

An exploration of sex and sexualities in the context of HIV and AIDS in the Lutheran Church of Christ in Nigeria (LCCN): A phenomenological study of Christian love and stigmatization in Nigeria –Adamawa state: A case study of the LCCN Todi Diocese

Cletus Haniel Dading

Student Number: 214528289

Supervisor: Rev. Dr Herbert Moyo

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College of Humanities

DECLARATION

I, Cletus Haniel Dading declare that

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DEDICATION

This Thesis is first of all dedicated to the Almighty God who has given me the privilege and the ability to put this work together; and to my lovely wife (Christiana Cletus) who despite all the financial challenges we faced as a family in the course of my studies, she remained resolute and patient, always encouraging me never to give up, and my children (Clara, Crowther, Christabel and Connell) for their love and sacrifice in the course of my study.

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ABBREVIATIONS AND ACRONYMS

A B C	Abstain be faithful and Condomize
A B D	Abstain be faithful or Die
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ATV	Adamawa Television Authority
Cart	Combination Antiretroviral Therapy
ECOMOG	Economic Community of West Africa
ECWA	Evangelical Church of West Africa
EVD	Ebola Virus Disease
HIV	Human Immune Virus
INERALA+	International Network of Religious Leaders Living with or Personally Affected with HIV and AIDS
LCCN	Lutheran Church of Christ in Nigeria
LE	Life Expectancy
LTI	Lutheran Theological Institute
LWF	Lutheran World Federation
NA	Nigerian Army
NACA	National Action Committee on AIDS
NEPWAN	Network of People Living with HIV and AIDS in Nigeria
NGO	Non-Governmental Organizations
NIMR	Nigerian Institute of Medical Research
NIS	Nigerian Immigration Service
NNBS	Nigeria's National Bureau Statistics
NPF	Nigerian Police Force
PCRP	Presidential Comprehensive Response Plan
PLWHIV	People Living with HIV
POWA	Police Officers Women Association
SCOAN	Synagogue Church of All Nations
STDs	Sexually Transmitted Diseases
TEKAN	Tarayar Ekkliisyoyin Kristi a Nigeria
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UTH	University Teaching Hospital

WHO World Health Organisation
VCT Voluntary Counselling and Testing

ABSTRACT

This study seeks to unpack the inextricable relationship between sex and sexuality and HIV and AIDS. It presents how sex ranks highest among the factors contributing to the spread of HIV in Adamawa state, particularly in Todi Diocese. The study acknowledges that sex and sexuality remains the most dreaded topic to most people in Todi Diocese. Being associated with the epidemic of HIV, sex and sexuality precipitates the difficulty accountable for the avoidance of the topic in public domain. Previous studies have revealed how the aforementioned subject matters were shrouded in secrecy; the diseases related to it (especially HIV) were viewed as a punishment by God to people who are sexually immoral, leading to the stigmatization and discrimination of people living with HIV (PLWHIV). The study therefore aimed at investigating why Christians who are called to love their neighbours, admonished to be their brothers' keeper stigmatize and discriminate people living with HIV.

The study was constructed along the theory of an HIV competent church as its primary tool. It is argued in this study that for the LCCN church to be an HIV competent church, it must respond compassionately and effectively to the plight of PLWHIV; LCCN should ensure that stigma and discrimination of PLWHIV is completely eradicated so people can fearlessly disclose their HIV status when tested positive and consequently start treatment as early as possible. Furthermore, the study argues that the stigma and discrimination which remains resilient in the LCCN has prompted some members of the church to turn their homes into prisons. This is done as an attempt to avoid public gatherings including church for fear of inhuman treatment by fellow members of the church and the community at large. The study challenges both the LCCN leaders and members as well, to liberate these fellow humans and give them a sense of belonging in the church and community as well.

The study attempts to explore the rationale behind the silence surrounding sex and sexuality which eventually leads to silence on the HIV epidemic in the LCCN. To provide answer to this question, two theories were used namely: The theory of an HIV competent church and the theory of liberation theology. The study is arranged in eight chapters. Participants in the study are divided into four groups: the Ministers (Pastors), Executive Council Members (EC), Members of the church living with HIV and the Youth group.

The question that the study seeks to answer is: why are the Christians who are expected to love their neighbour as they love themselves in Todi Diocese are stigmatizing and discriminating (PLWHIV)? The study takes the form of qualitative empirical approach.

