2019

A Training Program for Members to Minister to HIV/AIDS Patients at the Nyagiki Seventh-day Adventist Church, Kenya

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ABSTRACT

A TRAINING PROGRAM FOR MEMBERS TO MINISTER TO HIV/AIDS PATIENTS AT THE NYAGIKI SEVENTH-DAY ADVENTIST CHURCH, KENYA

by

Job Ogoti Getange

Adviser: Moses Taiwo

ABSTRACT OF GRADUATE STUDENT RESEARCH

Professional Dissertation

Andrews University

Seventh-day Adventist Theological Seminary

Title: A TRAINING PROGRAM FOR MEMBERS TO MINISTER TO HIV/AIDS PATIENTS AT THE NYAGIKI SEVENTH-DAY ADVENTIST CHURCH, KENYA

Name of Researcher: Job Ogoti Getange

Name of degree of faculty adviser: Moses Taiwo, PhD

Date completed: August 2019

Problem

During my pastoral experience at Nyagiki, I observed that although HIV/AIDS was a big threat in the church and society, many of the church leaders were not involved in addressing this crisis. There were no intentional church training programs to warn the members about its danger. The church did not make a budget of time or money to address this pandemic. The root problem that caused this situation was lack of health information literacy on HIV/AIDS to equip these leaders with knowledge and skills to deal with this crisis.

Method

The Doctor of Ministry Research Project was conducted at Nyagiki Seventh-day Adventist Church between March 2016 and August 2017 (18 months). There were 24

adult participants—18 women and 6 men—who were effectively trained on how to care for people living with HIV/AIDS in their communities. The 24 participants formed four groups and were assigned a specific church territory to visit. On the last Saturday of each month, the participants met in their focus groups to discuss progress made and then send reports to the researcher.

Results

The report from the participants indicate that there was a total of 246 general visits made and a total of 40 visits made to people living with HIV/AIDS. In the last month of the project, the participants were involved in speaking at a one-week camp meeting which was held in their community. Two participants spoke each day at this event to represent each of the four focus groups. On Friday of the camp-meeting (one day before completion) a graduation ceremony was conducted, and certificates of recognition were issued to the participants. The researcher was the chief speaker at this camp-meeting and 29 people responded to the altar call.

Conclusions

Nyagiki Seventh-day Adventist Church has indicated increased church attendance and the leaders have planned to build a bigger church facility. People who came to the camp-meeting from other churches in the community made requests to have similar research projects conducted in their churches. Consequently, I recommend continued interaction with Nyagiki and the surrounding community to keep the fire burning.

Andrews University

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A Professional Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Ministry

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Dedicated to my wife and best friend in ministry, Gladys, for her love, support, and inspiration throughout the journey. To my daughters, Purity, Charity, and Esther, for their spiritual and moral support. To my father, Pastor Jameson Getange, for being my role model and a great source of inspiration. Please accept my profound love and appreciation to you and I hope that this document will inspire you to make greater achievements that will honor God.

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ABBREVIATIONS

ARV	Anti-Retroviral
CBO	Community Based Organization
FBO	Faith Based Organization
FGM	Female Genital Mutilation
NACC	National AIDS Control Council (Kenya)
NASCOP	National AIDS and STDs Control Program
OVC	Orphans and Vulnerable Children
PABAS	People Affected by AIDS
PLWHAS	People Living with HIV and AIDS
STI	Sexually Transmitted Infection
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

ACKNOWLEDGEMENTS

I give my heartfelt appreciation to God for His presence and leadership in this project. I thank my first adviser, Dr. Moses Taiwo, for providing the guidelines and encouragement that I needed. I thank him for reminding me to use the right teaching strategy—andragogy—in disseminating knowledge to the adult participants. I thank my second reader, Dr. Vaughan Grant, for the instructions on the course, "professional studies" for health-care chaplains and guiding me to write chapter 3 of my project. I thank Dr. Mario Ceballos, the project coordinator, and all the professors who took time from their busy schedules to provide valuable instructions and guidance. I thank my mentor, Dr. Fred Okemwa, and all my cohort members for their support and encouragement.

I thank Nyagiki church pastor and members for allowing me to implement this project in their church. I thank all the 24 participants who worked with me closely in this project. I thank South Kenya Conference for their support and scheduling me and the participants to speak at Nyansongo camp meeting. My Mother, Eunice Nyamoita, for her unceasing prayers and encouragement reaching me across the oceans. My father, the late Pastor Jameson Getange, for encouraging me to go as high as the stars in the service of God. My brothers and sister (and their family members) for their spiritual, emotional, and material support. Finally, and most importantly, my immediate family—my wife, Gladys, and my daughters, Purity, Charity, and Esther—for their love, support, and prayers.

CHAPTER 1

INTRODUCTION

In the year 2004 while serving as the pastor of Nyagiki Seventh-day Adventist Church—2003-2006—one adult member of this church reported to me that she had visited a voluntary counseling and testing (VCT) center and had tested positive on HIV/AIDS. This member indicated that she had been overwhelmed with grief when this sad news was broken to her; "I saw deep darkness before me," she said. Unfortunately, she was alone when this news was shared to her and she did not feel safe to share it with her family members or the people at church as a way of avoiding stigmatization.

My interaction with this member helped me to understand three important facts. First, HIV/AIDS is real and affects people who are close to me, my church members. Second, people who test positive for HIV/AIDS often get overwhelmed and need the support of trained responders. Third, I must stop being a spectator, I must get actively involved in the fight to eradicate HIV/AIDS. In other words, I resolved to be a solution and not be part of the problem. The best way to actively participate—I thought—was to train church members to care for their fellow members who were infected (It is better to teach people to fish rather than provide fish for them). In 2014—10 years later—I enrolled to do "Doctor of Ministry in Health-care Chaplaincy" and my project is entitled, "A Training Program for Members to Minister for HIV/AIDS patients at Nyagiki

Seventh-day Adventist Church, Kenya." In choosing this project, I am helping to fulfill a dream that has been burning inside me for about 10 years.

Description of the Ministry Context

According to the church records, Nyagiki Seventh-day Adventist Church was planted in the year 1936 from Nyanchwa—the first missionary church in the entire *Kisii* territory—and was organized into a church in in the year 1950. The original church building was made of mud-bricked walls with a grass-thatched roof. This building collapsed in 1952 and the members erected a permanent soapstone structure in 1954 with unique chairs made from concrete cemented bricks. This structure exists up to the present time—with slight renovations made. Having had over thirty congregations descend from her, Nyagiki is one of the oldest churches in South Kenya Conference territory and seems to be going through a plateau stage.

Table 1

Nyagiki Church Membership (2004-2013)

2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
290	205	205	205	188	188	188	181	171	171

Source: Retrieved with permission from Nyagiki church clerk's records.

A critical analysis of the Table 1 shows that Nyagiki church membership had remained relatively constant in a decade (2004-2013). Between 2004 and 2005, Nyagiki

planted a new church—Nyansongo—and transferred about eighty-five members there (I was the officiating minister in organizing Nyansongo into a church in the year 2005). Over all, Nyagiki lost 34 members, in a period of 10 years who are not clearly accounted for. I served as a pastor of Nyagiki Church for four years (2003-2006). On top of serving this church, I was also assigned to pastor 19 other churches and 10 companies—making a total of 30 congregations.

Nyagiki Church enjoys a rural environment close to two cities—Ogembo (three miles) and Kisii (six miles). Geographically, Nyagiki falls under Nyanza province (there are a total of eight provinces in Kenya). Nyanza province is leading other provinces in having the greatest number of people living with HIV and AIDS (PLWHA) (Kalipeni, Craddock, Oppong, & Ghosh, 2004, p. 177). Under the current constitution—which was promulgated in 2010—Nyagiki now falls under "Kisii County." In the year 2004, the government of Kenya established a modern tea factory—Itumbe Tea Factory—two miles from Nyagiki Church. The presence of this tea factory in the area is both a blessing and a curse. It is a blessing because it has provided employment opportunities to people coming from far and near. It is also a blessing since it has facilitated some social amenities—such as good roads and electricity—to come to the area and a market for farmers to sell their produce. It is a curse because it has increased the level of pollution—both environmental and social. According to the research study done by Kennedy Nyabuti Ondimu, migrant workers are listed among the risky HIV/AIDS groups given the tendency of some of them engaging in unprotected casual sex (Ondimu, 2005, p. 72). Ondimu—who conducted his research among the migrant workers at Kericho tea plantations in Kenya—asserts that "physically demanding jobs, long working hours, meagre salaries, and crowded living

arrangements further promote drug abuse, drinking and promiscuity… most men, whether married or unmarried, stay alone and are more likely to visit a commercial sex worker every payday" (Ondimu, 2005, p. 94). Kalipeni et al. (2004) concur with Ondimu that migrant workers are a risky HIV/AIDS group (this affects both men and women who migrate to seek employment opportunities or new markets to sell their goods) (pp. 183, 184).

Nyagiki is situated on a hill surrounded by five other Adventist churches and two companies—within a circumference of about five miles—making a total of eight congregations. These congregations are shepherded by one senior pastor and one associate pastor; together they make "Nyansongo Camp Center" (having headquarters at Nyansongo Church, where a yearly camp-meeting is held, Monday through Saturday). The following is a list of the eight congregations and their membership as of May 2018: Nyagiki (192), Nyansongo (268), Riamakora (237), Nyanuguti (182), Chigware (109), Itumbe Central (162), Matongo II Company (76), and Engoto Company (51). The total membership is 1,277. It was a great honor for me and the participants to be granted permission—by the South Kenya conference—to be speakers at this camp-meeting in August 2017.

Statement of the Problem

During my pastoral experience at Nyagiki, I observed that although HIV/AIDS was a big threat in the church and society, many of the church leaders were not involved in addressing this crisis. There were no intentional church training programs to warn the members about its danger. The church did not make a budget of time or money to address this pandemic. The root problem that caused this situation was lack of health information

literacy on HIV/AIDS to equip these leaders with knowledge and skills to deal with this crisis.

Statement of the Task

The task of this project was to develop, implement, and evaluate an HIV/AIDS training program at the Nyagiki Seventh-day Adventist Church to equip the members to effectively minister to HIV patients in the church and in the community. This research project was carried out by 24 participants over a period of 1½ years. The participants were adult members of Nyagiki Seventh-day Adventist Church, South Kenya Conference.

Delimitation of the Study

This project was carried out by people who are members of Nyagiki Seventh-day Adventist Church, South Kenya Conference, and were 18 years of age and above. Participants were chosen from those who are familiar with the cultural context and are able to communicate fluently in *ekegusii* dialect. The *Ekegusii* language was the medium of communication and efforts were made to translate the materials from the English language (into Ekegusii language). Being fluent in English was an added advantage (but not required) given the fact that the books that were used are written in the English language. Since this project reached out to people living with HIV/AIDS, persons who have declared that they are HIV/AIDS positive were eligible to be trained, to help protect their vulnerability and to avoid conflict of interest.

Description of the Project Process

Having the project process was like having a plan for constructing a house.

Without a good plan, the construction is doomed to fail. The plan of my research project included one research question and six chapters. The six chapters are compared to different phases of building a house.

The Research Question

The research question protects the researcher from getting distracted and losing the focus. It is like a music conductor who ensures that that all voices in a choir are in harmony. The research question provides a goal for research and all activities must be in tune with the goal (Koenig, 2011, p. 75). Similarly, Swinton and Mowat assert that the research question is an important tool for the researcher; it must be interesting, simple and modest (Swinton & Mowat, 2006, pp. 54, 55). The research question was developed to guide the training. The research question in my project was a tool to keep me motivated and focused and to be an instrument (just like a plumb line in the hands of a builder) to assess the success of the project. The research question for this dissertation is, "Naaman found healing for his leprosy in the River Jordan. Can the people living with HIV/AIDS today find healing in the church?"

The Six Research Project Chapters

Chapter 1 is an overview of the project. It describes the ministry context, statement of the problem, statement of the task, delimitation of the project, description of the project process and the definition of terms. It also provides a summary of what each chapter is all about.

Chapter 2 discusses the theological foundations on how to deal with HIV/AIDS pandemic. Although HIV/AIDS is not mentioned in the Bible directly, it is often compared to leprosy. It is often reported that there was no cure for leprosy but there are

explicit examples both in the Old Testament and in the New Testament where people suffering from leprosy received a cure. Naaman is one of those examples (2 Kgs 5). Naaman was healed when the prophet, Elisha, commanded him to wash himself seven times at the river Jordan. The case of Naaman will receive an in-depth exploration. In the New Testament, there are several cases where Jesus healed people who were previously living with leprosy. However, due to the limitations of this project, the passage of Mark 1:40-45 will be focused.

Chapter 3 reviews relevant literature that talks about HIV/AIDS. Priority is given to literature giving information about HIV/AIDS in Sub-Saharan Africa and specifically those that talk about the situation in Kenya. Nyagiki is situated in Nyanza province (currently known as "Kisii County") which has the highest number of people living with HIV/AIDS in Kenya. Most of the books that have been reviewed are those which have been written after the year 2000. However, to provide a bigger picture, some literature written in the 1980s and 1990s have also been selected given the fact that the first cases of HIV/AIDS in Kenya—and most Sub-Saharan Africa—were first reported in early to mid1980s.

Chapter 4 focuses on the theoretical plan for implementation of the training program at Nyagiki. The researcher interacts with the education philosophies of Knowles, Jethro, Maslow, and Jesus Christ. Interacting with these great educators was strategically important to provide a user-friendly framework for training adults at Nyagiki. From Knowles, I learned how to interact with the participants acting as facilitator and not as a lecturer. This approach was effective in keeping the interest of the participants high. From Jethro, I learned about the wisdom of dividing the participants into small groups—

focus groups—and assigning each focus group a territory (zone) to visit. From Maslow, I learned about how to strive to prioritize the people's needs. For example, people who are starving need to be given food before listening to a sermon. From Jesus, I learned the process of disciple making. Jesus applied a lot of patience transforming his twelve apostles beginning from the known and ending at the unknown. His teaching strategy may be summarized as follows: "First, I do you watch me; second, we do it together; third, you do it I watch you; lastly you do it alone without me watching over you."

Chapter 5 analyses how the training program was implemented. To successfully construct a house, the constructor and the builders must be intimately connected. The researcher is the constructor and the participants are the builders in the research. The work undertaken by the researcher to implement the training program at Nyagiki included the following three steps: First, the participants were recruited and signed the consent forms. Secondly, the researcher provided the objectives of the training to the participants. Thirdly, the researcher and the participants implemented the objectives which included reading the book, "ministry of healing," visiting people living with HIV/AIDS in the community, meeting in focus groups (and submitting monthly reports to the researcher), participating in the annual camp meeting, and meeting with the researcher for group interviews at the end of the training.

Chapter 6 focuses on evaluation and assessment of the training project. During the creation week, God always looked back at the end of each day to assess the progress made. The tool for evaluation is the participants' responses to the six focus questions. The data was interpreted, and conclusions were drawn from that data. A summary of the conclusions will be presented for chapters two through five leading to the overarching

conclusions. Chapter 6 will also present evidences of my transformation as ministry professional and will provide recommendations for researchers who may be interested to do studies in the same field (or in related fields) in the future.

Definition of Key Terms

AIDS stands for Acquired Immuno-Deficiency Syndrome. AIDS causes a person's immune system less capable of fighting infections. The word "syndrome" means that AIDS is not a disease but a condition. "It presents itself as a number of diseases and symptoms that come about as the immune system fails" (Wanjama, Kimani, & Lodiaga, 2013, p. 3)

Church, according to *Wikipedia*, the free encyclopedia, the word "church" is used to refer to the group of people (body of all believers) who are loyal to Jesus Christ both in a local and in a universal setting. The Greek translation is *ekklesia* and this word appears twice in the New Testament and in both instances alluded to Jesus. First, Jesus uses *ekklesia* when He told Peter that he was the rock on which he was to build His church (Matt 16:18), Second, Jesus uses *ekklesia* in admonishing a wronged person to report to the "church" after other interventions to make reconciliation have failed (Matt 18:17), ("Christian Church," 2018). The word church is used in this research document in an immediate sense to refer to the local believers at Nyagiki Seventh-day Adventist Church and in a wider sense to refer to all people universally who believe and follow Jesus Christ.

Gusii language (also known as *Kisii* or *Ekegusii*) is a Bantu language spoken in the *Kisii* district in Western Kenya, having headquarters in *Kisii* town, (between the Kavirondo Gulf of Lake Victoria and boarder with Tanzania). It is spoken by the *Gusii*

people—one of the tribes of Kenya—numbering about two million ("*Gusii* People, " 2018). The members of Nyagiki used *Gusii* language as official language of communication. Gusii language is my first language (my "mother tongue") and it is the language that I used to interact with the participants and the church members.

HIV stands for Human Immuno-deficiency Virus. "A virus is a tiny particle that attaches itself to a cell of another creature and uses it to multiply, thereby making copies of itself" (Wanjama et al., 2013, p. 2). There are many types of viruses, the HIV virus is a lentivirus, a type that attacks the body's immune system eventually resulting to the Acquired Immuno-Deficiency Syndrome (AIDS). Once inside the body, the virus attacks and destroys types of white blood cells that form part of the human defense system (Wanjama et al., 2013, p. 2).

Nyagiki Seventh-day Adventist Church is the focus of my research project. Nyagiki is situated in Kisii County—to the western part of Kenya (about two hours from Lake Victoria). Nyagiki is a member of sister churches forming the South Kenya Conference (SKC). According to Adventist online directory, SKC has 830 churches with a membership of 190,840 (as of June 30, 2017) in a population of 3,095,984 ("South Kenya Conference-Adventist Organizational Directory," October 18, 2017).

Pandemic means that the effects are experienced globally—having a worldwide magnitude as opposed to an outbreak which is localized. As a global pandemic, HIV/AIDS is one of the greatest challenges of our time. Although some parts of the world have been affected more than others, every part of the world lives in fear of the scourge. In Africa, the rates of HIV infections in Sub-Saharan Africa are the highest in

the world, with up to 35% of the adult population infected in parts of Eastern and Southern Africa (Wanjama et al., 2013, p. 1).

Patient according to *Wikipedia*, the free encyclopedia, was originally used to refer to any person experiencing suffering, "one who suffers." The current usage of the word refers to any person receiving professional medical attention either on a short-term or long-term basis ("Patient," 2018, August 28). This word, "patient," is used in this research document to refer to people who have professionally been diagnosed with a condition (in most cases, HIV/AIDS) and are dealing with that condition with or without the assistance of medical experts.

Qualitative research was chosen for this research project. Qualitative research is subjective, and the researcher is part of the study. Those involved in the research are called *participants* who report their experiences and researcher focuses on interpretation (Koenig, 2011, pp. 115, 116). The participants form is divided into units called *focus groups* who focuses on collecting data. The advantage of qualitative research is that it is providing data that is rich, detailed, meaningful, salient, and relevant (Koenig, 2011, p. 124).

Stigma implies the branding or labelling of a person or a group or persons due to perceived physical, psychological, or moral condition believed to render the individual unworthy of full inclusion in the community. Because of stigma, some people are treated unfairly. It is associated with injustice and discrimination. HIV/AIDS patients tend to be marginalized because this disease is associated with same sex marriages, intravenous drug usage, commercial sex work, and marital infidelity (Browne, 2016, pp. 13, 14).

CHAPTER 2

THEOLOGICAL FOUNDATION IN RESPONDING TO HIV/AIDS PANDEMIC

Introduction

HIV/AIDS is a serious disease. The suffering that this disease has caused to humanity in the last thirty plus years of its existence are untold. There are similarities between HIV/AIDS in the present time and leprosy in the biblical times (Brueggemann, 2000, p. 332). Both are regarded as social diseases and the response to them from the public have been driven by both fear and ignorance. In as much as there is no permanent cure for HIV/AIDS now, it is reported that there was no cure for leprosy in the biblical times. Many people today look down upon HIV/AIDS patients as people receiving retribution for living sinful lives. In biblical times, society generally associated sickness with sin. Leprosy was regarded as a contagious disease and lepers were legally isolated to live separate lives from the general population. Today, there is some tendency to isolate people living with HIV/AIDS.

God appears in the Bible as a loving person who does not show discrimination. There is no sinner beyond the reach of God's arms of love. Jesus made effort to reach out to outcasts and sinners and to put a smile on their faces. Today if we have love in our hearts, we will overcome prejudice and we will reach out and touch the untouchables. With these thoughts in mind, it is reasonable to make a salient statement—that will serve

as a theme for this research project—"if our hearts are filled by God's love, we will touch people who are filled with suffering." The first half of this chapter will examine how Naaman was able to receive a cure for his leprosy. The second half of this chapter will examine how Jesus healed a man from his leprosy. In both cases, relevant lessons will be drawn on how to care for people living with HIVAIDS in our present time. Finally, recommendations for further research will be made leading to a conclusion.

