AIDS on the family?

1.
2.
3.

15 . What are the effects of AIDS on the economy?

1.
2.
3.

16 . What are the effects of AIDS on the Church?

1.
.....
2.
.....
3.
.....

17 . What has the Church done to reach out to those infected with HIV/AIDS?

1.
.....
2.
.....
3.
.....

18. What has been the impact of the Church's above response?

1.
.....
2.
.....

3.

I thank you for your time and views you have so freely and generously given.

Questionnaire for members of Health Board, Heads of Department , staff in the Health Department and Administrators and members of Facilities and programmes in the Diocesan.

I am a student of Kyambogo University doing research on The Challenges of HIV/AIDS: A case of Namirembe Diocese Church of Uganda..

The purpose of this study is academic and information given will be treated with strict confidence.

The study is for a report to be submitted as a partial fulfillment of the requirement for the award of the Masters Degree of Religious Studies of Kyambogo University.

Kabanda Paul Richard

Questionnaire for members of Health Board, Heads of Department , staff in the Health Department and Administrators and members of Facilities and programmes in the Diocesan.

SECTION A:RESPONDENTS BACKGROUND

1.Name of Respondent

.....

2.Responsibility of respondent

.....

3.Age completed:

4.Sex:(a) Male

(b) Female

5.Marital Status

Married

Single

Divorced

Widowed

MAGNITUDE OF HIV/AIDS.

- 6. Have you ever heard of an illness called AIDS ? Yes / No
- 7. Do you know if there is anything a person can do to avoid getting AIDS ?
Yes / No / I don't know
- 8. Do you know some one personally who has AIDS or the virus that causes AIDS or
some one who died from AIDS ? Yes / No
- 9. Have you ever talked about HIV/AIDS with your spouse or regular sex partner? Yes /
No / Not married / No regular partner

SECTION B: GENERAL PARTICULARS

10. If a person knows that he / she has AIDS , do you think that he / she should keep it
private or tell other people in the community ? Should keep it private / Should tell
others / Don't know or not sure.....

11. If keeping it private, what is the justification for keeping it private?

.....
.....
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.....
.....
.....

12. What HIV/AIDS awareness and prevention program activities are you promoting in your institution?

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.....
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.....

13. Do you have any on going campaigns? Yes / No

14. If no, what type of awareness and prevention programs are you planning for your congregations?

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.....

15. What are the priority issues that your institution has to address in order to effectively implement the HIV/AIDS activities?

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16. What constraints do you experience relating to your organizational structure in implementing HIV/AIDS activities?

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17. What field of operation does your organisation perform the best?

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.....

18. What activities do you feel most comfortable with their implementation?

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.....
.....

SWOT ANALYSIS.

19. What are the strength of your institution to successfully implement HIV/AIDS program?

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20. What weaknesses are faced that hinder the progress of your institution with regard to HIV/AIDS program?

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21. What are the external factors that create an enabling environment for HIV/AIDS activities?

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22. What are the external factors that may threaten the accomplishment of your mandate in so far as HIV/AIDS program as concerned?

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23. Do you consider Financial allocations (Allocated budget votes) sufficient to enable efficient operation for HIV/AIDS program activities?

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24. How is planning of activities done in your institution and how effective is it?

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.....
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25. What mechanisms are in place to perform monitoring and evaluation of activities?

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.....
.....

26. How do you ensure quality management of activities?

.....
.....
.....
.....

I thank you for your time and views you have so freely and generously given.

6. Have you ever heard of an illness called AIDS?
7. Do you know if there is anything a person can do to avoid getting it?
8. Do you know some one personally who has AIDS or some one who died fro AIDS?
9. Have you ever talked about HIV/AIDS with your spouse or regular sex partner?
10. If a person knows that he/she has AIDS , do you think that person should keep it private or tell other people in the community?
11. In your Opinion what can a person do to avoid getting AIDS?
12. If you have a question about HIV/AIDS, who do you ask or where do you go to get the information?
13. What activities does your church do to create awareness on HIV/AIDS?
14. How has your church supported people affected and infected with HIV/AIDS?
15. How has your church dealt with the case of stigma, silence and discrimination, denial, fear and inertia that inhibit it form addressing HIV/AIDS related issues more effectively.
16. How best can the strategy of approaching the HIV/AIDS epidemic be improved?
17. How effective is the condom in controlling HIV/AIDS?
18. What is the Church's position on the condom use?
19. What activities has the Church put in place to curb down the spread of HIV/AIDS?

20. What are the effects of AIDS on the family?

21. What are the effects of AIDS on the economy?

22. What are the effects of AIDS on the Church?

12 . What has the Church done to reach out to those infected with HIV/AIDS?

13. What have been the impacts of the Church on the above response?

14. Have the impacts been able to be maintained? Yes No

15. If Yes , how have they been able to be maintained ?

16. If No , why have they not been able to be maintained?

I thank you for the time and for your views you have so freely and generously given.