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CHAPTER ONE

GENERAL INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

The subject of sex and sexualities in the LCCN and Nigeria at large, is located in the private sphere. This makes it difficult for society to openly engage the realities of sex and sexualities. Related to the difficulty in talking about sex and sexualities in social gatherings, including within church spaces, is the issue of HIV which is largely spread through unsafe heterosexual intercourse. Instead of the church constructively engaging the HIV epidemic with life giving theologies Christians, like the rest of society, are stigmatising and discriminating PLWHIV. The relationship between stigmatization and sexualities in the context of the LCCN begs for an understanding of the sources of stigma and discrimination among Christians. This study investigates the reasons as to why Christians who are supposed to love one another (John 13:34) stigmatize and discriminate co- members who are living with HIV in Todi Diocese?

The researcher uses focus group discussions to explore socio-cultural, economic and political environment that informs the Nigerian understanding of sex and sexualities, stigma and discrimination as well as love for the neighbour. Attempt is made to investigate the silence surrounding issues of sex in connection to HIV and AIDS in the LCCN which is hugely embedded in secrecy. Effort is also made in the course of this study to explore the various approaches to safer sex which is of great significance in minimizing the spread of HIV in Todi Diocese. The focus of this study is on Todi Diocese in the LCCN, Adamawa state. To achieve this, the study has used a HIV competent church and liberation theology as tools to help understand the position of the LCCN. The study's expectation is to develop a proficient Church response to the HIV epidemic that can be inculcated in the LCCN as an instrument in countering the challenges of stigma and discrimination.

This is an empirical qualitative study. It is organized into eight chapters. Chapter one provides an inkling of the study designed around the following areas: Introduction, background to the research problems, brief history of the LCCN, motivation for undertaking the study, research problems, questions and objectives, the significance of the study, structure of the study research design and closing remarks.

1.2 Background to the research problem

When one examines the devastating effects of stigma of PLWHIV in Adamawa state, it will be right to agree with Dube that the emergence of HIV has fermented another epidemic that is even more life-threatening than the HIV itself (stigma and discrimination); people not only fear HIV as a health challenge, but also discrimination of PLWHIV because of its relationship with sex (2008:52). This indicates that those who are dying of AIDS related diseases are not only killed due to the related pain, but also the hatred attached to the epidemic. In a struggle to fight any serious war on the spread of HIV in Todi Diocese, the silence on sex and sexualities must first be dispelled or else, the battle cannot be won. Below is the background of how PLWHIV were stigmatized and discriminated in Adamawa state.

1.2.1 Background on HIV related stigma and discrimination in Adamawa State

Some PLWHIV in Adamawa state have expressed concern about the high level of stigmatization and discrimination in the state. This is confirmed by the state Coordinator of Network of People Living with HIV (NEPWHAN). Adamu asserts that, the PLWHIV in the state are constantly battling with stigmatization in their communities and places of work and their residents, most especially the tenants. Adamu's call for both media and religious leaders in the campaign against stigmatization and discrimination particularly in the rural areas is appropriate.¹ The stigma in the rural areas of Adamawa state especially in Todi Diocese as shown by the diagram presented in chapter four is higher than those in the cities. According to Agboola-Alli, stigma is killing Nigerians faster than the HIV itself. Therefore, HIV is no longer the number one enemy but the stigma.² As a matter of urgency, eradication of the two evils, that is, stigma and discrimination by both secular and religious leaders in Nigeria will play a significant role in the fight against the spread of the epidemic. Faghmeda admits, it is not the pain associated with HIV and AIDS that is killing them but rather the stigma attached to the epidemic and various names given to them by people who presume to be HIV negative; the negative attitude of people towards PLWHIV is killing them quicker than the disease itself (2011: 399). It is apparent that not all PLWHIV got infected through sexual misconduct and even if it is so, Christians are admonished not to judge that they may not be judged also (Matthew 7:1).

¹ People living with HIV raised concern over stigmatization in Adamawa. www.Premiumtimesng.com/news/topnews/5321people_living_with_hiv_raise_concern_over_stigmatization_in_adam.html (Accessed on the 16th December, 2015).

² Stigmatization is killing Nigerians faster than HIV infection. www.vanguardngr.com/2015/stigmatiation-is-killing-nigerians-faster-than-hiv-infection-aminat-agboola-alli-chairperson-nepwan-lagos-chapter-2/ (Accessed on 18th December, 2015).

Associating HIV and AIDS with immorality is fundamentally perceived as the primary reason for hatred towards those infected (Oluduro, 2010:4). HIV is a virus that infects both sinners and the righteous alike; it does not discriminate; the fact that some people got infected through unprotected sex or immoral behaviour does not qualify the virus “a sinner’s disease”.

Considering the increasing number of people becoming infected with HIV in Nigeria, the researcher observes that HIV will continue to spread unabated due to stigma and discrimination attached to the epidemic. The United Nations reports that “Nigeria has the largest number of children acquiring HIV infection, nearly 60,000 in 2012 — a number that has remained unchanged since 2009.”³ The high number of these children being infected by their mothers is owing to the fact that mothers deliberately avoid antenatal services for fear of being detected and stigmatized either by church members or the community at large. This number will continue to soar high if efforts to eradicate stigma and discrimination are not intensified.