Origin and Definition of Leprosy

Leprosy was present in Egypt and it is here that the Israelites first came into actual contact with it. When the Israelites left Egypt, God promised to keep them safe from the tragedy of leprosy and other diseases if they obeyed his laws (Exod 15:26).[1] Unfortunately, Israel was not always obedient to God and we have some specific cases of people who were afflicted with leprosy because of their sins. These included Miriam (Num 12:10-15), Gehazi (2 Kgs 5:27), and King Uzziah (2 Chr 26:16-21) (Nichol, 1978, p. 763). These three persons mentioned here were afflicted with leprosy as a punishment for sins committed. Miriam was punished for teaming up with Aaron to speak contemptuously against Moses' wife (Num 12:1-2). Andrews University Study Bible (2010, p. 183) argues that Miriam was punished but Aaron was excused because she is mentioned first (12:1) and it seems that she was the instigator of the criticism against Moses. Gehazi was punished for coveting against the material goods brought by Naaman and for bearing false witness (2 Kgs 5:25-27). King Uzziah was punished for the sin of pride in entering the temple and offering incense (a job that was meant to be performed

[1]Unless otherwise indicated, all Bible references in this dissertation are from the New International Version.

by the Levites only). Uzziah was a leper until the time of his death (2 Chr 26:16-21). It is remarkable to note that Miriam is the only female mentioned by name in the Bible who had leprosy and she is the only one from the list of three persons mentioned above who received healing. Her healing came about after Moses had interceded for her. She was isolated (stayed outside the camp) for seven days before she was received back into the fellowship of the Israelites (Num 12:13-15).

The word translated "leprosy" is derived from Hebrew word "*sara*" which means "to strike down." Leprosy can, therefore be viewed as a form of a "stroke." The Jews regarded a person suffering from leprosy as one smitten of God—a direct punishment from God for doing evil (Nichol, 1978, p. 763). Leprosy was considered to be the most terrible sickness and since it was assumed to be contagious, a person suffering from it was driven from society and was considered as an outcast worthy of little sympathy or compassion (Nichol, Cottrell, Neufeld, & Neuffer, 1978, p. 761). White (1940) says that leprosy was the most dreaded disease of all diseases known in the East. It was incurable and contagious. The victims were considered sinners suffering the consequences of their sin and they were ritually unclean (p. 262). They were excluded from their homes, from the cities, from the sanctuary, and from any gathering. If a leper approached another person, the leper was to cover his lips and shout, "unclean! unclean!" If he/she entered any house or building, it too became unclean, as did anyone who touched him/her. Nichol gives an explicit description about the suffering a leper could go through before his/her final demise. At the onset, the victim could not feel pain or inconvenience. Nevertheless, the disease gradually developed inside a person. Like in cancer patients, sometime the leper could experience times of recession when the symptoms could disappear for a

season. The picture was awful at the last stage of the disease;

> the nose and fingers might drop off, the eyelids disappear, the sight completely vanishes, and the sufferer looked more like an apparition than a living being. His/her was a living death. . . . The affliction spread until it reached some vital organ, and then culminated in the death of the victim. (Nichol et al., 1978, p. 761)

The Levitical Law on Leprosy

Leviticus chapters 13 and 14 extensively describe the laws and regulations on how to treat lepers. Leprosy is a generic term referring to more than one skin disease such as *psoriasis* and *vitiligo*. In *vitiligo,* the hairs of the affected part turn white. According to the Levitical law, once the leprosy disease was confirmed on a person, the high priest declared that person "unclean." This person had to tear his clothes and put a covering upon his/her upper lip and cry, "unclean! unclean!" Because leprosy was contagious, a leper had to live a separate life outside the camp. "Ostracized from the community, they were left homeless without the support structure of family and friends" ("Leprosy," 2018). Joel Marcus asserts that the situation of a leper was as good as a dead person; "sufferers were regarded as, in effect, corpses, and physical contact with them produced the same sort of defilement as touching dead bodies" (Num 12:12; Job 18:13); (Marcus, 2000, p. 208). Today people who are infected with HIV/AIDS suffer a similar social isolation (Bock, 1996, p. 156).

The priests played a crucial role like the work done by physicians today. The priest had the responsibility of examining the suspected person to declare them "clean," or "unclean." If a person tested positive on leprosy, he/she was separated from the society. If he/she was healed, then that person had to call for a priest who could go there and examine him/her. If the priest was satisfied that the person had been healed, then the person was required to go through series of rituals to be set free. The ritual included two

stages: one had to take place outside the camp where the person was living and the other had to take place at the temple where the priests had their "offices." The rituals included the sacrifice of animals or birds (Num 14).

To do their work successfully, the priests needed to exhibit a lot of patience and compassion. "He must learn not to shun the leper but to pity and help him. This is a lesson for the servants of God today. Like the priest of old, the minister of God today must have compassion" (Heb 5:2) (Nichol et al., 1978, p. 768). The disease of sin is compared with leprosy. In as much as leprosy spread slowly but gradually until it consumed the whole body leading to death, sin also spreads silently in the body and the victims may not be feeling the pain until the whole body is consumed leading to death. "So, sin at last comes to fruition, until the image of God in man is practically obliterated. As leprosy ended in death, so sin ends in death. It would seem, therefore, that leprosy is a disease especially adapted to typify sin in its various features as no other malady could" (Nichol et al., 1978, p. 768).

The Healing of Naaman From his Leprosy

Introduction: The Difference Between "Cure" and "Heal"

There is a difference between the two verbs "cure" and "heal." *Merriam-Webster* dictionary defines "cure" as follows: (a) to make someone healthy again after an illness, (b) to stop a disease by using drugs or other medical treatments, (c) to provide a solution for something (Hacker, 2011). The word "heal" is defined as follows: (a) to make sound or whole, (b) to restore to health, (c) to cause an undesirable condition to end, (d) to patch up a breach or division between friends, (e) to restore to original purity or integrity (healed of sin) (Hacker, 2011). Greider (2007) defines "cure" as the absence of illness

while “healing” is living with integrity in the face of illness or other suffering (p. 196). From these definitions, it clear that whereas “cure” has to do with the physical well-being of a person, “healing” encompasses the holistic well-being: physical, social, mental, emotional, and spiritual.

James Strong uses the Hebrew word *shalom* to capture the concept of total health. *Shalom* means completeness, wholeness, health, peace, welfare, safety, soundness, tranquility, prosperity, perfectness, fullness, rest, harmony, the absence of agitation or discord (Strong, 2007). It refers to a situation where there is total peace to a person and his/her environment; “*shalom* as a term and message, seems to encapsulate a reality and hope of wholeness for the individual, within societal relations, and for the whole world. To say joy and peace, meaning a state of affairs where there is no dispute or war, does not begin to describe the sense of the term” (Shalom, 2015). *Shalom* is related to the Arabic root *salaam*, which means to be safe, secure, and forgiven, among other things. “*Salaam* is also the root for the terms “Muslim” (and Islam), literally translated, he/she who submits to God and submission to God, respectively”(Shalom, 2015). In the Latin and Romance languages, *shalom* is translated to mean “peace.” “Peace” is viewed as an important possession in personal, social, political, and religious avenues. The Greek word for peace is *Eirene* which means quietness and rest (Shalom, 2015).

Exegesis on 2 Kings 5:1-27

The *New Interpreter’s Bible* describes Naaman as a great man, *Issaagadol* (Keck, 1995, p. 193). Naaman is favored by the King of Aram (ancient Syria) because of his successful military campaigns against Israel, perhaps referring to the Aramean victory over Ramoth-gilead (1 Kgs 22:19-23). In spite of his great accomplishments and

greatness, Naaman has a terrible skin disease which has a social stigma and is associated with death (Num 12:10-12) (Keck, 1995, p. 193). Although many translations retain the word "leprosy," when describing Naaman's medical condition, "most scholars now agree that the Hebrew word does not refer to leprosy as we know it today (Hansen's disease), but to a skin afflictions of various sorts, here probably *psoriasis* or *vitiligo*" (Keck, 1995). Mike and Tara Campbell help us understand the text. They say the Hebrew meaning of the name "Naaman" means "Pleasant" or "beautiful, delightful" (Campbell & Campbell, 2015). Naaman was a Syrian (Aramean), the commander-in chief of the armies of Benhadad (Syria). At this time, Joram was the King of Israel which had its capital city in Samaria. Elisha was a prophet of God residing in Samaria. Despite his prosperous personal and public life, Naaman was afflicted with leprosy. No help had come on his way until the slave girl who waited on Naaman's wife revealed that there was a prophet of God in Samaria who could help. Naaman obtained a letter from Benhadad (King of Syria) and proceeded with it to Joram (King of Israel). Joram suspected Naaman of coming with evil motives against him and rent his clothes. The situation changed when Elisha invited Naaman to come and meet with him. Naaman was healed of his leprosy by dipping himself seven times in the River Jordan according to the word of Elisha. This miraculous healing is mentioned by Jesus in Luke 4:27 (Campbell & Campbell, 2015).

Love Overcomes Injustice

Although the name of Naaman means "pleasant," his behavior in keeping a little girl captive in his home was no doubt unpleasant. The *Seventh-day Adventist Bible Commentary* describes it as a "cruel endeavor" (Nichol et al., 1976, p. 875). It is hard to imagine the suffering the girl went through in being separated from her family, her

friends, and her familiar environment. Furthermore, the fact that she is working without any salary—being a slave girl—aggravates the situation. Yet, the little girl is described as resilient and compassionate. Rather than repaying evil with evil, she overcomes evil with good. "But even in an alien land God had service for her to perform" (Nichol et al., 1976, p. 875). She offers a way for her master to receive cure for his leprosy.

Nichol asserts that love is a powerful force that delivers healing to Naaman. The healing is a product of someone whose heart was filled with love; "Filled with love towards her God, her heart went out in sympathy to her ailing master and his wife. Instead of wishing Naaman ill because of the misfortunes that had been brought upon her, she wished him well and hoped for his recovery from his terrible disease (Nichol et al., 1976, p. 875). The acts of mercy and kindness that Naaman received at the hand of the little maid are sharply contrasted with the reaction of the King of Israel, Joram. A person cannot give what he or she does not have. Joram was not filled with the love of God. He was not living in close connection with God. Joram was filled with fear and despair and that is what he gave to Naaman (p. 876). Elisha stepped in to rescue Joram from the embarrassment of failure and defeat. In the New Testament, after the transfiguration, Jesus too stepped in to save the disciples from the embarrassment of failing to heal an epileptic boy (Matt 17:14-18).

Love is a force that compels Elisha to desire for Naaman to receive healing. Furthermore, Elisha desired for Naaman to be acquainted with this love and to take it back when he would return to Syria. Elisha desired for him to receive more than a cure.

> But Elisha asked that he come to him to find healing of body and restoration of soul. The prophet was anxious that Naaman become acquainted with the love and power of Israel's God, and that he take back to his own people a message of comfort concerning the hope that all might have in him. (Nichol et al., 1976, p. 876)

Elisha's prayer seems to have been answered judging from Naaman's confession: "now I know that there is no God in the entire world except in Israel" (2 Kgs 5:15). Naaman became acquainted with the creator's wonderful love and care. Healing for Naaman was the most precious thing that he needed, and he was willing to part with his possessions for having received that gift. Elisha did not accept any payment for healing Naaman. Elisha knew that God was the great physician; he was only an instrument in God's hands. Therefore, Elisha sent Naaman away with a word of blessing, "go in peace" (*shalom).* The message of peace that Naaman received is similar to the message of peace contained in Jesus' farewell to His disciples (John 14:27) (Nichol et al., 1976, p. 878). Naaman had received more than a cure for his sickness. "He was like a new convert to God filled with joy and peace in his heart, healed of leprosy and converted in spirit" p. 878).

Gaebelein and Douglas concur with Nichol et al. about Naaman's changed life. The act of Naaman descending from his chariot to listen to Gehazi is a mark of humility. When Naaman first arrived in Israel, he was expecting great things. He was disappointed when Elisha told him to bathe in the small muddy river of Jordan. In pride, he mentioned that the rivers of Syria were much bigger and cleaner than this one. After his healing, Naaman was no longer proud and arrogant, but grateful, reverent, and humble (Gaebelein & Douglas, 1984, p. 190). Naaman was able to relate better with other fellow human beings. Before his baptism at the river Jordan, he expected Elisha to come out of his house and stand before him. After his baptism, he is the one that stands (*amad*) before Elisha ready to bless him (Keck, 1995, p. 195). A huge transformation takes place in the body of Naaman. It resembles the flesh of young boy (*na'arqaton*) "baby flesh." This

childish young stage is compared to the young and innocent life of Naaman's servant (*naarahQetannah*) (Brueggemann, 2000, p. 334).

Whereas Naaman went from the house of Elisha without Leprosy*, Gehazi* (Elisha's servant) went from his house with leprosy. Nichol et al. (1976) say that the reason why this happened was because *Gehazi's* heart was under the control of Satan. He was thinking about showing revenge for all the evil that the Syrians had brought to Israel. *Gehazi* is great contrast to the little girl, who referred to Naaman as "my master." Gehazi's heart is full of prejudice judging from the way he referred to him: "Naaman, this Aramean," (5:20) (Keck, 1995, p. 198). Gehazi thought that he would be justified to receive gifts from Naaman as part of the payment for all the evil that the Syrians had brought to Israel (Nichol et a., 1976, p. 878). Gehazi went forward asking God to bless his sinful mission, "as surely as the Lord lives, I will run after him and get something from him (2 Kgs 5:20). Gehazi has sown evil and reaped evil: Elisha goes on to name the things that Gehazi has not taken: fields of olives and vineyards, sheep and cattle, and servants. Elisha was reading Gehazi's mind to know the things he intended to do with the money that he had looted. The sin of Gehazi is deception, unbelief, greed, theft, and envy (Konkel, 2006, p. 431).

Elisha pronounces a curse to Gehazi; "Naaman's leprosy will cling to you and to your descendants forever" (5:27). The word used forever (*le'olam*) does not mean time without end but it means that the punishment was irreversible. The curse extends to us today to those whose hearts are filled with arrogance and covetousness, those who cause suffering to others in the name of God; "Elisha's words of rebuke were not only for his servant Gehazi but those in God's church today who manifest the same spirit as did

Gehazi (Nichol et al., 1976, pp. 879-880). This text gives a stern warning to opportunists like Gehazi who are ready to make a quick profit in the name of the Lord (Keck, 1995, p. 198).

The Relevance and Application of the Story of Naaman to HIV/AIDS Patients

Response driven by love. There are two parties that emerge from the HIV/AIDS patients: The guilty and the innocent. The guilty are those who feel that they are to blame for acquiring the virus. This would be through their promiscuous lifestyles. The innocent party are those who see that they have acquired the virus through other peoples' default or accident. To respond by love means that one party will not seek ways to spread the virus to another party whether they are innocent or guilty. Both must never fall into "I don't want to die alone" mentality.

Transparence and honesty. It is vitally important for married couples to be transparent to each other. They should both be encouraged to go for voluntary counseling and testing and share the results with each other. Doing so can save a life especially in a situation where one spouse tests positive and the other tests negative (the one who tests positive can use condom and avoid infecting the spouse who tests negative).

HIV/AIDS patients need healing and not merely a cure. When we understand that healing (*Shalom*) means more than physical health; it includes emotional and spiritual health, then we are safe to say that there is a cure for HIV/AIDS. This can be said of the people who are at peace with God and their fellow human beings, people who are strictly following their doctors' prescriptions and they are able to attend to their daily obligations.

Obey the call to receive help from the hospital. Naaman obeyed the call to go and receive help by dipping himself in the muddy river of Jordan seven times (It is unlikely

that he would have received this help if he had decided to disobey.) It is important for HIV/AIDS patients to seek for medical help though it may appear humiliating to them.

Encourage the youths to be driven by love and not by wealth. The story of Naaman captures the character of two young people. One is the unnamed little girl who championed the decision for Naaman to go to Samaria to seek help. The other young person is Gehazi who because of his covetousness harvested the leprosy of Naaman. This story should encourage young people to be modesty in their lifestyle and avoid falling into the trap of materialism. It is unfortunate to learn that some young people have fallen into the "sex for money" trap.

The church can play a greater role than the government of the day in caring for PLWHA. Both the heads of the states of Syria and Israel could not provide a cure to Naaman for his leprosy despite their wealth. While the king of Syria provided a letter and financial resources to Naaman, the King of Israel (Joram), appeared desperate and judgmental (Joram reasoned that Naaman's body had been fixed by God and there is nothing else he could do). Elisha, sensing Joram's desperation, said "let him come to me" (2 Kgs 5:8). Elisha was able to heal Naaman because he depended on God. By totally depending on God—with less or no financial resources—the church today can provide healing to PLWHA.

Jesus Touches a Leper (Mark 1:40-45)

Introduction

Jesus is a role model on how to care for people who are sick. Ellen White describes his method as follows: “The savior mingled with men as one who desired their good. He showed His sympathy for them, ministered to their needs, and won their confidence. Then He bade them, “follow me” (White, 1942, p. 143). Furthermore, White encourages Christ’s followers to use the same method in reaching out to people who are sick—to use less time in sermonizing and more time in personal work; “accompanied by the power of persuasion, the power of prayer, the power of the love of God, this work will not, cannot, be without fruit” (pp. 143,144).

Nichol et al. (1980) say that there was no recorded instance of a person getting healed from leprosy between the time of Naaman and the time of Jesus (a period of 800 years). The Jews in the time of Jesus regarded leprosy as a divine judgement on sin. The only known remedy was isolation. A leper was seen as a person under a curse from God and was abandoned by God and by human beings (Nichol et al., 1980, p. 573). Leprosy in Jesus time is associated with the present Hansen’s disease;

> As the disease progresses, pain turns into numbness, and the skin loses its original color and becomes thick, glossy and scaly. Sores and ulcers develop, especially around the eyes and the ears, and the skin begins to bunch with deep furrows between the swelling and the face of the afflicted individual looks similar to that of a lion (“Jesus Cleansing a Leper,” 2015).

The first account of leprosy healings by Jesus is recorded in three Gospel books (Mark 1:40-45; Matt 8:24; Luke 5:12-16). Mark’s account is more detailed (Nichol et al., 1980, p. 573). Later Jesus healed other leprosy victims (Matt 26:6; Luke 7:22; 17:12-14)

and he sent out his disciples to do the same (Matt 10:8). Nichol et al. (1980) give a major commentary on the Mark's account.

In Mark 1:40-45, a leper approached Jesus and begged him to heal him. Jesus reached out his hand and touched the man. "I am willing," he said. "Be clean!" Immediately the man was healed, and Jesus commanded him to go and show himself to the high priest (Mark 1:44). Marcus gives a strong clarification that the nature of the ailment of this man, though most English translations use the word "leper," this is not correct when we compare it with today's Hansen's disease (Marcus, 2000, p. 205). Marcus contends that the Hebrew word *sara't* has incorrectly been translated into Greek as *lepros*, and into Septuagint as *lepra*. "The Hebrew term *Sara'at/lepra* designates a variety of conditions in which the skin becomes scaly, but not what today is called *leprosy* (Hansen's disease). As described in Leviticus 13-14, "the ailment is one that develops quickly, and people sometimes recover from it; leprosy on the other hand, develops over a number of years and is incurable apart from modern drug therapy" (Marcus, 2000, p. 205). Consequently, Marcus translates Mark 1: 40 as "the man with scale-disease came up to him" (Marcus, 2000, p. 205). Gaebelein and Douglas (1984) concur with Marcus that the word *"lepros*" is a generic terminology used in biblical times to designate a wide variety of serious skin diseases. "It was not limited to what we know as leprosy, or, to use the preferable medical term, Hansen's disease" (Gaebelein & Douglas, 1984, p. 630). Although it is not known the kind of skin disorder the man was suffering from, it is apparent that it caused much suffering to him both physically and spiritually (Gaebelein & Douglas, 1984, p. 630).

The leper in the story had to overcome three obstacles in order to receive healing

(Nichol et al., 1980, p. 573). First, there was no known precedence of a person who had been healed by Jesus since the last healing had taken place in the remote past, 800 years before. The second obstacle that the leper faced was the popular belief that he was under the curse of God and therefore Jesus might not heal him. The third obstacle presented a physical problem: how could he get near enough to Jesus to present his requests? The law required lepers to keep distance from the "clean" people. It is worth noting that the leper overcome all the three obstacles and was able to make his request before Jesus. He came directly to Jesus and knelt down on his knees to make his plea. Darrell (2005) contends that the way the leper approached Jesus with confidence was an act of faith. He knew that Jesus was able to grant his request. He made the request without any presumption; "if you are willing" (Darrell, 2005, pp. 415-416).

Mark 1:41: Moved With Compassion

According to White (1940), Jesus expresses love and compassion to the leper by his act of stretching his hands and touching the leper. Jesus could have just pronounced a word and healing would have taken place, but he rather chose to touch him to show compassion. Whereas the Pharisees despised other people and set themselves aloof from the sick and the needy, Jesus showed love and compassion (White, 1940, p. 267). In comparison, Darrell (2005) asserts that the correct translation of the original text should read that Jesus was moved with compassion and not anger. This is further demonstrated by the symbolic touch, "Jesus' power to cleanse was greater than the leprosy's power to stain" (pp. 415-416). Gaebelein and Douglas (1984) take a different interpretation; they argue that the Greek word in verse 41 is *orgistheis* ("being angered"). Therefore, Jesus became angry, but his anger was not directed to the man or the disease but to Satan the

source of all human suffering. It was Jesus' mission to destroy the demonic powers and this mission always brought Jesus into open conflict (Gaebelein & Douglas, 1984, p. 630).

Mark 1:43: A Stern Warning

Another terminology that seems to be a point of contention is the word *embrimaomai* (to speak harshly, to "speak with a strong warning"). This terminology is used in the context of Jesus sending the healed person to go out *(ekballo*) and show himself to the priest. Gaebelein and Douglas (1984) argue that Jesus was not being harsh to the healed leper as a person. Jesus was expressing his feelings against the act of disobedience, which he knew that this person was going to commit, and which was going to make it difficult for Jesus to do his work openly. This act of Jesus where he shows hatred for sin but love to sinners is what Gaebelein and Douglas call "righteous indignation" (p. 630). According to Darrell (2005) the strong warning is directed to the public. Jesus warns the public not to proclaim abroad the miracle which he had performed while he sends the man who had been healed to go and show himself before the priest (p. 416). Keck (1995) gives a different interpretation of verse 43. He interprets the Greek word "*ekballo*" as "drive away" or "cast out." Jesus is not driving the person away from him but the demons that had possessed the man. Hence the violent emotional response in verse 43 seem more appropriate to an exorcism, casting out demons from a person to make him free (p. 545).

Mark 1: 45: But the Man Went and Spread the Word

The healed man is full of excitement and he goes everywhere telling everybody the great things that Jesus had performed in his life. Marcus sees the healed man as a

prototypical missionary. He goes everywhere proclaiming the good news of his healing which makes others to come to Jesus the way he had done earlier (Marcus, 2000, p. 210). Darrell (2005) interprets the Greek word used *kerusso* as proclaiming or preaching. Having been with Jesus prepares the person to preach/testify about what Jesus had done to him. This prefigures the work that we are to do today when we receive salvation (We need to go everywhere to proclaim the good news to make other people to come to Jesus).

Analysis of Jesus' Healing Ministry

The leper regards himself as ritually unclean as opposed to physically unclean (Marcus, 2000) and he petitions Jesus to give him cleansing. The Greek word that the leper uses is *katharizo*, "to cleanse," and not *therapeuo,* "to heal," "to cure" (Nichol et al., 1980, p. 573). In both the Old Testament and New Testament times victims of leprosy were spoken of as "unclean," needing "cleansing," rather than "sick" needing "cure." This distinction in terminology reflects the idea of ritual cleansing (Nichol et al., 1980, p. 573). The cleansing of the leper was a response to an act of faith in Jesus' healing power: "If you want to, you are able to cleanse me" (1:40b). His usage of the word *dynasai* (you are able to) indicates the leper's belief that Jesus has powers to do what is impossible for human power (Marcus, 2000, p. 209).

Both the leper and Jesus violated the Levitical law for coming close to each other in a conversation and for Jesus touching the leper. The act of Jesus stretching his hand to touch the leper is described as being "deliberatively provocative" (Marcus, 2000, p. 206). It overlooks the Jewish Levitical law in Leviticus 13-14. It also contrasts with 2 Kings 5:1-14 where Elisha avoids contact with the man whom he cures of scale disease

(Marcus, 2000, p. 206). Jesus often touched the sick in healing (Matt 8:15). Jesus is our role model on how we can touch the untouchables; “He knew that touching a leprous man meant uncleanness; nevertheless, he did so boldly” (Nichol et al., 1980, p. 573). Jesus risked contracting ritual impurity himself. “But instead of impurity passing from the man to Jesus, purity of Jesus’ holiness passes from him to the man, and the latter is cured (Marcus, 2000, p. 209). The ritual cleansing that Jesus performed to the leper symbolized the spiritual cleansing that Jesus is able to provide for people sick of sin; “Jesus had come to the earth for the specific purpose of cleansing sinners, whose spiritual illness was more deadly than leprosy” (Nichol et al, 1980, p. 573).

That Jesus cleansed this leper from his uncleanness gives evidence that Jesus had divine powers. Jesus has powers to cleanse souls from sin (Nichol et al., 1980, p. 573). Despite his divine powers, Jesus had respect for the human laws. He charged the person who had been cleansed from leprosy to go and show himself to the priests according to the laws of Moses (Nichol et al., 1980, p. 573). According to the Mosaic Law, the priests who served as public-health officers diagnosed leprosy and ordered segregation. Those who recovered from their disease could return home after reexamination, purification rites, and presumably certification (Nichol et al., 1980, p. 574). By sending this man to the priests, Jesus was showing to them that he had respect and recognition to the laws that he himself had imparted to Moses long before. In this way He hoped to disprove the false charges made by the priests that Jesus did not care about the law of Moses (Nichol et al., 1980, p. 574). In modern times, it is important to give encouragement to the people who are sick to go to health facilities to seek medical attention.

Emulating Christ in Ministering to the Needs of HIV/AIDS Patients

Keck (1995, p. 546) asserts that today we are guilty of practicing social isolation to HIV/AIDS and cancer patients the way the Jews did to lepers in the past. Just at the time they need to have a loving touch, a hug, a hand to hold, or a pat in the back from a family member or a friend, they experience distance and isolation instead. The situation becomes worse when their medical conditions grow into critical stages. Some of them become completely deserted:

> We may no longer confine persons with highly communicable diseases to isolation, but the subtle forms of social isolation we practice can be just as devastating. Jesus did not cut himself off from the leper. Instead, he healed the man by reaching out to touch him. (Keck, 1995, p. 546)

The *Wikipedia* (HIV/AIDS, 2014) speaks strongly against all forms of stigmatization against people living with HIV/AIDS. Some of the common practices of stigma that must be avoided include ostracism, rejection, discrimination, and avoidance. People must be trained to change their attitudes and behaviors to people living with HIV/AIDS. Some wrong behaviors include compulsory HIV testing without prior consent or protection of confidentiality, the quarantine of HIV infected individuals and in some case the loss of property rights when a spouse die. All forms of violence must be stopped when dealing with HIV/AIDS patients because these raise fear in their hearts and makes them to avoid seeking for help that they need (HIV/AIDS, 2014). A research that was done in Kenya among pregnant women revealed that the violence and stigma that these women experience from their husbands was a major cause of their refusal to go for HIV testing (Turan et al., 2011).

Garland (1996) asserts that those who are called by Christ's name (the church)

need to minister to the untouchables of society. They need to possess a non- judgmental spirit the same as the one Jesus had. They should reach out to HIV/AIDS patients without seeking to know how they got infected. Christians must be followers of Christ and must be people who are filled with compassion. They must banish a "holier than thou," self-righteous attitude from their hearts. It is wrong to assume that HIV/AIDS is only transmitted by sexual contact. The fact is that there are a many people who are HIV/AIDS positive who got infected through other means apart from sexual contact. Some of the examples of infection are: blood transfusion, breastfeeding, (mother to child), through infected needles (Garland, 1996, pp. 88, 89). Garland gives reference to a pathetic story of a pastor named Jimmy Allen whose four members of his household were infected with HIV/AIDS through other means outside sexual contact. The strange thing is that their church could not give the needed support and instead they recommended for pastor Allen to resign from his position (Garland, 1996, pp. 88, 89).

The church has a responsibility of extending the healing ministry of Jesus to the world that is full of sickness. It is true that there are many people suffering from the consequences of their sin. It is possible to have people suffering from HIV/AIDS due to sexual misconduct. The role of Christians is not to increase stigmatization or condemnation. Already many of the people know those facts and they do not need to be reminded about them. Rather than reminding people of their sins, the church members need to remind people of the forgiveness that we have in Christ. Let them know that this forgiveness has no limits or boundaries. There are people in the church who have the gift of healing and should use that gift to minister to sick people without giving credit to themselves. The rest of the church members can be involved in doing intercessory

prayers for the sick people. God is still in the business of working healing miracles to his people today. Church members should not place limits on God regarding healing. Every church member should be engaged in doing intercessory prayer on behalf of sick people (Garland, 1996, p. 91).

Conclusion and Recommendations

In this chapter, I have analyzed the plight of lepers in both the Old Testament and the New Testament times. I have used two cases (one in the Old Testament and another in the New Testament) to argue my points. Although it was often reported that leprosy had no cure and was contagious, I have given several examples to prove that this was a misconception (myth) and not the truth. The truth is that the word leprosy was a generic terminology used to refer to many skin diseases. Some of them were curable and non-contagious.

The case of Naaman in the Old Testament seems to fall into this category. Naaman is evidently seen interacting with several people and no instance is mentioned of him inflicting the sickness to them. The same applies to the leper in Mark 1: 40-45. It ends up that the sickness is not physical but spiritual (ritual). Getting sick was viewed by many as being punishment for sin committed. Ritual sickness calls for spiritual cleansing which is solely the work of God. Only God can forgive sins. It is a sad situation to realize that most of the people who were believed to be having leprosy were isolated from the people who were regarded as clean. The Bible says that all human beings have sinned and run short of the glory of God (Rom 3:23). Therefore, no person should be at the judgement seat to pronounce other human beings as more sinful than he/she. In other

words, all human beings are ritually unclean and need cleansing that only God can provide.

The modern terminology used for leprosy is “Hansen’s disease” This sickness is currently curable and poses no threat to anybody. The modern equivalent of leprosy is HIV/AIDS. HIV/AIDS currently has no permanent cure. This fact does not give anybody the license to mistreat the people diagnosed with HIV/AIDS. It is true that many people suffering from this disease are exposed to a lot of stigma. In this chapter, I have asserted that people living with HIV/AIDS deserve a fair treatment. This can be possible if we follow the example of Jesus who was always committed to treating sick people with love and compassion. This is doable if we have love in our hearts. In harmony with the theme of this project, “if our hearts are filled with God’s love, we will touch people who are filled with suffering.”

In sum, for the church to be effective in ministering to the needs of HIV/AIDS patients, she must emulate three things that Jesus used in healing the leper. First, the church must be ready to touch—physically and emotionally—people suffering from HIV/AIDS (however, to prevent infection, it is always wise to follow contact precautions as directed by the patient’s physician). A proper touch or pat on the shoulder of a patient is a powerful way to express love. Care providers should first seek permission from the care-recipients before this ministry is applied. Secondly, the work of the church is not to substitute but to complement the work of the physicians. Just as Jesus referred the leper to go and show himself to the priest, the church should always be ready to send patients to receive medical care as needed. It is important for care providers to be aware of their limitations and refer their patients to receive help from other professionals. Thirdly, Jesus

rebuked demons/sin, but he loved the sinners. The church ought to do the same. While it may be okay to wisely warn and rebuke sin, church members must unconditionally extend love and mercy to people who are struggling with sin. Fourthly, it is important for church members to seek for the forgiveness of the people who are living in sin. Both Moses and Jesus wrestled with God to extend forgiveness to the people who had sinned against them.

CHAPTER 3

LITERATURE FOCUSED ON HIV/AIDS IN KENYA

Introduction

Literature relating to HIV/AIDS is diverse. For the last 30 years, HIV/AIDS has been one of the most serious public health concerns throughout the world. Despite great scientific research and experimentation, there is no permanent cure for this disease. The academic platform has been flooded with a lot of literature about this killer disease. Time and space will not allow to review all the literature that has been produced on this sensitive topic. I will concentrate my effort to review literature dealing with the following three major topics: (a) Health Information Literacy on HIV/AIDS, (b) Prevention of HIV/AIDS, (c) Care and Support for People infected and affected by HIV/AIDS. Most of the works cited are those published after the year 2000. However, to have a bigger picture, I have also included literature published in the 1980s and in the 1990s (the first cases of HIV/AIDS were reported in the early 1980s). The context of my study is Nyagiki Seventh-day Adventist Church, South Kenya Conference. Literature that is focused on Kenya and sub-Saharan Africa will be given special consideration.

Health Information Literacy

The people's knowledge of health information is generally low. A study of 2,600 patients conducted in 1995 by two United States hospitals found that between 26% and

60% of patients could not understand medication instructions, a standard informed consent or basic health care information (Health Literacy, 2014). Health literacy is the ability to obtain, read, understand and use healthcare information to make appropriate health decisions and follow instructions for treatment. Research show that up to half of patients cannot understand basic healthcare information. Low health literacy reduces the quality of treatment and increases the risk of medical error. Various interventions, such as simplified information and illustrations, avoiding jargon, "teach back" methods and encouraging patients' questions, have improved the people's level of health literacy. Health literacy is a major concern for health professionals, as it is a primary factor behind health disparities. The Healthy People 2020 initiative of the United States Department of Health and Human Services has included it as an urgent new topic, with objectives for addressing it in the decade to come (Health Literacy, 2014).

Biomedical Approach

The biomedical approach to health literacy that became dominant (in the United States) during the 1980s and 1990s often viewed individuals as lacking, or "suffering" from, low health literacy, assumed that beneficiaries are passive in their possession and reception of health literacy, and believed that models of literacy and health literacy are politically neutral and universally applicable. This approach is deficient when placed in the context of broader ecological, critical, and cultural approaches to health; it has produced, and continues to reproduce, numerous correlational studies where there are adequate levels of health literacy. The people that have sufficient knowledge and skills and where members of a community have the confidence to guide their own health,

people are able to stay healthy, recover from illness and live with disease or disability (Health Literacy, 2014).

McMurray states that health literacy is important in a community as it addresses health inequities, as those at the lower levels of health literacy are often the ones who live in lower socio-economic communities. Being aware of information relevant to improving their health, or how to access health resources creates higher levels of disadvantage. For some people, a lack of education and health literacy that would flow from education prevents them from becoming empowered at any time in their lives (as cited in Health Literacy, 2014).

A more informed view of health literacy includes the ability to understand scientific concepts, content, and health research; skills in spoken, written, and online communication; critical interpretation of mass media messages; navigating complex systems of health care and governance; and knowledge and use of community capital and resources, as well as using cultural and indigenous knowledge in health decision making (Health Literacy, 2014).

This perspective defines health literacy as the wide range of skills, and competencies that people develop over their lifetimes to seek out, comprehend, evaluate, and use health information and concepts to make informed choices, reduce health risks, and increase quality of life. While definitions vary in wording, they all fall within the conceptual framework offered in this definition (Health Literacy, 2014).

Implications

It has often been said that knowledge is power, and information is the mother of decision. People need information to make informed choices and decisions. The *Bible*

says that people are destroyed because they lack knowledge (Hos 4:6). The Nyagiki church members need to be empowered with the correct HIV/AIDS information to help them and the community around them. Through my project, Nyagiki church members will be prepared to demythologize the society. My goal in this project is to ensure that every church member has the basic information about HIV/AIDS and will be ready to share that information with the people under his or her circle of influence and no person should die from HIV/AIDS because he or she did not receive information on time.

Definition of HIV/AIDS

Human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) is a disease complex of the human immune system caused by infection with human immunodeficiency virus (HIV). Following initial infection, a person may experience a brief period of influenza-like illness. This is typically followed by a prolonged period without symptoms. As the infection progresses, it interferes more and more with the immune system, making the person much more vulnerable to common infections like tuberculosis, as well as opportunistic infections and tumors that do not usually affect people who have working immune systems. The late symptoms of the infection are referred to as AIDS. This stage is often complicated by an infection of the lung known as pneumocystis pneumonia, severe weight loss, a type of cancer known as Karposi's sarcoma, or other AIDS-defining conditions (HIV/AIDS, 2014).

HIV is transmitted primarily via unprotected sexual intercourse (including anal and oral sex), contaminated blood transfusions, clinical needles, and from mother to child during pregnancy, delivery, or breastfeeding. HIV cannot be transmitted by saliva, tears, vomit, feces, mosquitoes, or bedbugs (Holden, 2003, p. 4). Prevention of HIV infection,

primarily through safe sex and needle-exchange programs, is a key strategy to control the spread of the disease. There is no cure or vaccine; however, antiretroviral treatment can slow the course of the disease and may lead to a near-normal life expectancy. While antiretroviral treatment reduces the risk of death and complications from the disease, these medications are expensive and have side effects. Without treatment, the average survival time after infection with HIV is estimated to be 9 to 11 years, depending on the HIV subtype (HIV/AIDS, 2014).

Genetic research shows that HIV originated in West-central Africa during the late 19th or early 20th century. AIDS was first recognized by the United States Centers for Disease Control and Prevention (CDC) in 1981 and its cause—HIV infection—was identified in the early part of the decade. Since its discovery, AIDS has caused an estimated 36 million deaths worldwide and approximately 35.3 million people are living with HIV globally (as of 2012). HIV/AIDS is considered a pandemic—a disease outbreak which is present over a large area and is actively spreading (HIV/AIDS, 2014). According to Weinreich and Benn (2004), the most affected area worldwide is sub-Saharan Africa where more than two-thirds (26.6 million) of all HIV-infected people live. In the year 2003 in Africa alone 2.3 million people died of AIDS and 3.2 million people were newly infected with HIV. The life expectancy in sub-Saharan Africa is 47 years; without AIDS, it would be 62 (Weinreich & Benn, 2004, p. 8). Epstein (2007) calls this situation “the African earthquake” (p. 67). Nolen (2007) argues that there were 28 million people living with HIV/AIDS as of the year 2007 (p. 17).

HIV/AIDS has had a great impact on society, both as an illness and as a source of discrimination. The disease also has significant economic repercussions. There are many

misconceptions about HIV/AIDS such as the belief that it can be transmitted by casual non-sexual contact. The disease has also become subject to many disputes involving religion. It has attracted international medical and political attention as well as large-scale funding since it was identified in the 1980s (HIV/AIDS, 2014).

HIV/AIDS in Kenya: Statistical Information

According to *Wikipedia,* the HIV prevalence rate in Kenya is declining—which is good news. This is has been made possible by two major factors: significant behavioral change and increased access to ART (antiretroviral drugs). The National adult HIV prevalence is estimated to have fallen from 10% in the late 1990s to about 6.1% in 2005. Women generally face considerably higher risk of HIV infection than men and experience a shorter life expectancy due to HIV/AIDS. "HIV/AIDS in Kenya," (2014) records an HIV prevalence rate of 8% in adult women and 4% in adult men. The Kenyan people who are especially at risk include injecting drug users and people in prostitution, whose prevalence rates are estimated at 53% and 27%, respectively. Men who have sex with men (MSM)—the homosexuals—are also at risk at a prevalence of 18.2%. The list includes discordant couples (where one partner is infected and the other is not), prison communities, uniformed forces, and truck drivers.

Table 2

Overview of the HIV Epidemic in Kenya in 2013

- 101,560 Kenyans were infected with HIV
- 12,940 children, 50,530 women, and 38,090 men were infected with HIV
- 65% of new HIV infections occur in 9 out of 47 counties (Nyagiki Church belongs to Kisii County where there were 5,975 new infections).
- 21% of new adult HIV infections occur among young women aged 15-24 every year.
- 1.6 million adult Kenyans were living with HIV
- 191,840 children (below 18 years of age) were living with HIV
- 63% of men and 80% of women know their HIV status.

Source: ("HIV/AIDS in Kenya," 2014).

According to the Kenya National AIDS Strategic Plan (KNASP) 2005/6-2009/10, about 65,000 Kenyan adults and 25000 children become infected with HIV every year, while a total of 150,000 die of AIDS related disease annually (Wanjama et al., 2013, pp. 13, 14). With the onset of HIV/AIDS, there has been quick increase of other diseases (opportunistic infections) including tuberculosis, malaria, meningitis, pneumonia, and typhoid (p. 72). Other complications caused by HIV/AIDS include absenteeism and low performance among the employees (especially those in the health sector), having internalized and genuine fear of contracting HIV from AIDS patients and blood contact. The worst of all seems the influx of orphans (kids without parents). There are approximately 11 million orphans in Africa and most of them live in Sub-Saharan Africa (Wanjama et al., 2013, p. 72). Callen (2010) asserts that we should not be overwhelmed by the numbers but be willing to change one life at a time. This is exactly the strategy used by Horizon International (A Faith-Based Organization) that has done a commendable job in establishing orphanages across several African

Countries (South Africa, Zimbabwe, Zambia, Kenya, and Uganda) (Callen, 2010, p. 29). D'Adesky (2004), concurs with Callen that we should not view HIV/AIDS patients as just numbers but lives to be saved one at a time. Furthermore, D'Adesky challenges the mainstream USA media not to ignore HIV/AIDS as a problem of Africa and Haiti. Stating that we can move mountains if we pull together (D'Adesky, 2004, pp. 4, 6).

Kenya's Response to HIV/AIDS: Three Phases of Response

In describing the response of the government of Kenya to the HIV/AIDS pandemic, two schools of thought were consulted. The first school of thought was advanced by Valet Mukotsanjera and the second thought was advanced by Doroth Rombo and Jane Njue. According to Mukotsanjera (2008) Kenya's national response consisted of three distinct phases, the first lasting from 1984 to 1991, the second from 1992 to 1997, and the third from 1998 to 2005 (Mukotsanjera, 2008, p. 87). Conversely, Doroth Rombo and Jane Njue (2012), describe Kenya's response in three phases, each phase comprising about 10 years (a decade): 1983 to 1992; 1993 to 2002; 2003 to 2014. The latter school of thought seems to be more descriptive and accurate; consequently, this school of thought has received more space in this project manuscript.

The First Decade 1983-1992

The response of the government of Kenya to HIV/AIDS in the first decade was slow. The first publicly declared case of HIV was in September 1984, a few cases had been observed in 1983. Mukotsanjera (2008) gives a slightly different date—1985—as the year when Kenya had the first declared case of HIV/AIDS (p. 87). In the first decade,

HIV was largely unrecognized among the Kenyan population. Rombo and Njue quoting from Lorch (1993) cite four reasons why the government of Kenya was passive in the first decade to deal with HIV/AIDS. The first reason given was that the government of Kenya was making effort to remain in power against the democratic waves that were sweeping across the world that led to the end of the cold war in 1989. Secondly, the government feared that making public HIV/AIDS prevalence could scare away tourists coming to Kenya from outside countries. Third, there was limited medical knowledge on HIV/AIDS. Lastly, there were limited financial resources to engage in research and intervention strategies to combat the spread and invest in HIV/AIDS education (Rombo & Njue, 2012). According to Epstein (2007), the major factor that delayed the response of the country to HIV/AIDS was the fact that Kenya's democratic space was limited and therefore no major decisions would be made or implemented without the permission and endorsement of the higher authorities (p. 68).