Most families in Nigeria are either infected or affected with HIV, and the impact is devastating in the country. The LCCN mostly rely on youth as the “back born”⁴ of the church and society at large. The high rate of death related to AIDS and other sexually related diseases that have led to the loss of so many youths in Nigeria and particularly in Todi Diocese, is a pathetic situation. The LCCN leaders, especially in Todi Diocese are working hard to build the Church for the future of our youths but little is done to combat the spread of HIV among its members. This Church’s mindset finds resonance in the words of Franklin D. Roosevelt who portrays that there is danger in giving priority to build the future for the youth while the youth themselves are neglected (1882 – 1945).

The colossal departure of youth to AIDS related diseases in Todi Diocese prompted me to begin to ask myself, what would become of the future generation if this departure of youths and Church members does not stop? The situation created fear and anxiety not only within a particular community or the above mentioned Diocese, but also within the entire LCCN. The

³ Nigeria’s high HIV/AIDS Prevalence rate. June, 2014. <http://www.punchng.com/editorials/nigerias-high-hiv-aids-prevalence-rate/> (Accessed on the 13th April, 2015).

⁴ “Back born” This is a statement made by the Arch bishop of the LCCN (Most Rev. Dr. Nemuel A. Babba) in 2013 at the Annual Convention, encouraging the youth to remain resolute in their effort to preserve the future of the church which will soon be handed over to them in the shortest possible time.

devastating effects of AIDS, has caused many loses in the Diocese: children have lost their parents; couples lost their loved ones, government at various levels, lost their skilled and experienced employers. The loss of these experienced and productive youth is a sign that the future generations will live with the negative impact of AIDS epidemic.

The battle against the spread of HIV must be fought from diverse fields involving different professionals. Medical experts have their role to play in combating the spread of the epidemic while the church gives hope and comfort to those infected or affected by the epidemic. There is a need for synergy from both secular and religious bodies. We cannot deal with AIDS without taking the spiritual dimension of life into consideration, and there is no way we can continue in a spirituality which leaves AIDS off the agenda (Nicolson, 1996:21). The relationship between HIV and AIDS and spirituality is such that the two are intertwined that the church must treat them as equals.

1.2.2 Socio-economic context of the people of Todi Diocese

Adamawa State is enormously blessed with both human and material resources, readily within the reach of any investor to harness. The state has a vast fertile land suitable for farming and other economic activities (Adamawa State Government, 2012). Most farmers do not need fertilizer owing to the fact that the land is fertile. When a particular piece of land is weak for farming one can move to any available portion.

While farming is a major occupation, village communities living on the banks of Rivers Gongola and Benue engage in fishing.⁵ The youth in Todi Diocese have the capacity to produce enough food not only for the consumption of the immediate communities around, but other communities as well, most especially in the present political dispensation, where the government in a determination to diversify economy is promoting agricultural farming, moving away from over-dependence on oil as the only source of income for the nation. However, the prevalent cases of HIV among the youth have drastically reduced their strength, leaving the farmlands without cultivation.

The predominant local industrial activity identified in the study is thatch weaving (Zana) and blacksmithing. According to Isuwa, the thatch is obtained from the wild grass in the bush. It

⁵ Learn about Nigeria,<http://ngex.com/nigeria/places/states/adamawa.htm> (Accessed on 4th October 2014).

ranges from 1-3 metres in height and is used for local roofing and fencing. The thatches are sold in local markets to provide incomes to the local people (2011:34). Isuwa observes that, a weaved thatch cost about 850 Naira which is equivalent to about 3 US dollars. It is stated that a person can weave about 30-50 thatches annually. Both fishermen/fisherwomen and farmers were said to be involved in this activity. Some of the local markets for exchanging goods and services are: Demsa, Numan town, Dong and Bali (2011:34).

1.3 Brief Historical Background of the LCCN

The LCCN is not detached from the ideals of Martin Luther. The Church is a product of the 16th Century protestant reformation movement. During the reformation Luther restored the gospel of salvation-justification by faith alone to a central position in the Christian faith (Reynolds 2012:17). This study endeavours to argue among other things that if the LCCN as stated above is not detached from the principles of Luther it should, in the era of HIV and AIDS epidemic, behave like Luther did when faced with epidemic in his days similar to our contemporary challenges (see chapter two and seven).

Nissen reports that the Lutheran Church of Christ in Nigeria was formed through the effort of a prayer group in Denmark (1993:17). Nissen further explains that the vision of this group to get involved in mission work was ignited by a speech delivered by Dr. Karl Kumm at the first World missionary Conference in Edinburg, in 1910 on the need to stem the tide of Mohammedan penetration into the Sudan (1993:17). The first missionaries to be sent to Nigeria were Dr. Niels Hoegh Bronnum, Dr. Margaret Young and Miss Rose Dagmar from Denmark were commissioned on the 8th January, 1913 (Nissen, 1993:22).

The group reached Rumasha near Lokoja in Nassarawa Province on 18th February 1913. Rumasha was the missionaries' meeting area before proceeding to the field. At Rumasha Margaret contracted dysentery and malaria fever on 26 May 1913. On 11th June 1913, Margaret bore a son, while still very ill. Margaret had always wanted to have a child in Africa, which will draw her heart closer to Africans. After two days, on 13th June 1913, tragedy cut short their joy as malaria prematurely ended Margaret's life. She was 27 years old. She had been praying to God to send her "where nobody else will want to go" (Nissen 1993:23). She was buried in Rumasha near Lokoja in Nassarawa province (Pweddron, 2005:13, Jensen, 1992:187). Jesus' words in John 12:24 were read, and later carved on the engraved plaque chosen by Danish friends: ... unless a grain of wheat falls into the ground

and dies, it cannot be fruitful; but if it dies, it produces much fruits. In this case, Margaret, Dr Niels Hoegh Bronnum's wife, could be likened to a seed that fell to the ground (Pweddron, 2005:13).

The above words had cushioned the pioneer's sudden, and irreplaceable paralyzing loss. Her death provided a powerful spiritual impulse, and wide publicity for the work of the Sudan mission. In their commitment, they took consolation to the fact that, "Faithful is He who calls them, and He will also bring it to pass" (1Thessalonians 5:24), therefore, the death of Margaret would not stop the mission from being accomplished. Miss Rose took the Youngs, Margaret's family in Scotland to Bronnum's parent in-law, before re-joining her missionary colleagues in Nigeria. Bronnum did not see the little child until 1915 when he went home for his ordination as Pastor (Pweddron 2005:14).

Bronnum reached Numan on the river boat on 29 September, 1913; he was not allowed to disembark until he got permission from the British Resident (G.W. Webster) in Yola. He proceeded to Yola, and when he was permitted, he returned to Numan on Sunday the 5th October, having decided to make that his centre for mission operations. He was however, allowed to erect temporary quarters outside the town pending a further decision (Pweddron 2005:14). He proceeded to Yola to request clearance for his mission work from the resident (the colonial governor of Adamawa province). When Bronnum returned to Numan on 5th October 1913, he applied for and got a piece of land (which was appropriated) on which to found his mission.

In the mid-1980s, the idea of creating dioceses was mooted at successive BMEs under the first bishop Dr. Akila Todi. At that time, it was thought that a maximum of three dioceses would suffice, considering the size of the LCCN. However, in 1994 a committee began to gauge the general opinion in the church. After a year, the committee recommended the establishment of five dioceses. These were to be founded in Gongola, with headquarters at Kem, in Kudu (later Bonotem) with headquarters at Ganye, in Shall-Holma (headquarters at Gombi); Todi (headquarters at Bali) and Yola (headquarters at Jimeta). In addition, two mission fields were created, Abuja and Taraba. The committee recommended that five

bishops should be elected to head the dioceses and that the national LCCN leader should be designated “archbishop”.⁶

As of 2015, the LCCN has 9 Dioceses, 47 Divisions (Deanaries), 358 Districts, 2000 congregations with 1,900,000 adherents who are served by 600 pastors.⁷

1.3.1 Brief Historical background of Todi Diocese

Regarding the creation of Dioceses, after 80 years had passed since Dr Bronnum arrived in Numan in 1913 in the 1990s and beyond, the LCCN has continued to grow both in membership and in scopes of its activities. The growth gradually led to the discussions of the need for a new organisation of the church. In 1973, when Akila Todi was consecrated, the church operated as one Diocese under one Bishop. In 1982, however, the Executive and General Church Council decided to explore the possibility of creating more Dioceses but it took another 10 years before the plans began to materialize (Pweddon, 2005:129). In 1992 the Executive and General Church Council set up a committee to prepare a report on the creation of new Dioceses. The report was submitted in November 1994 and was subsequently discussed widely in the church. The major issue was whether to create three or five Dioceses.⁸ It was eventually decided to create the following five Dioceses:

1. Bonetem Diocese with Headquarters in Ganye,
2. Gongola Diocese Headquarters in Kem,
3. Shall-Holma Diocese with Headquarters in Gombi,
4. Todi Diocese with Headquarters in Bali,
5. Yola Diocese with Headquarters in Yola.⁹

Four more Dioceses were later created in 2007, 2009, 2011 and 2013 respectively, to cater for the growing population of church members in these areas.¹⁰ Todi Diocese as mentioned above, was created in 1995 with four other Dioceses. Todi was named after the first LCCN President whose title was later changed to Bishop. The Diocese comprises of 13 Divisions¹¹

⁶LCCN Administration Department, recorded minutes of the committee for the creation of Diocese in LCCN, 1995.