Kenya was not the only country that exhibited passivity in the first decade of HIV/AIDS. This situation prevailed in most of the countries of Africa. It is apparent that the continent was going through denial stage (Gill, 2006, p. 55). Bindenagel-Sehovic, Annamarie asserts that South Africa, which now has the greatest prevalence of HIV/AIDS cases in Africa, between 1981 and 1998, acknowledged the problem but chose to prioritize on the domestic transition to democracy over the threat of HIV/AIDS. South Africa also had three phases of response to HIV/AIDS. Beginning low and become more active culminating in the establishment of a strategic planning (Bindenagel-Sehovic, 2014, pp. 16, 17). However, the policies of former president Thabo Mbeki—successor of Nelson Mandela—proved counter-productive. Mbeki was contending that AIDS was

caused by poverty and not HIV and therefore there was no need to allocate financial resources for HIV/AIDS patients to receive antiretroviral (ARV) therapy (Kalipeni et al., 2004, p. 5). Tragically, since there was no national HIV/AIDS state of emergency declared, there was little financial resources allocated to address this issue (Marlink & Kotin, 2004, p. 143). Gill asserts that HIV/AIDS was a blind spot for Nelson Mandela and Thabo Mbeki (Gill, 2006, p. 73). Thabo Mbeki was accused of playing games on his people while young people were drying up and falling just like beautiful cut flowers falling from a vase (Iliffe, 2006, p. 146). It is sad to observe that Nelson Mandela—like his counterpart Bill Clinton of United States of America—became aggressive in fighting against HIV/AIDS after retiring from active politics (Behrman, 2004; Gill, 2006, p. 66). According to Smart (2002), South Africa became serious in addressing the AIDS epidemic in the third decade of its existence (in other words, 20 years were lost in dilly dallying) (Smart, 2002, p. 194). In sum, it is safe to conclude that Kenya (like South Africa) lacked visionary leaders to deal with HIV/AIDS disaster at its onset and it became difficult to eradicate it in its advanced stages.

The Second Decade 1993-2002

In this decade, Kenya moved from one party autocratic rule to embrace multi-party democracy. The government was under strict scrutiny from the opposition party. There was more accountability and transparency. By 1992 it had become evident that HIV/AIDS was related to sexually transmitted infections and in 1994, the National AIDS and STD Control Program (NASCOP) was established. The focus of attention included sexually transmitted infection (STI).

The Sexual Education Bill of 1996 proposed the teaching of sex education to all secondary (high) school students. The bill failed. The proponents of the bill intended to engage the youths (high school kids) in a healthy talk to lay bare facts about how HIV/AIDS is related to sex and how to avoid "unsafe sex" that would lead to HIV/AIDS. The opponents aggressively reasoned that there was no need to talk about "safe sex" and "unsafe sex" to the youths because that could be tantamount to encouraging them to engage in sexual relationships (the position of the opponents was that any type of sex for unmarried persons was unsafe).

> With policymakers and stakeholders (especially the churches) divided on whether to teach sex education in schools, the opportunity was lost to bring to the forefront the spread of HIV and AIDS and devise preventive programs. The impact of HIV continued to be felt across the country. Indeed, it took just 3 years after the sex education bill failed to pass for the government to declare HIV a national disaster. (Rombo & Njue, 2012, p. 16)

The Third Decade and Beyond 2003-2014

In December 2002, the people of Kenya elected a new president, Mwai Kibaki, who took over from Daniel Moi (Moi had stayed in power for 24 years). The constitution was changed so that a president was now entitled to be in power for a maximum of two terms (each term having 5 years). In 2003, president Kibaki with his newly elected 9th parliament formed a new parliamentary group which took proactive steps in combating HIV/AIDS. Some of the steps that were taken included: first, launching extensive public education through government ministries. Second, availing government money for research initiatives on HIV/AIDS. Third, subsidizing the cost of medicine for the individuals who were already infected with AIDS. Furthermore, emphasis was placed on the existing ABC model: A, stands for abstinence, this targeted the youth and encourages them to be celibate until the time of their marriage. B stands for being faithful to one's

sexual partner- this applied to those who were married as couples and those who were cohabiting. C stands for condom use, directed at high-risk groups like commercial sex workers and long-distance truck drivers (Rombo & Njue, 2012, p. 16). Some of the church members in the churches where I served as a pastor for fear of promoting promiscuity among the church members campaigned for members to go for Conduct not Condoms. This intervention appeared justifiable but did not provide a solution to persons already infected with HIV/AIDS, for example the situation where one marriage partner was HIV/AIDS positive and the other was negative.

From the year 2003, government agencies and private individuals in Kenya did an assessment of the impact caused by HIV/AIDS. It was discovered that the effects caused by HIV infection were economic, social, and psychological. The findings were reported both in qualitative and in quantitative research. In sum it was found out that the greatest impact of HIV/AIDS was felt by the family unit. Children become the innocent victims when one or both parents are diagnosed with HIV/AIDS. “Stigmatization, dropping out of school, change of friends, increased workload, discrimination and social isolation against orphans all increase the stress and trauma of parental death (Rombo & Njue, 2012, p. 17).

In the year 2006, the government of Kenya passed two bills into law: The Kenya HIV and AIDS Prevention act and The Sexual Offenses Act. The latter addresses sexual offenses including rape, incest, and other acts of sexual violence which may cause the offender to transmit HIV/AIDS to the victim. The Prevention Act focuses on the sensitive issue of secondary and tertiary transmission of HIV. The Prevention Act was aimed at stopping a person who was HIV/AIDS positive from spreading the disease to his/her

sexual partner or anyone else. Such a person is mandated by law to report his/her status to the sexual partner and to make effort not to transmit the disease to him/or her. If such a person cannot report his/her status, then the medical practitioner has the protection of the law to report the patient's HIV/AIDS status to his/her sexual contacts. If such a person acts contrary and transmits the disease to another person, then this is an offense which should lead to prosecution. The offender is liable for a fine not exceeding five hundred thousand Kenya shillings or imprisonment for a term not exceeding seven years or both a fine and imprisonment (Rombo & Njue, 2012, p. 15).

Implications

The Sexual Offenses Act (of 2006) has been hailed as a major turning point in the fight against HIV/AIDS not only in Kenya but also in sub-Saharan Africa. Where disclosure is done voluntarily, a HIV/AIDS patient can lead a better quality of life receiving support from family members. On the other hand, trying to seek justice in the event of a crisis is counterproductive as regards building trust among family members, "Criminalization might cost the family its stability. HIV is highly stigmatized and therefore the HIV free partner might not stay committed to the relationship. The Act would serve discordant couples where one is positive and the other is negative if it were not for stigmatization and cultural gender expectations including economic gender divide that lead to negative outcomes for women living with HIV (Rombo & Njue, 2012). Another loophole with this law was the fact that not all people suffering with HIV/AIDS are willing to go for voluntary (not mandatory) counseling and testing (and some people may intentionally avoid going for VCT to dodge the law.

Initiatives to Prevent the Spread of HIV AIDS

Foreign Aid

Melissa Buehler (2011, p. 8) contends that since many countries in sub-Saharan Africa have limited financial resources, it is necessary to depend on foreign aid to Combat HIV/AIDS disease. Buhler showcases major international donors that have been instrumental in supporting Africa financially (p. 8). Some of the donors that she mentions include WHO, UNAIDS, and Global Fund. The resources provided by the international bodies have been supplemented by those provided by philanthropic organizations. Over the years, Africa has continued to receive aid but the cases of people getting infected has been overwhelming. The need to get aid has been more than the resources available. This situation has led to the donors becoming selective on who to receive aid. However, it has not been easy to establish the criteria for picking some countries to receive donor aid and leaving others out (both countries face the same crisis) (Buehler, 2011, p. 18).

Sue Holden (2003) contends that HIV/AIDS is a complex developmental issue and all sectors of development must actively play a part in eradicating it. According to Anderson and Patterson (2017), the big question is not how much money is given out to PLWHA but how much training is given on how to use that money for PLWHA to be self-dependent and self-sustaining. In other words, rather than give fish to donor-recipients, it is better to train them how to fish. Donors can give loans to groups to engage in enterprises such as goat farming, raising chicken, small scale farming, processing food, and making crafts to sell to tourists.

Nana Poku contends that we cannot solve the aids crisis in Africa without solving the debt crisis (the silent crisis). Solving the aids crisis requires huge sums of money and

yet many African countries are heavily indebted (Poku & Whiteside, 2004). “Any effective engagement with HIV/AIDS in Africa must simultaneously engage with the continent’s economic decline, if it is to be effective and sustainable” (Poku & Whiteside, 2004, p. 33). In 1996, the World Bank and IMF came up with a plan to cancel debts from countries that they termed, “Heavily Indebted Poor Countries (HIPC).” Conditions were laid down which were required to be fulfilled to qualify for debt cancellation. By September 1998, only five countries in Africa had qualified for this debt relief packages and this resulted in the industrialized countries getting compelled to review the conditions for qualifying for debt cancellation (Poku & Whiteside, 2004, p. 43).

Church Involvement

In the year 2000, there were 390 million Christians in Africa. Campbell argues that churches can be a positive force in the community to stop HIV/AIDS: This statement is based on two factors: First, churches are often the most well established community networks in AIDS vulnerable communities, and thus potentially have wide influence; and second, that church teachings of love and care open up many potential spaces for an increased positive role in supporting people living with HIV/AIDS (PLWHA) (Campbell, Skovdal, & Gibbs, 2011, p. 1204). An inquiry done by Edwin Hernandez discovered that church members have responded both positively and negatively to the people living with HIV/AIDS. The church members have simultaneously promoted acceptance (based upon its understanding of mercy) and rejection (based upon its understanding of holiness) of the HIV/AIDS population (Hernandez, 2005, p. 101).

On the other hand, churches can cast a negative impact in the effort to combat HIV/AIDS. The churches increase stigma against people living with HIV/AIDS when

they use any of the following approaches: First, selecting to read passages from the Bible that portray women as sinners who need punishment. Second, compelling women to be submissive to domineering husbands. Third, shutting the doors against those who are in non-heterosexual relationships (Campbell et al., 2011, p. 1212). Fourth, labelling as "unfaithful" those who use condoms:

> More widely it has been suggested that, within church groups, condoms have come to represent 'a tool for unfaithful wives' or for those who have premarital sex. The Mozambican example highlights how mainstream messaging about condoms may contradict the positions adopted by powerful churches, highlighting the need to involve church leaders in discussions about the design of health campaigns. (Campbell et al., 2011, p. 1211)

There was associated tendency for churches to speak more on HIV prevention, and less on the challenges of living with HIV/AIDS and undergoing treatment, or of the potential role of church members in supporting PLWHA. HIV prevention messages preached in churches were often limited to abstinence and fidelity which sometimes clashed with "mainstream" HIV prevention campaigns (Campbell et al., p.1211). Condom usage is a big issue among some devout catholic believers. This is because the Roman Catholic Church teaches against contraceptives as a way of family planning. Park, Currier, Harris, and Slattery describe a situation where a devout lady—Sheila Browne—of the Catholic Church did not believe in contraceptives. Her sexual activity with her husband—who was HIV/AIDS positive—was always unprotected and she got HIV/AIDS from him (Park et al., 2017, p. 138). According to Shorter and Onyancha (1998), there is hope for the church in Africa bringing behavior change that will check the spread of HIV/AIDS. The case in mind is the youths of the Baptist Church have taken the initiative to pledge to be abstinent until the time of marriage. Their movement is named, "love waits" and records show that it began in the USA, where half a million youths have

signed the pledge of abstinence. The movement has now spread to 76 countries including Kenya and Uganda (Shorter & Onyancha, 1998, pp. 107-109). One positive extra advantage of the "abstinence pledge" will be the reversal of teenage pregnancies which is a big issue in many African Countries (Webb, 1997, pp. 116, 117).

Support and Care of People Infected and Affected by AIDS

People living with HIV/AIDS (PLWHA) live in communities and mingle with people who are negative. To effectively minister to both groups of people—the infected and the affected—there should be resources and organizations in the community to be used. These organizations are technically known as "community-based organizations" (CBO's) (Kalichman, 2005, p. 193). Kalichman (2005) further argues that while in the community, the issue of HIV/AIDS should be addressed at both individual and group levels (p. 195). In the following paragraphs, I will highlight on the role the church—as part of community organization—can play in supporting PLWHA.

Church Involvement

Campbell asserts that many churches in Africa have made progress in moving beyond preaching about "prevention sermons" to preaching about "supportive sermons." Churches are community-based organizations and are to transform their communities if they make a commitment to do so. Campbell reports that in Malawi many churches in the rural areas are involved in caring for the sick, sponsoring HIV/AIDS education programs for the youth, and emphasizing the care of orphans as a religious responsibility (Campbell et al., 2011, p. 1214). A study done in Ghana found out that church members are motivated to care and support PLWHA when they heard their leader publicly speak about

HIV/AIDS (Campbell et al., 2011, p. 1214). A study done in Mozambique found that the involvement of church groups in the provision of assistance to be limited to psychological support and personal care, neglecting many of the material and financial needs of those affected. The possible reason for this could be because church members are poor, but could also be an indicator of resource-based stigma (namely the belief that PLWHA do not deserve to receive material support or services) (Campbell et al., 2011, p. 1214).

Another study done in Tanzania revealed that PLWHA, despite lacking material and financial resources, can cope with the threat better when they were assured of support from God. They received comfort in their ability to confide in God and have an open relationship with God. In Namibia, PLWHA found religion to be an important framework to make sense of their illness and to come to terms with it. "The self-blame resulting from the church's teachings even helped some to make sense of their status in a way that increased their sense of control over their predicament. Almost all participants reported that since being diagnosed with HIV/AIDS, religion had become very important to them—giving them a sense of meaning and purpose to life" (Campbell et al., 2011, p. 1214). A research done by Harold Koeing in the USA found out that 55% to 65% of Americans say that religion is important to their life and 79% find greater happiness, satisfaction with life (Koenig, 2011, pp. 13, 15).

Campbell et al., observe that many church members and church leaders in Africa are evolving from the situation of silence and condemnation to a situation of being active and open in dealing with HIV/AIDS. A study done in Kenya found out that many people disclosed their HIV-positive status to church pastors. A similar study in the Republic of

Congo found out that women were free to disclose their HIV status to church leaders and supporting their fellow women to disclose their status to others including their husbands. For people to be free to disclose their status, the church must be understanding and accepting and be ready to encourage the members to live positively (Campbell et al., 2011, p. 1214).

In some areas where church beliefs have prevented church members to act, social action was used to tackle HIV/AIDS. Campbell uses the example of Kenya where youths' groups affiliated to the churches and religious schools have resisted the moral doctrines of church leaders and actively engaged in HIV management and condom distribution-helping to create important social spaces for the prevention of HIV. Campbell et al., assert that for churches in Africa to be in the forefront of combating HIV/AIDS, there is need to develop new theologies that are based on love and compassion to the sick and disadvantaged in society:

> Such theologies could, for example, challenge stigma through emphasizing those aspects of the Christian message that potentially advocate for the forgiveness of sinners; the empowerment of women; a compassionate understanding of the impacts of poverty and other social inequalities on behavior; and recognition of the inherent dignity of all human beings. (Campbell et al., 2011, pp. 1204-1219)

Government Intervention

According to Dworkin Shari, the war against HIV/AIDS is gigantic and needs more intervention than the one provided by the churches. Some cultural practices help in the spread of HIV/AIDS. Some of these cultural practices are deep rooted and require strong government policies to eradicate, and they include: inequalities in resource distribution, widow inheritance, and child labor. Dworkin did her research in two places in Kenya—Kendu Bay and Kakamega. In this research, it was discovered that women are

frequently stripped of their property and other assets or evicted from their homes when a husband dies of HIV/AIDS or other causes. During the funeral, the in-laws (brothers-in-law and sisters in-law) come and loot the home taking away everything: pots, pans, furniture, clothes, and sewing machines. The woman is displaced and then migrates to the market or to the beach of Lake Victoria where she will exchange sex for money to survive. Some women enter the "sex for fish" trade. Furthermore, some of the women who have young girls (minors) encourage their daughters to enter into prostitution in order to support their mothers to earn a living (Dworkin et al., 2013, pp. 704-708). Park (2017) contends that forcing young girls to enter prostitution at a young age causes them trauma that remains on them as permanent scars. Park however recommends a person who experiences such trauma to seek professional counseling in order to reduce the effects of post-traumatic stress disorder (PTSD) (Park, 2017).

Taban Legget and Wilfreda Thurston contend that it is a ridiculous situation that some women feel that marriage is "unbreakable." For example, Christian women cite the marriage vow, "till death does us part" as a strong motivation to remain in an abusive relationship and if possible, to die inside it. Other Christian teachings such as forgiveness, love, patience, perseverance, and endurance on trials and affliction are promoting for women to stay rather than to leave. Women with Muslim origins feel that they stand at a disadvantage because the Islamic courts are dominated by men (Leggett & Thurston, 2009, pp. 36-40). Kathleen Greider (2007) asserts that sacred texts should not be used to discriminate against people who are vulnerable. Ezra Chitando (2007) concurs with Greider that sacred texts such as Ephesians 5:22-24 ("wives be subject to your husbands, as to the Lord. For the husband is the head of the wife as Christ is the head of the

church") are often misused to perpetuate male dominance. Patriarchy is not only present in Christianity but in all world religions (pp. 6, 7).

Some women are compelled to be inherited: widow inheritance (Where a woman whose husband has died is expected to have sex and/or marry or have a long-term relationship with a brother in-law or a male relative. This kind of arrangement does not stop but increases the spread of HIV/AIDS. The solution to this evil situation is to improve the women's ownership of property and assets. In the year 2010, Kenya voted on a new constitution and a national land policy both of which could create a vibrant new policy environment in which to improve upon women's property rights and reduce HIV/AIDS risks: "Now is the time to translate these innovative programs and national policy shifts into targeted research agendas within the HIV/ AIDS prevention science base, and to disseminate the findings of such research" (Dworkin et al., 2013, pp. 710, 711).

Material Support for Orphans

Studies done in Western Kenya reveal that where material support is provided, there is a positive outcome in dealing with HIV/AIDS. Some of the material things that orphans need include bed linens, mosquito nets, clothes, shoes, school uniforms, In Sub-Saharan Africa (SSA), a surviving parent, grandparent, aunt or uncle are the main caregivers for orphans, while some exceptionally vulnerable children live in orphan-headed households. Care in orphanages has been deemed expensive and cost ineffective due to high child-to-staff ratios, lack of social bonding and life skills, and stigma. Although care by biological relatives is preferred, families in high prevalence, low resource communities have become overwhelmed by the numbers and needs of orphans,

and remaining HIV-infected parents or other caregivers may themselves die before the orphan reaches adulthood (Hallfors, Cho, Mbai, Milimo, & Itindi, 2012, p. 1101).

In Sub-Saharan Africa (SSA) where most new cases and deaths occur, an estimated 15 million orphans have lost one or both parents. Orphan youth are more likely to face malnutrition, school drop-out, poor psychosocial well-being and earlier sexual debut. Efforts in providing basic needs to ensure that these orphans are kept in school should be encouraged.

> In a randomized controlled trial of 328 primary schools in Western Kenya, Duflo and colleagues found that providing student uniforms significantly decreased school dropout and marriage for both boys and girls, and pregnancy for girls when compared to providing teachers with comprehensive training to deliver the Kenyan HIV curriculum. (Hallfors et al., 2012, p. 1102)

After one year of exposure, this survey showed promising findings: There was increased disagreement with early sex, increased bonding with adults in the family, there was reduction in school dropout, sexual debut, and decreased support for wife beating (p. 1102).

Conclusion and Recommendations for Nyagiki Seventh-day Adventist Church

HIV/AIDS is a gigantic and complex issue and to eradicate it from society needs the combined effort of individuals, families, organizations (including the churches), the government and the international community. Given the fact that my project will engage Nyagiki Church to make positive contributions to eradicate HIV/AIDS, I would like to recommend the following strategies that Nyagiki can use in her effort to do so. First, Nyagiki must make sure that her members have correct information. People need correct information to make informed choices. The members must understand the basic information about HIV/AIDS.

Secondly, the members must act to stop showing stigma to the PLWHA. PLWHA should be loved unconditionally and be treated with dignity and respect. The Bible says that there is no condemnation to those who are in Christ Jesus (Rom 8:1). Jesus said, "For God did not send his Son into the world to condemn the world, but to save the world through him" (John 3:17). The church leaders must set up a good example for members to follow.

Thirdly, the church members must be ready to share their financial and material resources to PLWHA. They should not wait for them to die and then put flowers on their graves. The responsibility of caring and supporting others does not end. Some of the PLWHA leave orphans behind when they die. In some cases, children lose both parents and become helpless and traumatized. The church has a responsibility to care and support these orphans. Above all the church has responsibility to empower PLWHA with skills and knowledge on how to fish for themselves.

Fourthly, the church must act as advocates for the weak and vulnerable. It has been shown that children and women suffer a lot when father/husband figure is absent in the family. In Kenya, customary laws do not permit daughters to inherit property from their parents. This situation makes women to be vulnerable. The situation becomes worse when they are married, and their husbands die. When this happens, some of them are compelled to move away from home, and some are forced to be inherited (widow inheritance). Nyagiki church members have a responsibility of advocating for the rights of children and women. They should be fearless to speak against evils such as widow inheritance, child prostitution, and child labor.

CHAPTER 4

A DESCRIPTION OF THE TRAINING PROGRAM

Introduction

This training will be conducted at the Nyagiki Seventh-day Adventist Church in the South Kenya Conference. About thirty adult church members will be trained to minister to people who are suffering from HIV/AIDS in the church and in the surrounding community. This training program will involve people who are 18 years of age and above and will last for a period of two years. To make the training effective and efficient, there is a need to have great strategies. This paper has made conscientious effort to use several strategies including andragogy, *Ubuntu/Umundu*, Maslow's hierarchy of needs, Jethro's principles, and Jesus' teaching model. The training process will be conducted in six phases which include engagement phase, exploration phase, explanation phase, elaboration/extension phase, evaluation/assessment phase, and the graduation/commissioning phase.

The Training Strategies

Andragogy

Andragogy is method of teaching adults that was championed by Malcolm Knowles who is considered to be the father of Andragogy in USA (Foley, 2004, p. 89). Andragogy is derived from the two Greek words *andras* which means man or an adult, and a*gogos*, which means "leader of." Andragogy is therefore defined as the art and

science of teaching adults. Andragogy is contrasted with pedagogy. Pedagogy is derived from two Greek words *paid* which means "child" and *agogos*, which means "leader of." Pedagogy is the art and science of teaching children (Knowles & Associates, 1984, p. 5). In pedagogy, the teachers speak, and the students listen. This method of teaching was prevalent before the 20th century. From the middle of the 20th century, we see radical changes taking place and this is attributed to Malcom Knowles (Conoway & Zorn-Arnold, 2016, pp. 37-42). From that period onwards, there was a paradigm shift: the learner—rather than the instructor—is central to the process of learning (Knowles & Associates, 1984).

Conoway and Zorn-Arnold (2016) developed six pillars to describe andragogy. The six points are summarized below:

Experience

Experience is the knowledge we acquire by exposure to real life situations. It is practical learning as opposed to abstract learning. Experience is one of the most important of the six principles posted by Malcolm Knowles (Conoway & Zorn-Arnold, 2016). It promotes diversity since no two people possess the same experience. Many adults can recall their past experiences and to connect with their present learning. "adults naturally acquire life experience that is used as a framework to interpret past behavior as well as a guide to future decisions" (Conoway & Zorn-Arnold, 2016). Knowles agrees with Conoway and Zorn-Arnold that adults are the richest resources for one another (Knowles & Associates, 1984, p. 10)

Wilson and Hayes (2000) argue that there is a difference between "learning from experience" and "experiential learning." The former happens in everyday contexts as part

of day-to-day life. Experiential learning, on the other hand, is systemized learning, "specialized discourse," that is organized to incorporate the location, a particular way of thinking, and a particular ideological position or set of values (Wilson & Hayes, 2000, pp. 73-74). To understand and value the experiences of other people, it is important to understand the location and environment in which they were shaped. People do not get experiences in a vacuum. People are shaped by the particular environment where they are brought up (Wilson & Hayes, 2000, pp. 76-78).

Self-Directness/Autonomy

Students become autonomous in what, when and how they learn. They set their own learning goals and objectives, they lay their own strategies on how to fulfill their learning goals, they set their own deadlines and evaluate the progress made in reaching the outcomes (Conoway & Zorn-Arnold, 2016). Wilson and Haya assert that andragogy is individualized learning. Students make their own learning plans and take responsibility for the outcomes (Wilson & Hayes, 2000, p. 58). Nicholas Corder agrees that andragogy is student-centered learning. The student takes greater personal charge over his or her own learning (Corder, 2002, p. 43).The instructor acts as a facilitator, coach, or resource person—not a lecturer (p. 55). According to Siplon and Novotny (2007), women need to be equipped with autonomy in order to deal effectively with HIV/AIDS. Women need to identify their needs, values, and concerns and then make choices and plans relative to the available resources. Autonomy means "self-determination," "self-reliance," "self-discovery," and "self-direction." In other words there is no room for imposing plans and procedures on others (Siplon & Novotny, 2007, pp. 90, 91).

Distance learning is a common phenomenon in the modern world. Many students

are opting to doing distance learning (Bash, 2005, p. 149). Weigel (2002) argues that doing online courses is not only cheaper but it is also convenient; students can save the time and money of commuting and staying in educational institutions (Weigel, 2002, p. 127). The trend for most students is to do online courses and then transfer the credit to the colleges/universities where they are enrolled to receive their degrees (Howell, Williams, & Lindsay, 2003, p. 2). Bash (2003) states that about 90% of students in the United States have access to a computer (Bash, 2003, p. 47). The future of distance learning will depend on the students' ability to use computers and technology.

Need to Know

Conoway and Zorn-Arnold (2016) assert that it is appropriate to inform adult students why they must do specific tasks. The students are well informed of the learning objectives from the start. Their coaches explain to them the relevancy and the cost of the learning objectives, "Adults need to know that the resources they are investing (time, efforts, money) will be worth it in the end. So reinforcing that point throughout the course is important" (Conoway & Zorn-Arnold, 2016). Knowles agrees with Conway; he says that adults learn in order to be able to perform a task, solve a problem, or live in a more satisfying way (Knowles & Associates, 1984, p. 11). The role of the coach in andragogy is to empower the students to be in charge of their destiny; they direct the passion and energy of the students and do not force or compel them which will make them develop resistance (Conoway & Zorn-Arnold, 2016, pp. 1-6).

Readiness to Learn

Older adult learners tend to be readier and more prepared to engage in studies than young adult learners. Some young adult learners enter college having little passion

to engage in studies. Furthermore, some of them take a long time to decide which course of studies to take. Older adult learners, on the other hand, tend to be more ready to be engaged in study and tend to take their studies more seriously knowing the benefits they will get if they succeed in school (Davenport & Davenport, 1984, pp. 152-159).

Orientation to Learning

For adult students, the future is now. “Their orientation is learner centered (versus teacher-centered) and problem centered (Conaway & Zorn-Arnold, 2015, pp. 37-42). Adult learners tend to be all set to engage in learning and do not need their teachers to remind them (Conaway & Zorn-Arnold, 2015). Adult learners tend to study for the present; instead of subject-centered orientation that is future focused, adults embrace a problem-centered orientation that makes them to apply what they learn in their current lives. Adults live for the present and not for the future (Imel, 1989, pp. 1-4).

Intrinsic Motivation

Children go to school because they must. They are extrinsically motivated by the forces of reward and punishment (Ozuah, 2005, pp. 83-87). Adults go to school because they want to. Tice argues that adults return to school in order to enhance their quality of life and that of their family (Tice, 1997, pp. 18-21). Justice, on the other hand, argues that adults who are over 40 years old return to school more for personal growth and development rather than enhancing their vocational status (Justice, 1997, pp. 28-33). According to Conway and Zorn-Arnold, adults return to school to be role models for their children; “the pride and accomplishment that adult students expect from fulfilling their degree is what motivates them the most” (Conaway & Zorn-Arnold, 2015, pp. 37-42).

Ubuntu/Omundu

Ubuntu is the African counterpart of andragogy. Ubuntu is derived from the southern African Nguni language family. The bantu-speaking people of Eastern Africa use *omundu* as a transliteration of *Ubuntu*. The Swahili fashion is *mtu* (human) and *utu* (humaneness). Swahili is spoken by over 110 million people in the eastern part of Africa (King & Wang, 2007, p. 63). *Ubuntu* means humanness or fellow feelings, kindness, or empathy. Nobel Laureate Desmond Tutu defines Ubuntu as the essence of being a person. A person is regarded complete when in intimate relationship with other fellow human beings. A person is not complete alone. We are made for interdependence (King & Wang, 2007, p. 64). *Ubuntu* is a timeless social philosophy that transcends time and boundaries. "It is an African worldview enshrined in the maxim, *umuntu ngumuntu ngabantu* (I am what I am because of who we all are)." A person is a person through other persons and the selfhood is achieved by how we treat others and on the basis of what we do for others (King & Wang, 2007, p. 64). The Eastern Africa transliteration is *omundu nomundu wa bandu* (an individual is an individual because of other individuals in society) (Nafukho, Amutabi, & Otunga, 2005, p. 11). Bangura (2005) argues that *ubuntugogy* and *omundogogy* transcends andragogy.

> *Ubuntogogy* is the art and science of teaching and learning undergirded by humanity towards others. . . . *Ubuntology* transcended *pedagogy* (the art and science of teaching children), *andragogy* (the art and science of helping adults to learn), *ergonagy* (the art and science of helping people to work), and *heutagogy* (the study of self-determined learning). (Bangura, 2005, p. 13)

Ubuntuism is based on human teaching and learning of all people in society without identifying them as children or adults (King & Wang, 2007, p. 65).

If every human being on earth practiced *Ubuntu,* we could not have wars, poverty,

or human suffering. The resources could be shared equitably. Nussbaum asserts that Ubuntu is a philosophy that defines the essence and purpose of human existence. A person is blessed so that he/she can bless others. People are willing and able to share not only their pains, but also their joys (Nussbaum, 2003, p. 9).

It is because of *Ubuntu* that some people in Africa were inspired to rise and do great things to benefit other fellow Africans. Nelson Mandela was in jail for 27 years for trying to redeem his country from apartheid. Julius Nyerere lived a simple life to assist his people in Tanzania to enjoy better lives; Kwame Nkrumah dreamed of Africa becoming "United States of Africa"—helping people to have good political governance for better economic life and peace in the continent. Jomo Kenyatta of Kenya started the "*harambee*" (pulling together) spirit.

Steve Bantu Biko (1946-1977) of South Africa is a good example of Ubuntu ideology ("Steve Biko," 2016). He was an anti-apartheid activist who was bold enough to lead university students' movements among blacks and people of color to challenge the evils of apartheid in South Africa. He was arrested and was transported naked to a prison 680 miles away. He died on arrival in September 1977. Biko's middle name is Bantu. His parents gave him this name because they were thinking about the African social philosophy *Ubuntu*; "a person is a person by means of other people." Biko's greatest contribution was in motivating black people to have an identity and to regard themselves as beautiful. He was famous for his slogan "black is beautiful," which he described as meaning: "man, you are okay as you are, begin to look upon yourself as a human being" ("Steve Biko," 2016).

Jethro and Andragogy

Ber (2008) argues that throughout the book of Exodus, there is evidence of opposing powers of conflict and resolution (p. 147). Conflict is seen in the side of Pharaoh and God, but God overcame the conflicts and allowed the exodus to take place. The forces of chaos and conflict do not spare the family of Moses. His two sons were almost murdered by God but Moses' wife, Zipporah, intervened to save them (Exod 4:24-25) (Ber, 2008, p. 147). God's presence is not readily visible in the book of Exodus 18 (p. 150). Moses seems to be battling things alone until his father in-law, Jethro, came to meet Moses. It is remarkable that God would use a gentile to communicate his wishes to his people. God is not a respecter of persons (Acts 10:34).

Jethro saves Moses from burnout. He confronts Moses with these words: "the way you are doing things is not right" (Ber, 2008, p. 165). The words of the narrator is that Moses' plan would "wear him out" which can be translated from the Hebrew verb *NBL* to mean " to wear oneself out," "to be foolish" (Ber, 2008, p. 165). Lockshin makes a more radical translation by associating the verb that is employed with the verbal root *BLL* "to be confused" (Lockshin, 1997). "So in Jethro's rhetoric, Moses' way of management is presented as a tiresome job, exhausting, foolish, and crazy activity (Ber, 2008). Jethro envisions that if the plan that he proposed to Moses would be followed, then success and victory will be their reward (Ber, 2008). Ber asserts that there is a happy ending in the book of Exodus 18. Peace and harmony are reached through willingness to retreat, to listen, and respond with understanding (Ber, 2008, p. 169).

Abraham Maslow and Andragogy

Maslow's hierarchy of needs is a theory in psychology proposed by Abraham

Maslow. Maslow fully expressed his theory in his 1954 book *Motivation and Personality* ("Maslow's Hierarchy of needs," 2016). Maslow categorized the human needs into six levels and put them into a pyramid beginning from the most important to the least important:

Physiological Needs

Air, water, and food are survival needs for both animals and humans. Clothing and shelter provide protection from the elements. Maslow listed sexual fulfillment as one of the physiological needs ("Maslow's Hierarchy of needs," 2016). A good teacher should always check to find out whether a learner has physiological needs to be addressed before engaging him/her in the learning process.

Safety Needs

People have a need to feel safe. This includes the physical safety (absence of war, child abuse, and family violence), financial safety (stable jobs and employment), health and wellbeing.

Love and Belonging

This includes needs for friendship, intimacy, and family

Self-esteem

Human beings have a need for stable self-respect and self-esteem. Treat people with love and respect.

Self-actualization

"What a man can be, he must be." This refers to a person's full potential and the

realization of that potential. For example one person's potential is to become an ideal parent, another person may desire to become the best athlete, while another person may desire to become a painter ("Maslow's Hierarchy of needs," 2016). In later years of his life, Maslow admitted that self-actualization is not enough. Human beings have a desire to connect with the supernatural power and then to receive fulfillment by exhibiting the qualities of peace and goodness (Koltko-Rivera, 2006, p. 304).

Self-transcendence

Maslow explored a further ultimate goal of all human beings: "a higher goal outside oneself, in altruism and spirituality" ("Maslow's Hierarchy of needs," 2016).

Jesus the Master Teacher

David Parkins asserts that to be an effective teacher one needs more than content knowledge. A great teacher must have the ability to effectively communicate and effectively engage the students in the learning process (Perkins, 2007, p. 34). Many educators see Jesus as a great teacher of all time. Maxwell (1992) calls him "the master teacher" (p. 18). Francine Wasukundi (2012) gives about six strong factors that makes Jesus stand out as a great teacher (p. 264).

1. He asked questions (Matt 17:25; Mark 3:4; Luke 10:26).
2. He tested the ability of the disciples to discern and to think (Mark 6: 34-44).
3. He attracted the attention of his disciples (Mark 4:9, 23).
4. He sent his followers out on mission trips: He sent Seventy-two disciples and Twelve apostles consecutively to the field—some kind practical training or

attachment (Mark 3:3-19). When they came back, he asked them to give reports of their mission trip.

5. He provided enough instructions (Matt 18:15-22).
6. He engaged his disciples in a dialogue (Matt 10:5; 19:16-29).

Edward Watke (1995) argues that Jesus was a competent teacher because he involved his disciples in their own learning. Jesus used the outlook and information that his students gave to discern the deeper longings of their hearts. Roger Bybee (1996) describes the 5Es sequence for teaching and learning: Engage, Explore, Explain, Extend (or elaborate), and Evaluate. The evaluation is both the students and the teachers to determine how much learning and understanding has taken place (Bybee, 1996). David Perkins (2007) emphasizes that evaluation and assessment should be an ongoing diagnostic process that allows the teacher to determine if the learner has indeed learned (p. 86).

William Robertson (2008) describes Jesus as the greatest constructivist of all time. This is evidenced when we analyze the way Jesus related with his disciples. He continually challenged them through the use of experiences, parables, and questions in order to help them think for themselves and develop new concepts (p. 1). Jesus avoided spoon feeding his followers and instead he allowed them to discover and analyze new concepts. Robertson asserts that Jesus' use of the parable of the sower is strong proof of Jesus as a constructivist. Through this parable Jesus moves his disciples from the known to the unknown (p. 1).

What is constructivism? Brooks and Brooks (1993) define constructivism as a learning strategy that builds upon students' existing knowledge, beliefs, and skills.

Students work to synthesize new understandings based on their current experiences and their prior learning. According to Eisenkraft (2003), in constructivism, learners of all ages build new ideas on top of their personal conceptual understandings. Students and teachers experience work together in applying and building on prior knowledge, "learners construct meaning while continually assessing their understanding of concepts" (Eisenkraft, 2003, pp. 57-59). Duffy and Jonassen (1992) point out that each learner has their own construction, their own understanding , rather than some common reality (Duffy & Jonassen, 1992, p. 6). Hofstein and Yager (1982) argue that the facilitator utilizes open ended questions in order to assess their understanding and to engage the students in learning. Robertson (2008) asserts that Constructivism is a very important method of teaching because it makes the learners to take responsibility in learning by being involved in active strategies that require them to problem solve and think critically. Students gain a deeper and broader knowledge that is both practical and functional in their everyday lives.

Nyagiki Participant Training Process

The best way to build a house if one does not have lump some capital is to do so in phases: First lay the foundation, then build the walls, then put up the roof, then put up the doors and windows, then do the plastering, lastly do the painting. Building in phases will make a person who does not have enough resources to feel less overwhelmed. The training program at Nyagiki will be done in several phases and it is expected that the participants will finish the training feeling strong and enthusiastic.

Engagement Phase

The Recruitment Process

Thirty participants will be recruited. The goal is to have a minimum of 20 participants but given the fact that some participants may opt to drop out of the training, it will be prudent to begin with a bigger number to provide room for those who may drop out. All participants must be at least 18 years old. The selection criteria of all participants will be based on their willingness to be involved in the leadership training program. Participating in this study is completely voluntary. There will be freedom to join in the study and to withdraw from the study at any time without any penalty. Confidentiality will be strictly observed.

An announcement will be made in the church bulletin and the first 30 people to sign in will be selected. The announcement letter will outline the checklist of things needed to make one qualify to enter the training. Each participant will be issued with a handout having all the information of what to expect in the training. Each participant will be required to sign a form of consent agreeing to participate in the training. Each participant will also have a witness who will also countersign. The process of recruiting participants will be done in a very friendly and transparent manner

Pretest

The participants will be given a chance to role play in visiting a HIV/AIDS patient by the bedside. This activity is to assess the level of knowledge the participants have in caring for a sick person. Participants will say how to care for this person in three levels. Level one will be sharing the normal trends on how other people without training will care for this person. Level two will be inviting few participants to care for the

person. Level three will be the researcher to care for the sick person.

Exploration Phase

Provides students with a common base of experiences "the learners' identify and develop concepts, processes, and skills based on open-ended approach in which students actively explore their environment or manipulate materials (Robertson, 2008, pp. 5-8).

Spiritual Retreat

Participants will be invited for a one-day long retreat. The purpose of the spiritual retreat is to give the participants a chance to connect with each other and to God. Participants will get to know each other's names their likes and dislikes. Participants will be encouraged to divide into small groups of two or three for prayer purposes. Each member will be encouraged to share personal needs and prayer requests to his/her prayer partner.

As an ice breaker during the retreat, participants will be discussed about *Ubuntu/Omundu* ideology. It will be emphasized that to show compassion to people who are vulnerable is part and parcel of the African culture and philosophy. It will also be emphasized that Heaven agrees with the *Ubuntu* ideology. Jesus Christ came to fulfill *Ubuntu* and not to destroy it. Several passages will be used to show that Jesus is a God of compassion and love.

Few passages will be used to show that Jesus is the personification of Ubuntu. Jesus showed compassion to a leper (Mark 1:40-45); and to the woman caught in adultery (John 8:1-11). The application that will be drawn from these illustrations is to remind the participants that they have a responsibility to care for people who are suffering from HIV/AIDS following the example set by Jesus. The retreat will conclude with the

formation of focus groups. Nyagiki Church is divided into four territories/Zones. Participants will form four groups and each group will have a leader and a secretary and will be assigned to one territory of the church. Special prayers of dedication will be offered.

Explanation Phase

Students uncover the content surrounding the concepts they have been exploring; "it gives teachers opportunity to introduce primary content materials such as formal terms, definitions, and other content information" (Robertson, 2008, pp. 8-10).

General Information

Specific information will be given on how to care for people who are sick. I will make effort to demonstrate the effective ways to care for the sick people and to visit some people in the area who are sick. I will take four people to accompany me on the demonstration tour. Members will discuss and build at least 30 verses (Each member to come with at least one verse) that can be used to encourage people who are sick. Members will also discuss relevant songs that can be used.

Book Reading Report

Each participant will be encouraged to read the book *Ministry of Healing* by Ellen White. The purpose of reading this book is to develop the Christian foundations for caring for people suffering from sickness. A chance will be given for the participants to share the information gained among themselves and before the church members at the camp meeting.

Health Information Literacy on HIV/AIDS

Each member will be given essential information related to HIV/AIDS. Members will be trained to differentiate between facts and myths. Handouts having relevant information will be given to each member. The researcher will recommend books that can be read to enlarge their knowledge. The purpose of this reading is to help participants to be well informed so that they can give quality care to people suffering from HIV/AIDS. It will also help them to be qualified to answer questions that may arise in the process of providing care to these people.

Elaboration Phase

Elaboration phase is designed to extend the students' conceptual understanding in areas of skills and behaviors. Students are given opportunities to practice and refine their skills and behaviors in authentic contexts to deepen and broaden their understanding both inside and outside the classroom (Robertson, 2008, pp. 10-12).

Monthly Meetings and Reports

Each focus group will be meeting once in a month to plan ministry and to give reports. The group leader will chair the meeting and the group secretary will record the discussions. This will be a right forum for the members to share experiences of their visitation program to receive support and encouragement from their fellow members. Each group will be expected to give a written report of the number of people visited each month. A form will be given to help each group give relevant information. The group secretary will receive reports from their members and then forward it to the chief secretary. The chief secretary will forward the reports to the researcher. The researcher

will evaluate the reports and give necessary feedback.

Visitation Program

The goal of the groups is to provide care for the people suffering with HIV/AIDS who have self-declared their status. People having different diagnoses will also be visited. All the members forming a group will not be required to visit each single case. The plan will be having two people visit each single case, but the groups will be very flexible in their approach. In some cases, only one person will be needed to visit. The patients will be contacted to give their suggestions on how they would like to be visited. The strategy is to reach out to all people in the community who are suffering from different kinds of sicknesses. Instructions on the proper way of doing home visitations will be provided. Lessons of proper listening and having a non-judgmental spirit will be emphasized.

Follow Up

Jesus healed a blind person by touching him twice (Mark 8:22-26). At the first touch the person was not able to see clearly—he saw people moving as trees. The person's eyesight was completely restored at the second touch. The participants will have a follow up plan on all people visited. At the end of each visit, participants will leave their contacts address with the patients and make them aware that they are free to call if they need more help. When patients are visited more than once, they feel valued and are able develop deeper relationships.