⁷LCCN Pocket Diary, 2015.

⁸ General Church Council Minutes of November 1994. Ref. 32/94, Numan: LCCN Archives

⁹ Report of the Committee for the creation of more Dioceses in LCCN, 1994,p.3

¹⁰ The three Dioceses are: The Arewa (Northern Diocese) with Headquarters in Kala'a, Abuja Diocese with its Headquarters in Nyanya, Mayo-belwa Diocese with its Headquarters in Mayo-Belwa, and Taraba Diocese with its Headquarters in Jalingo.

¹¹ Division or Deanery is headed by a Dean with 5-10 Districts under his jurisdiction.

(Deaneries), 78 Districts,¹² and 331 Congregations¹³ The three main religions in Todi Diocese are Christianity, Islam and Traditionalism.

According to the Bishop of Todi Diocese (Rt. Rev. Clement Dogo), the Diocese is challenged vigorously with the scourge of HIV epidemic. People in the Diocese including the pastors are reluctant to go for HIV tests even when the bishop reminds them of the need for HIV testing. The bishop's plea however, has not yielded any positive result. One of the reasons accountable for their hesitation is the phobia pastors have for being detected and stigmatized by members of the church who may not accept them as their pastors when they discovered that their pastor is found HIV positive.¹⁴ For fear of stigmatization both pastors and members eschew HIV testing which eventually leads to onward transmission of the virus to their victims unknowingly.

1.4 Motivation for the Study

In this study, my motivational stimulation is driven due to the attitudes of both church leaders and members towards sex and sexualities and the high level of stigma and discrimination which has prompted some church members to develop fear for the HIV testing and consequently continue to spread the HIV in the aforementioned Diocese. Another area of concern that inspired the researcher to carry out this study was the way issues of sex and sexualities were avoided by the LCCN pastors which subsequently lead to the silence of the church on HIV. The silence of LCCN's ministry on sex and sexualities in the midst of the devastating scourge of the HIV epidemic is too loud. Why is the church silent in the context where many factors as shown above contribute to the continuing spread of HIV? HIV is a global health concern, reducing the life expectancy in Nigeria, particularly in Todi Diocese. From the literature reviewed, despite efforts by the international community to curb the spread of the HIV epidemic, the rate of new infections is still very high in Nigeria as noted in the background to the research problem. Christians believe in the longevity and sanctity of life, which makes it imperative for us to be involved in anything that will prolong life and postpone death. Death should be seen as the enemy not AIDS or those infected by its virus (McCain, 2008:18). The LCCN ought to intensify effort in order to put a stop to the spread of

¹² A District is headed by an ordained minister and one or two Catechists depending on the need.

¹³ LCCN Pocket Diary,2015.

¹⁴Discussion with Rt. Rev. Clement Dogo on the21st January, 2015 telephonically.

the virus in every way so as to prolong the lives of its members and community members as well.

According to Rt. Rev. Dogo,¹⁵ HIV is affecting the wider society and the church is not excluded. Many members and pastors are found to be living with HIV. Many of their children are left orphans as parents die leaving them under the care of their relatives who often show little or no concern for their well-being, especially for their educational pursuits; women are mostly at the receiving end in Todi Diocese (2015). In Todi Diocese, the HIV epidemic seems to have female faces as noted by Dixon, where six out of ten new infections are among women. Women are not only more at risk in the sexual act with a partner who has HIV, but also have fewer opportunities to avoid the HIV infection. They may be physically abused, targets of terrible war-related sexual violence, abandoned to raise children or ignored by authorities (2010:81). The LCCN can no longer remain silent when it continues to lose its potential future leaders to the epidemic. The LCCN pastors could hardly bring themselves to talk about sex and sexualities and HIV and AIDS and the use of condoms at all. More so, pastors often assume that such discussions were always morally wrong and immature. It is on this argument that Nicolson confirms that the theologians working on AIDS are few, yet among those only few indicate interest to do so (1996:21).