Public Outreach Program

The participants will be prepared to share publicly the information learned. This will be done in the month of August and will be a one-week activity (from Monday to

Saturday) at the annual camp meeting. The researcher will be the keynote speaker at this camp-meeting. The participants will team up with the researcher to give a "health-talk" which will last for a period of 30-40 minutes each day (Monday to Friday). The strategy is to have each focus group have one day in a week to present. The content to be shared will be the information gathered form the books and their personal experiences in home visitations.

Evaluation/Assessment Phase

Students assess their own understanding and abilities and allow the teacher to evaluate the students' understanding of key concepts and skills development (Robertson, 2008, p. 12).

At the end of the one-year period, the overall assessment of this training program will be conducted by the researcher to determine the impact of the training program on the lives of the participants. There are three methods that will be employed in the assessment process: (a) focus groups, (b) personal interviews and (c) reflection journals.

Focus Groups

There will be four groups comprising 5-6 members. Each focus group will meet for about 90 minutes to discuss and answer seven questions. All the four groups will have the same set of questions. These questions will be short, simple, and down to the earth. The participants will have a chance to have the questions in advance to help reduce anxiety and give them a chance to think about the answers to give. The group leaders will lead in the discussions and the group secretaries will record the answers. Each group will meet separately for deliberations and then will join to present their findings.

Personal Interviews

This method of assessment is appropriate to ensure there is maximum contribution and feedback from each participant—in a relaxed setting without fear or intimidation from fellow group members. A signing sheet will be provided for the members to sign to make an appointment to meet with the researcher. Communication will be given about the time, location, and the duration for each interview session. Each interview will last between 20 and 30 minutes. The sessions will be recorded to store information for future use. The participants will be duly appreciated and affirmed for their willingness to participate in this exercise.

Reflective Journals

At the end of the one-year period, the participants will be asked to write a one-page reflection paper describing their positive and negative experiences. Participants will be requested to share major lessons learned and provide recommendations for future trainings. The reflection papers will be submitted hard copy or by email.

Post-test

Students will be given a chance to role play on caring for a person suffering from HIV/AIDS. The researcher will assess progress made by comparing it with the pretest.

Graduation/Commissioning Phase

The participants will be encouraged to participate in the graduation ceremony. This event will mark the end of formal training of the participants. While the training session will end, ministering to people who are sick will continue at Nyagiki Church. Nyagiki Church members will be invited for this occasion. The reading will be made

from Matthew 25:31-46 (the sheep and the goats). Participants will be given a certificate showing their names and special prayers will be offered. The purpose of this event will be threefold. First, graduation event is intended to give special recognition to the participants in receiving the training. The second purpose of the graduation ceremony is to motivate and empower the participants to use the knowledge gained to serve others. The third purpose of the graduation ceremony is eschatological in nature. The participants need to be encouraged to look forward to the *parousia* (second coming of Jesus). Jesus has promised to give special reward (eternal life) to people who are involved in relieving the needs of their fellow men/women: "His master replied, well done, good and faithful servant! You have been faithful with a few things; I will put you in charge of many things. Come and share your master's happiness!" (Matt 25:21).

Conclusion

A story is told of one person who was quickly walking home on a cold snowy winter night. His body was slowly giving way to the cold and he doubted whether he was going to make it home alive. And then he saw another man fallen by the wayside shaking with cold. After spending a few seconds debating in his mind whether he should help him or not, he finally decided to help. He used a lot of energy to pull him off the ground and hold him in balance to walk forward. As the two men put their arms around each other's waist to support each other in the journey, they generated enough heat that made each of them reach his home safely.

It is not a waste of time and money when we sacrifice our time and resources to help people who are vulnerable. The blessings we receive are like a two-way traffic—they flow to others and to ourselves. The researcher will make assertive effort to explain

the benefits of making use of the African *Ubuntu/Umundu* ideology in showing love and compassion to people suffering from HIV/AIDS. The participants will be inspired in their work by the example of the great master teacher who gave his life to save people from eternal death. His life was completely consumed in ministering for others and as a result he was exalted to heaven to sit on the throne with God. Angelo Amato says that a good teacher is like a candle, it consumes itself to generate light for others (Amato, 2000, p. 282).

CHAPTER 5

NARRATIVE OF THE INTERVENTION IMPLEMENTATION

Introduction

Chapter 5 provides a narrative of my project challenge. This is an implementation of the plan and strategies discussed in chapter 4 and takes place in a period of 18 months. To keep the motivation high for the participants over this extended period and to provide quality training, adult-friendly approaches are used in communicating information and implementing the objectives. These approaches are borrowed from four educators namely: Malcolm Knowles, Jethro, Abraham Maslow, and Jesus Christ. The training ends on a high note with the participants speaking at a camp meeting leading into a graduation ceremony. The project of training Nyagiki church members to deal with the threat of HIV/AIDS was successfully accomplished.

Development of the Training Strategies

Malcolm Knowles' Andragogy Model

I made use of the andragogy method as championed by Malcolm Knowles. Under this teaching method, I allowed the participants to share their experiences and to be self-autonomous. I empowered the participants to be ready to discuss their perspectives and not to allow other people to impose information on them. Much of the learning was "distance learning" given the fact that I supervised the learning from United States of

America. I acted as a facilitator, coach, or resource person. The African translation of Andragogy is "*ubuntology*" which means "I am because we are, and we are because I am." In the words of the apostle Paul, all human beings are a single body. When one part of the body is sick and suffering, it affects the whole body (1 Cor 12:26). In application, if one person is suffering from HIV/AIDS the whole body (all human beings) suffers and should feel morally responsible to help the person that is suffering

Jethro's Model

In keeping with Jethro's advice to his son in-law—Moses—I endeavored to engage the participants by allocating responsibility to them. The "Chain of command" was practiced. The participants were grouped into four zones and each zone had a chairperson and a secretary to help facilitate monthly meetings. The four zones were representative of the four territories of the Nyagiki SDA Church. The group secretaries shared information to the executive secretary who shared information to the researcher.

Abraham Maslow's Hierarchy of Needs Model

According to Abraham Maslow, physiological needs such as air, water, food, clothing, and shelter are both basic needs. This list followed by need for safety, need to be loved and to belong, and need for self-respect and self-esteem. In the effort to care for people living with HIV/AIDS, the participants were encouraged to be observant of the needs of the people living with HIV/AIDS and to bring those needs to the church so that the church would plan to assist those lacking basic needs such as food and shelter.

Jesus Christ's Discipleship Model

I utilized some of the techniques that Jesus used in training his twelve apostles. I

began from the known to the unknown. I encouraged the participants to be critical thinkers who were willing to reason from cause to effect. We discussed information together, I demonstrated for them on how to do ministry and then I sent them out—in groups of twos or more—to do ministry and then they reported back to me their accomplishments. I closely supervised their work and appropriately provided feedback.

The Training Process

The process of training the participants may be compared to the work of cooking *ugali* (corn meal). *Ugali* is a staple food in many parts of Kenya (and other countries in the Eastern and Southern parts of Africa). The ingredients of *ugali* are simple (water and corn flour) but it takes a lot of skills to cook a good *ugali* meal. The process includes, having enough fire (most people use firewood), bringing water to the boiling point, adding flour in two major stages, using energy to thoroughly smoothen the dough with a cooking stick (pounding and turning the dough must be done repeatedly until the dough is completely refined). Just as it takes time and effort to cook ugali, it took time and effort to train the 24 participants. It will take the work of the Holy Spirit to be refined for service. Just like the apostle Paul, I made three missionary journeys to Kenya to provide training and to gather data. In reporting this training, three phases have been used namely: Engagement/Exploration phase, Explanation/Elaboration phase, and Evaluation/Assessment Phase.

Phase One: Engagement/Exploration—
March 23-April 3, 2016

The research participants were recruited, and the rules of the game were explained in detail. The consent forms were signed, and the ball was set in motion. Tim Sensing

asserts that Qualitative research must be done in a qualitative way and must ensure that the best practices are followed. Some of the best practice ingredients that were present in my research include the following ingredients: informed consent, confidentiality and anonymity, academic integrity, inclusive language, and continuous evaluation and assessment (Sensing, 2011, pp. 34-38).

The Recruitment Process

On March 26, 2016, the church elder announced that those who wanted to participate in the study were to remain behind after the sermon. Information such as the minimum age, duration of study, visitation program and monthly meetings was shared. After this, pieces of paper were given out for those who wished to join the training to sign their names. It was announced that the first 30 participants to turn in their pieces of paper, could be recruited. A total of 24 adult members signed up for the training (eighteen women and six men) and all of them were recruited.

Consent to Participate

It was made abundantly clear that participation in the research project was free. The members are free to join in the training and free to withdraw at any time without any penalties. After reading through the Andrews University IRB (Institutional Review Board) protocol describing the rules and expectations of the participants, the members signed the consent forms (Sensing, 2011, p. 34). Furthermore, each participant was required to have a witness to countersign his/her form.

Name of the Group

The participants unanimously voted to have their group named “Elisha.” The

reason why this name was chosen was because Elisha had been kind to Naaman who was suffering from what was considered an incurable disease—leprosy— (2 Kgs 5). Elisha played a simple role to have this miracle happen: He referred the person to go and wash seven times at the river Jordan and he was cured. The participants were passionate to provide a cure to people suffering from HIV/AIDS. They recognized that the role they could play was to refer people to Jesus, "The great physician."

Building Rapport

Participants were given a chance to familiarize themselves with each other. Each team player was given approximately three minutes to introduce himself/herself: mentioning the full name, home area, and any point of interest. I set an example and allowed others to follow suit.

The Pretest

The participants were given a task to role play visiting a HIV/AIDS patient lying in bed looking seriously sick. One the participants played a role of sick person lying in bed pretending to be seriously sick and volunteers were asked to come in to minister to his emotional and spiritual needs. The researcher observed as several participants played the role of a "chaplain" in providing care.

The Participant's Toolbox

It would be disastrous to send soldiers to war without giving them weapons. The following are a set of spiritual resources that each participant was encouraged to possess. Choosing these spiritual resources was informed by the fact that religion supports healing. Many modern doctors believe that religion enhances health and should be

integrated into medicine (Chamberlain & Hall, 2000, p. 4). Some of the health blessings that come when people practice good religion include: “longer life, less illness, better physical and mental health, marital stability, less divorce, less suicide, less abuse of alcohol and other harmful substances (Chamberlain & Hall, 2000, p. 80). “Religion is Good Medicine” (Chamberlain & Hall, 2000, p. 17).

1. A copy of the Bible: It was encouraging to know that each participant had a personal copy of the Bible. We took time to build a list of Bible texts that could be suitable to be used in caring for people who are feeling unwell emotionally, physically and spiritually. The major texts that were chosen include the following: 2 Kings 5; 2 Chronicles 7:14; Psalm 103: 1-3; John 8:1-11; John 10:10; James 5:13-18.

2. “Ministry of Healing” Book: The researcher provided each participant with a copy of this book written by Ellen G. White. The purpose of giving this book was to encourage the participants to get acquainted with Jesus’ Model of caring for sick people. Jesus is fine example of the ministry of healing.

3. A copy of the song book (Adventist hymnal in *ekegusii* language). The participants chose a theme song to guide their ministry. The song is entitled, “the great physician is now here.”

4. General conference (of Seventh-day Adventist) documents on HIV/AIDS. These documents were released by the health and temperance department at the general conference session in Indianapolis, Indiana, 1990 (Health & Temperance, 1990, pp. 93-94, 109-113). They were very helpful in my project especially in preparing the participants to speak at the camp meeting because of their brevity and simplicity. Since

these documents address HIV/AIDS from the Adventist Church perspective, they were very relevant to the camp-meeting audience.

5. Textbook on HIV/AIDS. A book that gives information about prevalence of HIV/AIDS in the country of Kenya. The book is entitled, *HIV AND AIDS: The Pandemic.* It was written by Leah Wanjama, Elishiba Kimani, and Mildred Lodiaga and was published by The Jomo Kenyatta Foundation (JKF) (2013, pp. 1-128). Four books were given out to be shared among the participants (One book for each focus group).

Table 3

The Four Focus Groups (Zones) and Number of Participants

Zone	A	B	C	D	Total
No of Participants	6	6	6	6	24

Source: Compiled by the researcher, Job Getange, March 2016.

Table 3 shows that four focus groups were formed with each group comprising of six members.

Communication Protocol

Each zone had a leader and a secretary. I commissioned each group to visit members in their zone. Each group met once in a month and gave a report of their ministry in the community. Members agreed to meet on the last Sabbath of each month for deliberations and to submit their visitation report. The group leader was then obligated to submit the report to the executive secretary who was charged with the

responsibility of emailing the report to the researcher (Sensing, 2011, p. 130).

Community Outreach

To show an example on how to do ministry in the community, I led the entire group to visit one lady in the community who had been sick and admitted in the hospital. At the time we visited, this lady had been discharged from the hospital and was at home undergoing recovery. She and her family had sent an invitation for us to visit. On arriving, we sung several songs and I read words of encouragement from the Bible. After that I prayed committing her into the hands of God.

Following Jesus' example, a small group (inner circle) was formed, consisting of the three elders in the group and we visited two families in the community. One family had lost their son several months earlier and another family had a member who had declared his HIV/AIDS status and he invited us to visit him.

Inauguration Ceremony

The research project was officially launched on Saturday 04/02/2016. The program ran from morning till 4:30 p.m. in the afternoon and included Sabbath school, sermon presentation, Holy communion, potluck lunch, and the music concert. Before the sermon, the participants were invited to come forward and a prayer of dedication was offered by the conference representative who was in attendance. I presented the sermon from John 8: 1-11 which was entitled, "Neither do I condemn you, go and sin no more." After the sermon, the church members were invited to participate in the Holy Communion which included foot washing, the unfermented wine, and the emblem of bread. The congregation broke for a potluck lunch after which a music concert by the church choir was held at the park—outside the church building. The church choir

members wore green clothes to match the green vegetation outside. The benediction was offered, and the congregation was dismissed.

Spiritual Retreat

The original plan was to take the participants to a spiritual retreat about five miles from their church to spend time for spiritual relaxation and refreshments. After deliberations with the participants, a consensus was reached for them to have an inauguration ceremony at their church which included Holy Communion. This was conducted on April 2, 2016 and is outlined above.

Phase Two: Explanation/Elaboration—April 04, 2016-March 31, 2017

The Issue of Funding Explained

After several months of visiting the HIV/AIDS patients, the participants reported to me that the needs were overwhelming. Some of the people living with HIV/AIDS expected to receive financial support to help them meet some of their basic needs such as food and money to buy drugs. This arose from the fact that the researcher resides in America, which is regarded as a rich country by many Kenyans.

This experience is like what Peter and John went through when they met a beggar at the entrance to the temple (Acts 3:1-10) who was expecting to receive money from them. Peter and John were honest in their response, “silver or gold have we none, but in the name of Jesus arise and walk. The participants were encouraged to be honest in interacting with the vulnerable people and never to give false promises. In the consent forms that the participants signed, it was clearly stipulated that no monetary payments could be made either to the participants or to the care-recipients.

Case Study: Joe Muriuki

A "Case study" is the situation where the researcher uses another person or church as an example of the ideal illustration that can be imitated or copied by others. "A case study allows the researcher and participants to examine the lived experiences of others" (Sensing, 2011, p. 141).

Joe Muriuki declared, "I have lived a full life despite being HIV positive" (Muriuki, 2014). Muriuki is a Kenyan citizen who was diagnosed with HIV aids in 1987. At that time, Muriuki had visited a small clinic to receive medical help after experiencing minor ailments. After testing his blood sample, the doctor threw a bombshell at him, "Muriuki, you could be HIV positive, and you are the first victim I have come across with the virus" (Muriuki, 2014). Muriuki went for advanced examinations in two other hospitals in Nairobi and the results were the same, he was HIV positive. Muriuki was devastated by this news but the worst was yet to be revealed. Muriuki was told that he had only, three months to live and he was advised to tell his wife to abort her three-week old pregnancy. Furthermore, Muriuki was fired from his place of work and would not get another job. According to Muriuki, this was a very traumatizing experience because at that time, HIV was only associated with homosexuals and people of loose morals (Muriuki, 2014).

Muriuki was the first person in Kenya to publicly declare his HIV status. Muriuki decided to move from the capital city—Nairobi—and go back to his ancestral home—Nyeri—to die. The good news is that Muriuki never died after three months. His wife was HIV negative and gave birth to a baby boy who was also HIV negative. His wife was like an oasis in the desert, she disregarded the calls from her blood relatives urging her to

pull out of her marriage to protect herself from getting infected with HIV by her husband. On the other side of the coin, Muriuki continued to meet rejection and stigma because of his HIV status. He could not get a job in his own hometown, he could not even open a bank account. The stigma that he received did not end quickly. In 2006, Muriuki got a visa to travel to USA but his visa was stamped, "HIV" status and he was advised never to have sex with anyone while in the USA and never to go beyond the time granted in the visa.

It is inspiring to know that Muriuki beat all obstacles to reach where he is today. As of November 2014, Muriuki was a PhD candidate having teaching assignments in three universities in Kenya. His son—the one he was advised to abort—was headed to Malaysia to do a master's degree in Technology. Muriuki founded "Know Aids Society" to educate the whole country about the condition of HIV/AIDS. At the time of this writing, Muriuki is almost 60 years and he hopes to graduate with a PhD in May 2015 (Muriuki, 2014).

There are five important lessons to learn from Muriuki's story. First, it is important for all persons to go for regular VCT to know their HIV/AIDS status. Second, it is important for people to share VCT findings with members of their family, especially their spouses. Third, it is important for those who test positive on HIV/AIDS to practice high standards of self-discipline to self-care and to avoid spreading the virus to their spouses and other people under the sphere of their influence. Fourth, it is important for PLWHA to engage in productive activities to bless themselves and to bless others. Fifth, it is important for PLWHA to shun all kinds of negative distractions and move forward to achieve their personal and professional goals.

Monthly Meetings/Reports

The participants met in their focus groups once in a month. The meetings took place at 2 p.m. on the last Saturday of the month. The agenda of such meetings was to review the work done in visiting members in that month and to prepare a written report to be submitted to the executive secretary. The group then planned the work for the following month. The participants were encouraged to prepare to provide solutions to any challenges that they faced along the way.

Home Visitation Program:

Table 4

Participants' General and Special Visits at Nyagiki (April 2016- March 2017)

	zone A		zone B		zone C		zone D		Total	
Date of Report	GV	SV	GV	SV	GV	SV	GV	SV	GV	SV
04/30/2016	4	0	3	3	5	2	10	0	22	5
05/30/2016	8	0	3	1	9	1	7	1	27	3
06/30/2016	8	0	5	4	7	2	8	0	28	6
07/30/2016	8	0	11	2	18	3	7	0	44	5
08/30/2016	3	0	8	4	3	0	4	0	18	4
09/30/2016	4	0	16	8	10	0	5	0	35	8
10/30/2016	5	0	2	2	7	1	7	0	21	3
11/30/2016	5	0	8	4	8	0	3	0	24	4
3/30/2017	4	0	2	2	10	0	11	0	27	2
Total	49	0	58	30	77	9	62	1	246	40

Source: Compiled by the researcher, Job Getange, April 2017.

Key: **GV** stands for General visits: Number of general visits made in each period.
SV stands for special visits made to people who have self-declared their HIV/AIDS status.

Table 3 shows the visits made by the participants to the Church's four zones in a period of nine months. It is good to understand that this is a compilation of the report of the participants visiting people in the community whether the participants visited alone or whether they visited in groups of two or more. Another point worthy of clarification is that a visit to a home where there are more than one person in attendance is considered a single visit when the people were met in a group under one session.

As shown in the graph, in a period of nine months, Zone A participants made 49 general visits and 0 visits to HIV/AIDS patients. Zone B made 58 general visits and 30 visits to HIV/AIDS patients. Zone C made 77 general visits and nine visits to HIV/AIDS patients. Zone D made 62 general visits and one visit to HIV/AIDS patient. The total general visits made by all the four zones were 246. The total visits made in nine months to HIV/AIDS patients were 40.

Remarkable Monthly Experiences

In May 28, 2016, a member of group D, (EN) reported an experience of visiting a married couple who were having a dispute. The wife was laying the blame on her husband for not revealing to her that he was HIV/AIDS positive at the time they got married and infecting her with the virus. EN listened to the grievances from both sides and he advised them to attend VCT at the hospital. The couple accepted to do so. EN helped the couple to understand that failure to have protected sex would lead to increase of viral load and hence making the situation worse. He advised the couple to focus on the present and not on the past.

On June 26, 2016, Group D visited a couple living with HIV/AIDS who had refused to go for treatment claiming that they "are saved" and God will take care of them.

Group D helped this couple to understand that God is the one who gives the gift of healing to the church (1 Cor 12). Jesus spent much of his time when he was on earth healing people of their sickness. In John 10: 10 Jesus asserts, “I came that they may have life and have it to the full.” After this visit, the couple were convinced that it is God’s will for people to visit hospitals in order to get help.

On July 31, 2016, Group A reported that two people revealed their HIV/AIDS status and they were encouraged to go for VCT. Group A also reported that they visited five non-believers who decided to come to the church and become members through baptism.

On October 04, 2016, group B reported that they had visited people having non-HIV/AIDS sicknesses: two people with back pains and seven people with cirrhosis (liver disease). While the focus was on HIV/AIDS patients, the participants went on a second mile to bless other people in need.