Talking about HIV as a pastor in the LCCN risks being labelled “one of them” (the HIV infected persons). Therefore, people in general and particularly pastors, find it difficult to even visit HIV and AIDS Wards in various hospitals where they are admitted. Ministry to the AIDS patients is disconnected with spirituality in Todi Diocese. The researcher anticipates to be among the few theologians in the LCCN who might develop interest in working vigorously to save the lives of those who are potentially vulnerable to the HIV epidemic. Nicolson warns against leaving the challenge of HIV to a particular group of professionals. However, he advocates that Theologians, Medical personnel, Social workers and members of the society must harness their synergy in order to win the battle against the spread of the virus (Nicolson 1996:20).

¹⁵Dogo is the present Bishop of Todi Diocese who confirmed to the researcher that AIDS has killed many members of the church, even though there was no statistics, because families do not want it to be publicly known that their son or daughter died of AIDS related diseases. But as a leader, many members used to confide in him that some members died of AIDS-related diseases while many of them are living with the virus.

In Nigeria the matter of health has been compartmentalized and pushed only to the medical experts. But HIV is not just a medical or social problem only. It affects the whole person in every aspects of personality. Reasons may vary why people contract the virus, but concerted effort must be geared towards alleviating the suffering of those infected. Reamer opines that when people say, “You got exactly what you looked for, then suffer it alone and die alone”, they are not being realistic, because HIV infection is a public health concern, rather than a private, individual matter (1991:51). No section of society is left untouched by the epidemic of HIV and AIDS. Therefore, all hands must be on desk to combat the spread of the epidemic.

This study is motivated by three factors: Firstly, the primary reason for the researcher's motivation is the high level of stigma and discrimination of PLWHIV. The level of stigma and discrimination in the LCCN; this stigma and discrimination is killing people emotionally and socially. For fear of being ridiculed, many persons have decided to live with their situations to avoid being stigmatized and classified as sexually perverse. This attitude places people at risk of becoming ill, as they do not get tested and access timely HIV treatment and care. It also increases the risk of onward transmission to sexual partners. Another driving force for this research is the silence of the LCCN on issues of sex and sexualities and HIV and AIDS. This propelled me towards this study. The LCCN is rightly placed in various communities of Todi Diocese to be a voice of the voiceless (those stigmatized and discriminated on the bases of their HIV positive status) and the down-trodden. The LCCN has all the available resources within its disposal to assist its members living with HIV, but little or no attention is given to them.

1.5 Statement of the Problem, Questions and Objectives of the Study

This section provides the statement to the problem before giving the objectives and research questions for this study

1.5.1 Statement of the problem

Despite meaningful development of church based HIV and AIDS programs in Southern Africa especially South Africa, the reality is completely different in Nigeria. As rightly observed by Moyo: members of the church are losing their beloved children on daily basis through the scourge of AIDS, yet the church seems to believe that HIV and AIDS is not in the church but in the community (2006:28). Perhaps the LCCN presumes that the HIV

epidemic does not affect her directly and that may probably be the reason it is not making any frantic effort in halting its spread. HIV and AIDS is not something that happens outside of the Church and families. With the increasing number of people becoming infected with HIV, it is evident that everyone is affected by HIV and AIDS, whether in the church or in every community (Speicher and Janice, 2007:3). The church especially the LCCN does not have to respond to the HIV epidemic because of its prevalence in the church. Even if there is no single member in the LCCN who is living with HIV and dying of AIDS related diseases, it is the duty of the church, which in accordance with the Bible, ought to be salt to the world (Matthew 5:13) by getting involved in the fight against the spread of HIV.

The meeting held by the HIV and AIDS Committee in Jos was beautifully tagged, “Visions and Goals for LCCN Diaconia work”. Its report demonstrated efforts inteneded to curtail the spread of HIV epidemic. In their deliberations, the committee acknowledged that the LCCN is surrounded by problems of HIV and AIDS, children orphaned by AIDS; it is Jesus’ example to us that we, His church, should care for those in need and even in these difficult times, we are still our brother’s keeper. The congregation of LCCN will arise to the diaconial challenge and concentrate on the work with HIV prevention and care for the victims and families of the infected and to eradicate stigmatization and discrimination of PLWHIV (Jeta and Tumba, 2000). The committee further demonstrates their commitment to raise and train a team of volunteers in the LCCN to participate in the work of HIV and AIDS awareness and moral instruction to help stop the virus from spreading. This meeting did not yield a positive result because the impact has not been felt. Those who are living with HIV have not been taken care of. The decision of raising a team of volunteers has not been actualized and HIV continues to spread unabated. Although the committee was aware that stigma and discrimination among LCCN members was very strong, pastors and the HIV and AIDS committee have done nothing in a struggle to eradicate it. The information gathered indicates that the LCCN was only involved (passively) in HIV and AIDS programs for only four years since the beginning of the epidemic.

In 2004 the society for Family Health wrote to the LCCN informing it that Adamawa state with 7.6% tops the list in the HIV and AIDS prevalence rate in the North; and that Adamawa occupies the fourth position nationally, based on the 2003 sentinel survey result” (see appendix 13a). In reply the Administrative Secretary of the LCCN (Doli) acknowledged that, the LCCN was involved in HIV and AIDS programme for about two years ago, and that the

church will continue to create awareness on the epidemic" (see appendix 6d). By the information acquired during my visit to the LCCN for facts finding as part of my field work, the researcher discovered that the letter written by the administrative secretary of the church (see Appendix 13b) was the last official communication between the LCCN and other organizations involved in the fight against the epidemic, and that was confirmed by the Director of missions, who said, the last time the LCCN talked about HIV and AIDS was in 2005.¹⁶ With this report, it is obvious that the competency of the LCCN is nowhere near congruence with the reality of the HIV and AIDS epidemic.

The HIV epidemic is like an army that has invaded the country (Nigeria) as declared by McCain. It is a very tiny army, so small that it takes a very powerful microscope to see it. This army is already having deadly effect on Nigeria. It is waging a very comprehensive campaign against Nigeria, destroying members of the military, educators, health professionals, and the business community. It attacks young people when they are at the strongest and have their whole lives in front of them. It is a very deceptive army because its most successful means of attack is at a time and in a way when people are enjoying themselves the most. This silent army has already killed more people in Nigeria than the civil War and all other conflicts in which Nigerian soldiers have been involved (2008:8-9).

In the northern part of Nigeria where the level of knowledge of the citizens on sex and sexuality and HIV and AIDS is low due to the predominant silence on the subjects of sex and sexualities both by secular and religious leaders is enormously destroying the inhabitants in large numbers. For some people it is ignorance which contributes to the spread of the HIV while others deliberately infect innocent people and got re-infected with other strains of the virus. It is not realistic that the LCCN does not know how to respond to the challenge of HIV, but perhaps does not see it as a priority as argued by Dixon, that the church does not see its response to the HIV epidemic as one of the cardinal priorities (2010:113). Whatever the case may be, what threatens the lives of people in the community and particularly in the church needs to be treated with utmost urgency.

¹⁶Discussion with Rev Timawus Linus in his office on 21st January, 2015.

1.5.2 Research Question

The key research question is: Why are the Christians who are expected to love their neighbour as they love themselves in Todi diocese stigmatize and discriminate people that are living with HIV?

In order to provide an answer to this question, one has to answer the following sub-questions:

1.5.3 Research Questions

1. What is the relationship between stigma and the continuing spread of HIV in Todi diocese?
2. How does culture, Socio-economic and political developments impact on Sex and Sexualities and HIV and AIDS?
3. What does the LCCN need to do to be a HIV competent church in the context of Nigeria?
4. Why is silent on sex and sexuality and HIV and AIDS too resilient in the LCCN

1.5.4 Research Objectives

1. To demonstrate the link between the spread of HIV and stigma and discrimination.
2. To explore how culture, socio-economic and political developments impact on sex and sexualities in the context of HIV and AIDS.
3. To explore ways of developing an HIV competent church in the Nigerian context
4. To investigate the justification behind the silence of the LCCN on sex and sexuality in the context of HIV and AIDS

1.6 Significance of the study

The significance of this study is to develop a proficient Church response to HIV and AIDS health crisis that can be used by the LCCN as an instrument in countering the challenges of stigma and discrimination.

This research is aimed at interrogating the rationale behind stigma and discrimination in the LCCN which has its root from silence of the church on sex and sexuality. This also has a direct link to the contraction and the spread of HIV in Todi Diocese. The research further aimed at building strong relationships among the LCCN youth by educating them on God's design for sexuality which the church leaders are not comfortable to talk about. Significantly, the findings of the study could serve as a motivation for the church to make concerted efforts

towards providing sex education for its members who are languishing in ignorance on sex knowledge.

Despite the pathetic situation in which humanity has now found itself, the church seems to be indifferent and unresponsive. Also, it seems not to recognize its role in confronting this problem. The LCCN and its leaders seem to be in a slumber. Therefore, the reason for choosing the topic and the motivations point to the exigencies for a study that will contribute to the eradicating of stigma and discrimination in the church. As such, it will pave way for early treatment and liberate those who are in self-exile because of their HIV status. Through this study, the researcher will make effort to establish what works and does not, when exploring ways of dealing with stigmatization and discrimination of PLWHIV. This will enable the researcher to make recommendations in an attempt to use and develop useful strategies. In addition, the research can lead towards new ways of knowing. These new ways of knowing will in turn, guide the church in drastic decision which lead to finding solutions to the HIV epidemic.