On November 06, 2016, Group B reported that they visited a person suffering from Asthma and they encouraged him to go to the hospital to seek help. They also reported that they visited a couple that was HIV/AIDS positive who had stopped taking their drugs. This couple was advised to go to the hospital for re-examination.

On December 4, 2016, Group D reported a critical situation of meeting a person who had suffered from cancer for eight years. The person had serious wounds with a deep hole. This person reported to the group that he visits local clinics as an outpatient. This happened because he lacked enough funds to go to a bigger hospital. The participants reported this matter to the church and arrangements were made to assist this person financially.

Personal and Group Interviews

Personal phone interviews were conducted. Each participant was assigned a maximum of three minutes. The phone interview was held on Saturday morning, January 14, 2017, and the participants were able to share their experiences and how they liked the home visitation program and the challenges they faced. The event took place in the middle of the project and was aimed at providing motivation and encouragement to the participants.

Participants Visit the Researcher

All the participants visited me in my home on February 10, 2017. This was during the funeral and burial of my father who had died on January 24, 2017. The visit of the participants to my home met two important achievements: first it sends a strong message that the researcher is also vulnerable ("a wounded healer"). The second achievement was for me to make an evaluation of the effectiveness of the participants to minister to individual members and to big congregations.

The participants were accompanied by their pastor and a few other church members, a total of about fifty people. They gathered in my house around 10 am in the morning after having travelled in a bus for about thirty miles. They stayed in my house for about one hour and then they moved outside for a public funeral assembly. The activities in the funeral program included short speeches, sermonettes, and songs. The choir composed of the participants and other church members sung two songs. It was a comforting experience for me and my family.

Phase Three: Evaluation/Assessment: April 1-
August 5, 2017

Reflective Journals

I originally planned that each individual participant was going to write one-page reflective journal to share their experiences of the training. After deliberations with the participants, it was agreed for the participants to provide feedback at the focus group sessions—they agreed to do this assignment collectively rather than individually. The focus group sessions were held, and the outcome is reported in chapter 6.

Post Test

The participants were given a chance to role play on caring for an HIV/AIDS patient lying in bed feeling serious. One person laid in bed and several volunteers took turns in providing spiritual care to this patient. The researcher carefully watched this activity and compared it with the pre-test. The participants were given a chance to discuss this activity to provide feedback. The critical analyses from the researcher indicated there was remarkable improvement when compared to the pretest. The participants expressed a lot of positivity and courage in providing care.

Camp Meeting Program

The participants and the researcher had the chance of speaking at the camp-meeting. Every year a group of seven churches and two companies meet for a spiritual refresher which begins at 9 a.m. and ends at 5 p.m. People commute daily to attend an open air gathering for six days (Monday through Saturday). The trees provide shelter from the sun and a good public address system is used in addressing the attendants. Each of the four focus groups was assigned to give a health talk for 20 minutes each day. The

researcher was assigned to present the main sermon each day lasting for 45 minutes. The participants were prepared to communicate information in a culturally sensitive way. Pike (1993) asserts that we always need to be aware of the cultural differences when sharing information across cultures. People may ignore good information if they feel that their cultural perspectives have not been respected. For example not all Native Americans will look one directly in the eye (Pike, 1993, pp. 299-301). In my own cultural setting, youths will not feel comfortable to discuss the topic of sex with their parents of the opposite sex.

Saturday, July 29, 2017

We spent this day doing rehearsals for the camp-meeting. The Nyagiki church members were gathered at their church and the researcher presented a sermon entitled "The Transformation of the Ethiopian Eunuch" (He came to Jerusalem as a person, but he went to his home as a Christian). This was because of the work of the Holy Spirit. The members were encouraged to pray for the Holy Spirit to lead and cause transformation in people's lives. After lunch break, the participants met separately to draft the schedule for camp meeting (topics and dates to present). The participants met in their focus groups to choose two people to represent them. The researcher was available for those who needed to connect on individual basis.

Monday, July 31, 2017

Two participants from zone A gave the health talk: they gave the definition of HIV/AIDS, the symptoms, and the Seventh-day Adventist Church response (Health & Temperance, 1990, pp. 109, 110). The sermon was based on Genesis 39:12 and was entitled "Run out and save your life." Joseph ran away and saved himself from committing adultery with Potiphar's wife. We need to run away from sin especially from

the sin of adultery.

Tuesday, August 1, 2017

Two participants from zone B gave the health talk focusing on how HIV/AIDS viruses are transmitted, the treatment, and the global impact of AIDS (Health & Temperance, 1990, pp. 110, 111). The sermon was entitled: "Be a good keeper of your brother and your sister" based on the book of Judges 19:22-30. A foolish man slept while his wife was raped all night, and, in the morning, she died. This was a moving story helping couples to defend each other and not to engage in lifestyles that will put their spouses at risk.

Wednesday, August 2, 2017

Two participants from zone C presented the health talk. They encouraged the listeners to be proactive in sending the warning against HIV/AIDS everywhere, including schools, churches, and homes (Health & Temperance, 1990, pp. 111, 113). The sermon was based on the book of Hosea chapter 3 and was entitled "Grace brings a sinner home." Hosea's wife was a prostitute who left home and went to live with her lovers. However, Hosea used his resources to buy her back and bring her home. God's loves sinners and he gave his son to redeem them back. Where sin increased, grace increase much more. When we show love to other people, we exhibit the character of God. (The conference president attended the camp meeting on this day to provide support and encouragement to the researcher and the participants).

Thursday August 03, 2017

Two participants from zone D presented the health message entitled, "Mobilizing pastors, teachers, parents, church members, communities to be engaged in providing information to help people avoid getting infected with HIV/AIDS." Information was given to help people learn how to exercise fidelity before and after marriage (Health & Temperance, 1990, pp. 93, 94). The sermon was based on the book of Luke 23:26-43 and was entitled "The cross: the place to receive forgiveness." Just as God has forgiven us of our sins, we also need to be ready to forgive those who sin against us.

Friday, August 4, 2017

The participants attended their graduation and received their certificates. The sermon was based on the book of 1 Peter 1:7 and was entitled "Cast your burdens upon him." Sermon was an encouragement to pray; to be free to talk with God just the way we are open to talk with our intimate friends.

Saturday, August 5, 2017

The sermon was based on 2 Samuel 9:13 and was entitled, "A lame man at the King's palace." The sermon was an expository sermon describing King David showing generosity to Jonathan's son, Mephibosheth, who was lame. Mephibosheth was Saul's grandson (Saul was an enemy to David). Because of Jesus sacrifice at the cross, God is going to allow human beings (who have been made lame by sin) to live in his heavenly palace for all eternity. Just as God is kind and patient with us, we need to be kind to each other (Avoid a non-judgmental attitude). After preaching this sermon, I made an alter call and 29 people responded to the call.

Table 5

Nyansongo Camp-Meeting Attendants (July 31-August 05, 2017)

Day	Mon	Tue	Wed	Thurs	Fri	Sat
Attendance	72	161	364	535	432	1125

Source: Retrieved from Nyansongo camp-meeting secretary's records, August 2017.

Table 5 shows the daily attendance of people at the camp meeting. It was compiled at about 11 pm each day—just before the health talk and the sermon. It does not reflect the attendance at the camp meeting throughout each day. Whereas there are people who attended full time (morning till evening), other people opted to attend only part time.

The participants who spoke at the camp-meeting expressed a lot of knowledge, enthusiasm and courage. An example is a lady who spoke in the presence of her father-in law on the sensitive topic of using condoms as a weapon to prevent HIV/AIDS (among the Kisii people, usually ladies tend not to address sensitive topics in the presence of their parents' in-laws). Such a courage is like the ones the disciples of Jesus demonstrated—after His ascension—and it was said that "they turned the world upside down."

Graduation/Commissioning

The participants had a chance to attend the graduation ceremony which was held on Friday, August 4, 2017 at the camp site. It was very inspiring that all the 24 participants recruited lined up to receive their certificates which were given in a public setting. The participants wore special uniforms (white tops and black bottoms) and were invited to parade at the stage. The researcher read from Matthew 25:31-46 (the sheep and

the goats). The area pastor made some remarks encouraging the participants to be faithful in the calling that they had received from God. He motivated them to look forward to the second coming of Christ where they will be rewarded for the good work that they will do.

Each participant was given a certificate bearing his/her name, the course of study, the period of training, and the name of the researcher. The certificates were signed by three people: the researcher, the church pastor, and the church elder. A special prayer of dedication was given by the area pastor.

CHAPTER 6

EVALUATION AND LEARNINGS

Project Summary

The Doctor of Ministry Research Project was conducted at Nyagiki Seventh-day Adventist Church between March 2016 and August 2017. There were 24 adult participants—18 women and six men—who were effectively trained on how to care for people living with HIV/AIDS in their communities. The 24 adults were first equipped on relevant basic information about HIV/AIDS. Special lessons were given on how to make home visitations and how to share information in a friendly atmosphere.

The participants formed four focus groups and each group was assigned an area—zone—to cover. The focus groups met once each month to give their progress reports in reaching out to their communities. At the end of their training, the participants were involved in speaking at a one-week camp meeting which was held in their community. Two participants spoke at this event each day to represent each of the four focus groups. The climax of the training was the issuing of certificates to the participants which was conducted on Friday of the camp meeting week. The graduates were commissioned to continue doing the ministry of caring for HIV/AIDS patients in their communities. Other highlights in this chapter include: recommendations to Nyagiki Seventh-day Adventist Church, my transformation as a ministry professional, and the conclusion.

Evaluation Method: Focus Groups
Questions Answered

There were six focus questions that were discussed by the participants. The questions were the same for all groups, but the answers given were different. The focus groups discussed the questions and they were encouraged to give at least one salient answer to each question. The response is outlined below. I have endeavored to copy directly the responses given (responses were written and submitted to me by the group secretaries).

1. *What positive experiences can you share for participating in the HIV/AIDS training program?*

Group A: "People can live longer and better so long as they accept their status and know that God is the giver of life." *Group B:* "With sweet words and encouragement . . . indicated to us that making friendship with them can make HIV/AIDS patients to live longer than expected." *Group C*: "HIV/AIDS patients appreciated our visits and enjoyed hearing the word of God and our prayers." *Group D:* "We as a group, discovered that we can live longer and better years if we know our status."

2. *What areas were not very helpful to you?*

Group A: "Some of these patients expected material or financial support. *Group B*: "Moving to individuals directly was not helpful because many don't want to expose themselves." *Group C:* "Some patients we visited needed healthy foods to keep them strong. It was unfortunate that we did not have any food to offer to them." *Group D*: "The method of knowing our fellows who are affected with HIV/AIDS (Identification)."

3. *What areas would you recommend changed if we were to start all over again?*

Group A: "If we could have a kit from where the sick is given at least something."

Group B: "Avoid direct approach to the affected because those with stigma tend to despise themselves." "Improvise a method to create awareness through churches and funeral meetings." *Group C:* "The HIV/AIDS patients take strong drugs which tend to weaken them. We should make effort to support them to have food security." *Group D:* "When visiting the sick people, we need to avoid discrimination and separation."

4. *How did this training change your attitude to people living with HIV/AIDS?*

Group A: "This study helped me to see that HIV/AIDS patients have chances of living longer and normal lives." *Group B*: "The training helped me to understand how HIV/AIDS patients feel and respond to stigma. It also helped me to know how to care for them while maintaining confidentiality." *Group C:* "HIV/AIDS causes a lot of suffering to the people who are infected. We need to be faithful to each other within marriage and to pray to God always so that he may protect us from getting infected." *Group D:* "People who are infected with HIV/AIDS are able to lead normal lives and can enjoy activities such as singing, reading God's word, and eating together to create love."

5. *How beneficial were the outreach programs?*

Group A: "It made some patients like reading the Bible because we told them that it was the source of life." *Group B:* "It was a blessing to us and the people who received the message. You can't give what you don't have, we shared out what we had first gained.' Group C: "This program helped me to study more about the word of God." Group D: "The outreach program helped the care-recipients to receive encouragement and hope."

6. *How do you think this training program made you a better leader and Christian?*

Group A: "It made me to be tolerant and know that this life has challenges and

without the word of God, one can lose hope in life." *Group B:* The training helped us to get detailed information and this made us to become role models to other members in the church." *Group C:* "This training helped me to know how to approach, comfort, and care for people who are living with HIV/AIDS. It also helped me learn how to take good care of my fellow Christians." *Group D:* "This training was a motivation to read more books and become better equipped to walk the Christian journey."

Intervention Outcome

The monthly reports indicated that there was a total of 246 general visits made and a total of 40 visits made to people living with HIV/AIDS. In the last month of the project, the participants were involved in speaking at a one-week camp meeting which was held in their community. Two people spoke each day at this event to represent each of the four focus groups. On the Friday of the camp-meeting, a graduation ceremony was conducted, and certificates of recognition were issued to the participants. The researcher was the chief speaker at camp-meeting and 29 people responded to the altar call. The people coming to the camp-meeting from other churches in the community made requests to have similar research projects conducted in their churches.

The following are some of the specific results of this intervention. First, this intervention helped create more peaceful homes. The case in point for this factor is the couple that were having a dispute but when they were visited by EN, they resolved their issues and they accepted to go for VCT (see chapter 5).

Secondly, the intervention helped to clarify some of the misunderstanding about the need for receiving medical attention. This is evidenced by the couple—mentioned in chapter 5—who had decided not to go to the hospital arguing that God would provide

healing in their home. Group D helped this couple to understand that God gives the gift of healing to be used for his glory. It is not sinning to seek the help of the physicians. Jesus himself sent lepers to go and be checked by the priests at the temple after receiving healing. The priests at that time served as physicians.

Thirdly, Nyagiki is experiencing membership church growth. The total membership (as of May 2018) is 192, up from 171 (as of March 2016). As a result of this growth, the church facility is not able to accommodate all the people attending the services. Consequently, the church has made plans of constructing a new church facility and the work is in progress—the foundation slab has been done and pillars erected, as of October 2018. The church-sponsored high school has been relocated and its building facility has been demolished to create room for the church to be built. The capacity of the new building will be 900 people (the current church can accommodate up to 200 people). Furthermore, the plan of the new church facility has been modernized to include a baptismal pool and "flush toilets." A second fundraiser (in a period of two years) was conducted on March 10, 2018 where a total of one million Kenyan shillings (US$ 10,000) was raised. For many church members, this was a divine miracle. The person who was the chief guest at the fundraiser—a wealthy area politician—voluntarily offered himself to play that role and has provided a major boost. He came with a team of rich friends and promised that he was going to provide his truck—free of charge—to transport materials for building this church and to continue financially supporting this project until it gets completed. Nyagiki seems to be on fire for God—there is a great revival taking place that has never been experienced before in her history of over seventy years.

Conclusions

To analyze the progression of the research project, I have endeavored to provide conclusions from previous chapters—chapter 2 through chapter 5. These conclusions will prepare the way for an overarching conclusion.

Theological Conclusion—Chapter 2

The book of 2 Kings, chapter 5 narrates the story of Naaman who overcame major obstacles along his way to receive healing. Some of the obstacle he overcame include Joram (King of Israel) and Gehazi (Elisha's servant)—both showed violence towards him. Nevertheless, with the help of his servants and the help of God's servant (Elisha), Naaman goes to the River Jordan and after dipping himself seven times, he received healing. The story of Naaman and Miriam are strong illustrations to dispute the popular misconception that there was no healing for leprosy in the Old Testament. The Hebrew word *shalom* is used to illustrate the total healing that Naaman experienced after dipping himself in the river Jordan seven times. Healing is complete when it encompasses both the physical, the mental, and the spiritual (body, mind and spirit) aspects of a human being. In other words, healing is complete when it is holistic (whole person care).

Another important lesson to learn from Naaman's healing is that of the role the laity (church members without professional clergy training) in doing ministry. There is evidently intentional cooperation between Elisha (clergy) and the servants (laity) of both Naaman and Elisha. This cooperation should be promoted today in doing ministry organized by the church and even at the hospital setting. The apostle Peter's teaching on priesthood of all believers is very relevant (2 Pet 2:9). The right application of this

teaching by the ministers and chaplains will play a bigger role in preventing burnout on the part of the clergy who love to do ministry alone.

Theoretical Conclusion—Chapter 3

A lot of books were reviewed in preparing for this chapter. I focused on the books talking about HIV/AIDS in Kenya. The findings indicated that the way the country of Kenya addressed the issue of HIV/AIDS at its onset was slow, judgmental, and tragic. A great number of people lost their lives across Kenya (and Africa), people who would be living today if quick and drastic measures had been taken at the onset. Today, the churches and faith-based organizations need to work together with the government agencies to ensure that the gains made so far are scaled up to prevent further spread of HIV/AIDS in Kenya. Furthermore, both parties can work together to stop social evils—such as widow inheritance, child prostitution, child labor, and female genital mutilation—which are associated with the spread of HIV/AIDS. Above all it is worth noting that the church should not always wait to get the support of the government before acting. Jesus said that his followers are to be a light in the world and that means that the church should be at forefront in ministering to the vulnerable population.

Methodological and Implementational Conclusion—Chapters 4 and 5

The strategy that was used in addressing HIV/AIDS pandemic was very important in determining good results. In engaging the participants for a period of 18 months, I utilized concepts from the four educators namely, Malcom Knowles, Jethro, Abraham Maslow, and Jesus Christ. The research project was carried out in five phases: Engagement, Exploration, Explanation, Elaboration, and Evaluation. Contextually, using

the philosophy of *ubuntology* was very important: "I am because we are." In caring for HIV/AIDS patients, it is beneficial to exercise *Ubuntu* graces such as empathy, compassion, and affirmation. It is important to use the right strategy in ministry. The fact that all 24 participants were enthusiastic and passionate in doing ministry for 18 months without having anyone drop out could be attributed to the right strategy used in doing ministry. Ministry, just as in fishing, is successful when the right strategy is used.

Overarching Conclusion

When Jesus saw the crowds, he had compassion on them, for they were like sheep without a shepherd (Matt 9:36). Jesus—the great physician—is an expert in providing healing to the sick people. The healing that Jesus provides goes beyond the physical health of a person. It includes the spiritual, emotional, and psychological aspects of health. This is evidenced by the example of the forgiveness that he provided to the paralytic of Capernaum who was brought to Jesus by four men—who made an impossible thing to happen because of their faith, courage, and determination. White (1942) says that this person was sick as a result of living a sinful life and the Pharisees and the doctors of the day had pronounced his condition as incurable and unpardonable (White, 1942, p. 73). Jesus pronounced spiritual healing to him by saying, "son, your sins are forgiven" (Mark 2:5). The expectations of many of the people who were present was for Jesus to provide physical healing, but Jesus provided to him what He thought this person needed most—spiritual healing. From this experience, we can safely conclude that for some people, spiritual healing is what they need more than the physical healing. But it is excellent if they can have both and Jesus is able to do that. Secondly, we need to help people unconditionally—irrespective of their moral condition.

People who are living with HIV/AIDS need help from people who have enough faith to make impossible things to be possible. Caring for this vulnerable population requires people who are loving, thoughtful, positive, and kind; people who can see beyond the valley of dry bones (Dube & Kanyoro, 2004, p. 107). Like Job, people who know that there is life after the outward skin has been destroyed (Job 19:25-27). Such a people must be people permanently and intimately connected with Jesus Christ (John 15:5-7; 1 Cor 12:12; Eph 4:15, 16); the ones that Jesus prophesied that they would do greater things than he did because he was ascending to his father (John 14:12). Such people are the members of God's church. God has empowered His church with the power of the Holy Spirit. The Holy Spirit gives spiritual gifts to the church and one of those gifts is the gift of healing (1 Cor 12:9). It is therefore without dispute that the church that relates to Jesus Christ will play a great role in ministering to people living with HIV/AIDS; just like the servant girl of Naaman and Elisha the prophet, the church will be a strong agent to point people to Jesus where they will find holistic healing.

Personal Transformation

Tim Sensing (2011) asserts that both the researcher and the participants should experience transformation in the process of conducting qualitative research (p. 212). The following are some of lessons that I gained in conducting this research project.

Empathy versus Sympathy. I have learned to do more for people who are in need than just showing sympathy (being sorry about what they are experiencing); I have learned to empathize (doing something to alleviate their suffering) with them. At Nyagiki I participated in donating an offering to help a lady who desperately needed money to

buy a machine to measure her blood pressure daily. I also participated in giving donations for the new church project.

Social Media Literacy. In this research project, I was able to engage the participants in "distant learning," most of my interaction with the participants was by phone calls, phone conferences, text messages, "What is up," and by emails. The 21st century is saturated with a lot of social media that can be used to advance God's kingdom and I am passionate about being part of this experience.

Being a Wounded Healer. In January 2017 (In the middle of my research project) I lost my father—a retired minister who had been a great source of inspiration in my ministry and career. Family members, friends, and church family members joined together to provide spiritual and emotional support that I needed to navigate through the rough waters. I need always to remind myself that I am human and open avenues for others to care for my needs.

Writing a Book. I would like to write a book dealing with HIV/AIDS that will be a valuable tool to help church members effectively care for PLWHA from a theological stand point. This book may be translated into the Swahili language and would benefit people living in the countries of Eastern Africa—including Kenya.

Developing a Missionary Spirit. When Jesus sent his disciples out on a missionary journey, he instructed them to travel light and to move forward in faith knowing that God would provide (Matt 10:9-15; 1 Pet 5:6, 7). Through my sacrificial living—I was working on a part-time job and getting low income—I was able to make three missionary journeys without outward sponsorship. In my last journey, I was a guest speaker at the camp meeting and accepted the arrangement of church members and their pastor to stay

in a simple church house (pastor's residence) where I enjoyed free accommodation and food. In practicing simplicity, I can save money to return tithe and offering and support people in need.

Developing Ubuntu Spirit. Serving as a full-time staff chaplain in a big hospital gives me opportunities to practice ubuntu spirit every day. Some of the things that I do to express my Ubuntu spirit include: addressing people by their names, applying gentle touch to people going through misfortune, escorting guests to find their way at the hospital, sharing greetings and a smile to strangers I meet along the way.

Using my Ministry Opportunities Wisely. One of the 24 research participants died after a short illness—two months after completing my research project. The person who died had been an active participant (he was a secretary in one of the focus groups and faithfully submitted his monthly reports to me). It is true that some of the people I meet (especially in the hospital setting), I will never have another chance of meeting them. Therefore, it is crucial that I offer my best care and service. The offer I provide may make an eternal difference in their lives.

Recommendations

Several recommendations have emerged from the comprehensive analyzes of the information contained in all the chapters of this research project.

1. After my research study at Nyagiki, several people coming from other churches requested for similar work to be done in their churches. I therefore recommend specifically to students and other immigrants coming from the continent of Africa to take this "Macedonian Call" seriously. The fields are indeed ripe for the harvest, but the reapers are few (Matt 9:37).

2. Chapter 3—Literature Review—disclosed that the situation of HIV/AIDS in Kenya has been compounded by the presence of such evils as child labor, child prostitution, widow inheritance, female genital mutilation (FGM). Furthermore, it was found out that customary laws in Kenya do not permit ladies to inherit land from their parents/husbands, this situation reduces the financial abilities for ladies causing some of them to resort to prostitution as a way of getting income. Interventions need to be made to stop these evil practices.

3. I recommend that Nyagiki church develop an emergency fund to support PLWHA. This need was voiced by the focus groups. The cost of buying drugs is high and on top of that they need to eat nutritious foods. Having an emergency fund will be a brilliant intervention to help meet critical situations like the man who was visited but did not have money to go to the hospital. The beneficiaries need to be trained on how to raise their own money to avoid a spirit of dependence. Nyagiki may improvise ways of giving out clothes and food to the community. This attitude is supported in the Bible (Jas 1:27; Jas 2:14-17).

4. I recommend to Nyagiki to keep the fire burning. Keep on reaching out to the communities around the church. Involve more youths and adults to do this work. Short presentations can be made at church regularly as people gather for their weekly worship services (on Saturdays). People need to remember that their work in the Lord is not in vain (1 Cor 15:58; Matt 25:34-40).

5. I recommend to the Nyagiki congregation to keep on reading books to increase their knowledge on health information. It would be good to have a church library

having relevant books on healthful living. Church members—especially the youth—would greatly appreciate this intervention.

6. Finally, I recommend to the General Conference of the Seventh-day Adventist Church to distribute the health guidelines to all churches in the world. I read the guidelines and found them concise and easy to read and understand. These guidelines were developed back in 1990 but have not been made accessible to its constituent churches.

A Final Word for Nyagiki

It is very inspiring to see the church's passion to do ministry and to build a larger church facility. I believe that once this is completed it will be a beautiful structure on top of a hill symbolizing the city built on a hill that Jesus told his disciples about (Matt 5:14-16). In as much as people do not put light under a bushel, do not hide the information—health information literacy—concerning HIV/AIDS. Allow that light to shine in the communities brighter and brighter. Please depend on God, continue to embark on this important journey and be that city set on a hill that glows with light for everyone to see.

APPENDIX A

CHURCH BULLETIN ANNOUNCEMENT

There will be a training on "**ministering to HIV/AIDS patients**" conducted by Pastor Job Ogoti Getange from Andrews University, Michigan USA. The training will last for a period of one year maximum. To be included in the training, you must meet the following criteria:

1. You are member of Nyagiki Seventh day Adventist Church, Kenya
2. You are 18 years old and above literate in both English and *Ekegusii* languages. You should have an email address and preferably have access to a cell phone or a computer.
3. Be able to regularly interact with the trainer and other participants online. There will be monthly meetings to share information and experiences.
4. The exact dates for classroom training will be communicated to you later after consulting with all participants. It is suggested that each day of classroom training will begin at 9am and end at 5pm. There will be short breaks within sessions and one hour for lunch (1pm to 2pm).
5. After the training the participants will be encouraged to share the information gained with the church members at Nyagiki Seventh-Day Adventist Church, at Nyansongo camp meeting, and to the people in the community who will show interest.

6. Outreach to HIV/AIDS persons will be included in the project.
7. People who are HIV/AIDS positive are not members of the training
8. There will be one spiritual retreat.
9. The participants will be issued with certificates at the end of the training.
10. There will be no fees charged for attending and participation will be voluntary. Participants can withdraw from the training any time without any penalty whatsoever.
11. Each participant is encouraged to read the book “Ministry of healing” written by Ellen G. White before the training begins.
12. A maximum of 30 participants are expected to take part in this training. If you are interested, please send an email to getange@andrews.edu. The first 30 emails received will be selected. Please keep a copy of the email that you send and the time you do so.

APPENDIX B

IRB APPLICATION PROTOCOL

1. **Principal Investigator**: Job Ogoti Getange. I am conducting a research as part of my Doctor of Ministry Project, in partial fulfillment for my Doctor of Ministry in health-care chaplaincy at Andrews University, Berrien Springs, Michigan.

2. **Title and Purpose of the Study**:
   Title: A Training Program for Members to Minister to the HIV/AIDS Patients at the Nyagiki Seventh-Day Adventist Church, Kenya.

   Purpose: The task of this project is to develop, implement, and evaluate an HIV/AIDS training program at the Nyagiki Seventh-day Adventist Church, Kenya to equip the members to effectively minister to HIV/AIDS patients in the church and community.

3. **Background:** During my four years of pastoral experience at Nyagiki (January 2003 to January 2007) I observed that although HIV/AIDS was a big threat in the church and society, many of the church leaders were not involved in addressing this crisis. There were no intentional church training programs to warn the members about its danger. The church did not make a budget of time or money to address this epidemic. The root problem that caused this situation was lack of health information literacy on HIV/AIDS to equip these leaders with knowledge and skills to deal with this crisis.

Nyagiki SDA church had two members who had publicly self-declared their status as being HIV/AIDS positive. In addition, there were three individuals from the community who had publicly self-declared their status. The purpose of the training is to equip church members to minister to individuals who have publicly self-declared themselves as being HIV/AIDS positive and this is how I will identify them.

4. **Population and Subjects Selection**:

Nyagiki Seventh-day Adventist Church is in Kisii County to the western part of Kenya. It is in a rural setting between two major cities: Kisii and Ogembo (four miles from Ogembo and seven miles from Kisii town). Most of the members of Nyagiki belong to the Kisii tribe and speak the same dialect, Ekegusii. Except for a few who are employed by the government, most of them are subsistence farmers. Some of the farming activities in the region include the growing of tea, bananas, corn, and horticultural crops. Most families have at least one milk-producing cow.

I became a pastor of Nyagiki Church in December 2002 and served for four years until 2006 when I received a study leave to study at the Andrews University Seventh-day Adventist Theological seminary, USA. Currently Nyagiki has 171 baptized members of which 91 serve as leaders: seven are elders, three are deacons, 24 are deaconesses, and 57 are leaders in other departments of the church. Most of the church members are well known to me. The participants will be drawn from this church. They must be 18 years old and above and having good

health. People living with HIV/AIDS will not be registered to participate in the training.

5. **Recruiting**: I will use bulletin and verbal announcement. I will not use any pressure or coercion. I will give my email address and the first 30 persons to send me an email will be selected. There will be no concealment or deception in the project. Since this training will take a maximum of one year, I envision that about 10 people will drop out and that will make me end up the training with 20 people.

6. **Procedures:**

Retreats

One retreat will be organized during the one-year period. This retreat will primarily feature on bible study and prayer to encourage the leaders to depend on God for success. Certificates will be issued to those who have received full training.

Monthly Leadership Meetings and Seminars

Intentional monthly leaders' meetings will be organized for the one-year period. In these monthly meetings, there will be a designed course of study in which the concept of information literacy will be explored. Specific topics will be given to show that HIV/AIDS patients are important and valuable people in need of our love and attention- not victims of discrimination and stigmatization.

Outreach Program

The training will start with 30 church members of Nyagiki SDA church. There is a possibility of some of these people dropping out. I estimate that I will

have about 20 people remaining in the training. I will divide the 20 people into small groups (2-4 people for each group). Currently we have five people who have self-declared their HIV/AIDS positive status. I will assign each group to visit one person at a location where the person chooses. After visiting the individuals for training, they will bring a report back to the larger group for discussion and sharing of ideas.

There will be an opportunity for them to share the information that they have received with their fellow church members at Nyagiki and at Nyansongo during the time of camp-meetings in the month of August. There will be no need to wear gloves because bodily fluids will not be involved

7. **Risk**: There will be a minimal Risk. The task will be to train church members at the church facility on how to minister to their fellow members by providing health information literacy. This information is meant to promote healthful living to prevent themselves from getting infected with HIV/AIDS. The second task will be to do outreach to people in the church and in the community, who have self-declared their HIV/AIDS positive status and who need information to understand that they are valuable before God and can contribute to making their lives better. No bodily fluids will be involved.

8. **Data collecting:** Three methods of data collection will be involved in this research. These include (a) focus groups (b) personal interviews, and (c) reflective journals. These methods of data collection will be employed basically to assess the impact of the training program. These assessment methods will be conducted

by the researcher at the end of one-year period designated for the training program and will be held at the Nyagiki Seventh-day Adventist Church. For focus groups and personal interviews, the researcher will have a maximum of 10 questions that he will use as the guideline in collecting the information from participants. The questions will be the same. The nature of these questions will be (a) simple and concise, (b) open ended, (c) non-threatening or embarrassing, and (d) without any ambiguity.

There will be three focus groups. I envision that in the end about 20 people (out of 30 who originally will register) will remain in the training at the end of one year. Each focus group will therefore be composed approximately 6-7 people. Participants will be voluntarily involved. Each of these focus groups will be conducted for a maximum of 90 minutes.

For personal interviews, the researcher will have face to face dialogue with each of the participants. This face to face dialogue will be voluntary. No one will be coerced or manipulated to take part in the interview process. These personal interviews will take about 30 minutes for each participant. There will be eight questions to guide the interviewing process and these questions will be the same for all participants.

For focus groups and personal interviews, the researcher will run the recording system to ensure that no information is lost. This will be done after the researcher has obtained consent from the participants. No one will be recorded without a personal consent.

For reflective journals, the participants will be prompted voluntarily to write a page or two about their experiences in the training program. The researcher will assure the participants that the information shared through their reflective experiences will be confidential and non-accessible by any other party. Since the participants involves males and females, they will be encouraged to use pseudonyms on their reflective journals. Different pseudonyms will be used for male and female participants for the researcher to be able to process fairly the information received from both genders.

9. **Securing data:** The data obtained through focus groups and personal interviews will be confidential. No one will be able to connect the information obtained to any other person. For reflective journals, pseudonyms will be used as means to foster strict confidentiality of the participants. The data that will be collected through these methods will be secured in a password protected computer for at least three years.
10. **Consent**: All subjects will give informed consent to participate in the project. The copy of the informed consent letter that will be signed by every participant is here attached with this submission.
11. **Voluntary Participation**: Participation will be voluntary, and subjects will be free to join or leave at will without any penalty or loss of benefits.
12. **The Curriculum of the Training**

The training will cover the following listed topics:

A. Historical Perspectives: History of HIV/AIDS in Kenya

B. Statistics of prevalence

C. Health information literacy about HIV/AIDS

   i. Causes of HIV/AIDS

   ii. Treatment for HIV/AIDS

   iii. Measures to Prevent the spread of HIV/AIDS

   iv. Case study: successful publicly self- declared person living with HIV/AIDS (Joe Muriuki, INB African news, Nov 9th, 2014)

D. Spiritual Perspectives

   i. Naaman 2 kings 5 (He made effort to receive cure)

   ii. Jesus as role model (His effort to minister to the lepers)

   iii. Spirit of prophecy (counsels from the book, "Ministry of Healing")

   iv. Theme: "When our hearts are filled with God's love, we will touch people filled with suffering."

E. Practical perspectives (Outreach Program)

   i. Sharing information to fellow members at Nyagiki Church

   ii. Sharing information to people in the community

   iii. Reaching out to those who self-declare their status

   iv. Motivation for outreach: Mat. 25 (the sheep and the goats)

APPENDIX C

RESEARCH STUDY CONSENT

Andrews University
Seventh-day Adventist Theological Seminary

Consent to Participate in a Research Study (Informed Consent Form)

Title of the project: A Training Program for Members to Minister for HIV/AIDS Patients at Nyagiki Seventh-Day Adventist Church, Kenya

Principal Investigator: Job Ogoti Getange. I am conducting a research in partial fulfillment of the requirements for my study in Doctor of Ministry in health-care chaplaincy at Andrews University, Berrien Springs, Michigan, USA.

I invite you to be part of the research study about HIV/AIDS. The objective of the study is to equip the church members with information and tools so that they can effectively minister to HIV/AIDS patients at Nyagiki SDA Church and the surrounding community.

Duration of Participation: I have been informed that the training will take a period of one year.

Procedures: I have been informed that the areas that will be covered in the one-year period includes reading a book, "Ministry of Healing" (by Ellen G White), one spiritual retreat, one classroom training session, outreach program to people living with HIV/AIDS

I am aware that I will be able to regularly interact with the trainer and other participants online. There will be monthly meetings to share information and experiences.

At the end of one-year period, I will voluntarily be involved in assessments of the training program by taking part in a focus group and personal interviews. Also, I will be voluntarily asked to write one page or two of my personal experience during the period of study.

Benefits: I have been informed that there will be no incentives or benefits offered during the research study but as a participant, I will benefit directly through the

knowledge and skills on caring for HIV/AIDS patients that I will be privileged to learn.

Risks: There will be minimal risks or discomforts involved. I am aware that there will be outreach program to people living with HIV/AIDS at Nyagiki SDA church and in the community.

Publication: I have been informed that the researcher plans to publish the results of this study, but my personal information will not be included. My privacy will be ensured, and my research records will be kept confidential. It is possible that other people may need to see the information I provide as part of the study, but they wouldn't have access to my personal information.

Storage of Data: I understand that the researcher will store my data in a password protected computer. My name and any other identifying information will be secured safely. Only the principal investigator will have access to my research information. The research data may be shared with other investigators but will not contain any information that will identify me.

Voluntary Participation: I have been informed that Participating in this study is completely voluntary. Although I decide to participate now, I may change my mind and withdraw at any time. I do not have to answer questions that I do not wish to. If I decide to withdraw before the study is complete, I may do so without penalty.

Contact Information: I am aware that should I have any questions that need to be answered regarding this study, I can contact the faculty supervisor, David Penno, using the address below:

David Penno, PhD, Associate Professor of Christian Ministry, Doctor of Ministry Project Coach
Seventh-day Adventist Theological Seminary
Andrews University
4145 East Campus Circle Drive, S207
Berrien Springs, MI 4904-1560
(269) 471-6366
penno@andrews.edu

I can also contact the researcher, Job Getange, using the address below:

Job Ogoti Getange
[redacted]
Email: getange@andrews.edu
Phone: +[redacted]

Consent: I have read the contents of this consent form and I have satisfactorily received verbal explanations and answers to my questions. I hereby give my voluntary consent to participate in the training.
By signing this document, you are agreeing to participate in the study. I will give you a signed copy of this document for your records and I will keep one copy with the study records.

I agree to participate in the study

_____

Name of the participant Signature Date

_____

Name of the researcher Signature
Date

_____

Name of the witness Signature
Date

APPENDIX D

IRB RESEARCH APPROVAL LETTERS

October 29, 2015

Job Getange
Tel: [redacted]
Email: getange@andrews.edu

RE: APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS
IRB Protocol #: 15-128 **Application Type:** Original **Dept.:** Doctor of Ministry
Review Category: Full **Action Taken**: Approved **Advisor:** David Penno
Title: A Training Program for Members to Minister to HIV/AIDS Patients at the Nyagiki Seventh-day Adventist Church, South Kenya Conference.

This letter is to advise you that the Institutional Review Board (IRB) has reviewed and approved your IRB application for research involving human subjects entitled: "*A Training Program for Members to Minister to HIV/AIDS Patients at the Nyagiki Seventh-day Adventist Church, South Kenya Conference*" IRB protocol number 15-128 under Full category. This approval is valid until October 28, 2016. If your research is not completed by the end of this period, you must apply for an extension at least four weeks prior to the expiration date. We ask that you inform IRB Office whenever you complete your research. Please reference the protocol number in future correspondence regarding this study.

Any future changes (see IRB Handbook pages 10-11) made to the study design and/or consent form require prior approval from the IRB before such changes can be implemented. To request for extension, modification and completion of your study please use the attached form.

While there appears to be no more than minimum risk with your study, should an incidence occur that results in a research-related adverse reaction and/or physical injury, (see IRB Handbook page 11) this must be reported immediately in writing to the IRB. Any project-related physical injury must also be reported immediately to the University physician, Dr. Reichert, by calling (269) 473-2222.
We wish you success in your research project. Please feel free to contact our office if you have questions.

Sincerely,
Mordekai Ongo
Research Integrity & Compliance Officer
Institutional Review Board - 4150 Administration Dr. Room 322 - Berrien Springs, MI 49104-0355
Tel: (269) 471-6361 Fax: (269) 471-6543 E-mail: irb@andrews.edu

October 13, 2016

Job Getange
Tel: [redacted]
Email: getange@andrews.edu

RE: APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS
IRB Protocol #: 15-128 **Application Type:** Original **Dept.:** Doctor of Ministry
Review Category: Full **Action Taken**: Approved **Advisor:** David Penno
Title: A Training Program for Members to Minister to HIV/AIDS Patients at the Nyagiki Seventh-day Adventist Church, South Kenya Conference.

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Any future changes (see IRB Handbook pages 10-11) made to the study design and/or consent form require prior approval from the IRB before such changes can be implemented. To request for extension, modification and completion of your study please use the attached form.

While there appears to be no more than minimum risk with your study, should an incidence occur that results in a research-related adverse reaction and/or physical injury, (see IRB Handbook page 11) this must be reported immediately in writing to the IRB. Any project-related physical injury must also be reported immediately to the University physician, Dr. Reichert, by calling (269) 473-2222.

We wish you success in your research project. Please feel free to contact our office if you have questions.

Sincerely,
Mordekai Ongo
Research Integrity & Compliance Officer
Institutional Review Board - 4150 Administration Dr. Room 322 - Berrien Springs, MI 49104-0355
Tel: (269) 471-6361 Fax: (269) 471-6543 E-mail: irb@andrews.edu

October 12, 2017

Job Getange
Tel: (
Email: getange@andrews.edu

RE: APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS
IRB Protocol #: 15-128 **Application Type**: Continuation **Dept.:** Doctor of Ministry
Review Category: Full **Action Taken**: Approved **Advisor:** David Penno
Title: A Training Program for Members to Minister to HIV/AIDS Patients at the Nyagiki Seventh-day Adventist Church, South Kenya Conference.

This letter is to advise you that the Institutional Review Board (IRB) has reviewed and approved your IRB continuation application for research involving human subjects entitled: "A Training Program for Members to Minister to HIV/AIDS Patients at the Nyagiki Seventh-day Adventist Church, South Kenya Conference" IRB protocol number 15-128 under Full category. This approval is valid until October 12, 2018. If your research is not completed by the end of this period, you must apply for an extension at least four weeks prior to the expiration date. We ask that you inform IRB Office whenever you complete your research. Please reference the protocol number in future correspondence regarding this study.

Any future changes (see IRB Handbook pages 10-11) made to the study design and/or consent form require prior approval from the IRB before such changes can be implemented. To request for extension, modification and completion of your study please use the attached form.

While there appears to be no more than minimum risk with your study, should an incidence occur that results in a research-related adverse reaction and/or physical injury, (see IRB Handbook page 11) this must be reported immediately in writing to the IRB. Any project-related physical injury must also be reported immediately to the University physician, Dr. Katherine, by calling (269) 473-2222.

We wish you success in your research project. Please feel free to contact our office if you have questions.

Sincerely,
Mordekai Ongo
Research Integrity & Compliance Officer
Institutional Review Board - 4150 Administration Dr. Room 322 - Berrien Springs, MI 49104-0355

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VITA

Name: Job O. Getange

Date of Birth: March 9, 1965

Place of Birth: Kisii, Kenya

Married: July 23, 1995 to Gladys K. Ogoti

Children: Purity, Charity, and Esther

Education:

2014-2019	Doctor of Ministry in Health-Care Chaplaincy, Andrews University, Berrien Springs, MI
2012--2014	Clinical Pastoral Education (Completed 5 1/2 Units of CPE) at Adventist Midwest Health (Chicago) and Bronson Methodist Hospital (Kalamazoo).
2007–2012	Master's in Divinity (emphasis in chaplaincy) from Andrews University, Berrien Springs, MI
1987-1990	Bachelor of Arts in Theology from Andrews University, Baraton Campus, Kenya

Ordination:

1998	Ordained to Seventh-day Adventist Ministry at South Kenya Conference

Experience:

2017-Present	Minister/Chaplain Florida Conference of Seventh-day Adventist Church (Serving as a Chaplain, AdventHealth, Tampa)
2016-2017	Chaplain, Florida Hospital, Tampa
2014-2015	Chaplain, Spectrum Health, Grand Rapids, MI
1990-2007	Multi-Church District Pastor, South Kenya Conference