1.7 Structure of the Study

Chapter one serves as general introduction of the study. The following themes were discussed: Background to the research problem; the geographical location of Todi Diocese; the socio-economic context of the people of Todi Diocese; brief History of the LCCN, and Todi Diocese, the motivation for the study; statement of the problem, Questions and Objectives of the study; the significance of the study, research design and the conclusion.

Chapter two focuses on the stigmatization and discrimination of PLWHIV; the impact of stigma and discrimination; Understanding of sex and sexuality from the biblical perspective; the concept of sex and sexuality was discussed. In chapter two, modes of transmission of HIV were presented; reducing the risk of infection through safer practices from the church perspectives were discussed, how Martin Luther approached epidemic in his time and finally the conclusion.

In chapter three the following will be discussed: research design and methodology that will be adopted. First, the data production process was presented and then moving to data analysis. The following sub-topics were discussed as follows: Qualitative empirical research;

the research site and procedure to gain access; procedure and methods for data collection; research sample and participants; procedure and methods of data analysis; confidentiality and ethical considerations and the conclusion.

Chapter four discussed the cultural, socio-economic and political development that impact on sex and sexuality. In this chapter the researcher upholds that culturally, women in Todi Diocese are subservient to their partners, without contributing to any sexual issues, which in itself is a threat to combating the spread of HIV. Similarly, the chapter discussed the socio-economic impact on sex and sexuality, owing to economic depression in Todi Diocese, which prompted both married and single women to live on the magnanimity of men which requires that they remain submissive to their sexual partners irrespective of their HIV status. The political development in the country which has negative impact on sex and sexuality in the context of HIV and AIDS were discussed.

The chapter (four) began with the data presentation and dealt with the impact of corruption on HIV and AIDS in Nigeria, especially in Todi Diocese. Unemployment-the machinery that facilitates the spread of HIV in the Diocese was discussed. The chapter established how poverty and the spread of HIV is inextricably linked; the people who were mostly affected by poverty (women and children) in Todi Diocese will also be discussed and finally the conclusion.

Chapter five discussed various factors which are militating against the control of HIV in Todi Diocese. Through the focus group discussions, this chapter responds to three main questions answered by the participants: what are the causes of the spread of HIV in Todi Diocese? Do people voluntarily disclose their HIV status after being tested positive? What is the position of the LCCN pastors on safer methods? Among other things discovered through group discussions were arranged in the following themes: Multiple concomitant of sexual partners; Gender and economic inequality; Lack of knowledge on HIV and AIDS; Nigerians denial of being HIV positive; various claims of possible cure by some religious leaders; peace keepers as trajectory of the spread of HIV in Todi Diocese and the conclusion.

Chapter six revealed how stigma and discrimination is linked to the spread of HIV in the LCCN Todi Diocese. Similarly, the chapter presented data obtained through focus group discussion. The following themes were discussed in this chapter: Through discussions, the

stigma and discrimination in Adamawa state and the LCCN at large were discussed; the detrimental language of stigma and discrimination towards PLWHIV in Todi Diocese was discussed; some of the participants were representing different Dioceses in the LCCN as stated in the location of the study that the LCCN Headquarters is situated in Todi Diocese, the discussions of the participants is a representation of what is happening in other Dioceses, however, the focus of the study was geared towards Todi Diocese and finally the conclusion.

Chapter seven explores how to develop a HIV competent church in Nigerian context. The chapter discusses the following themes: the competence of the LCCN in dealing with the menace of HIV and AIDS; the culture of silence on sex and sexuality in the LCCN Todi Diocese; the challenge of pre and post test counselling to the HIV infected persons in the LCCN Todi Diocese; the necessity for theology of compassion in the LCCN instead of judgement and condemnation. The chapter draws insight from Luther's response to epidemic which is a lesson to be emulated by the LCCN leaders and finally the conclusion.

In chapter eight, the study was brought to a conclusion, and summary of the major points discussed were provided. Recommendations as well as suggestions were made on the way forward for further research on other relevant areas that were not covered by this study.

1.8 Research Design and methodology

The study took the form of qualitative empirical approach. According Mouton Johann (2001:148), Qualitative empirical research aims at providing an in-depth description of a group of people or community." This is to enable the researcher to handle both the spoken and written information from interactions with participants through focus group discussions.

The research methodology of this study is qualitative in nature and seeks to investigate the lived experiences of the people living with HIV through an interpretive approach. Under the sub-headings of design and methodology the following aspects will be covered: the research design and methods; research question; methods of collecting data such as analysis of existing literature, archival research and field research; scope of study; process of data collection; focus group discussion; data analysis and interpretation, limitations and ethical considerations. See chapter three.

1.9 Conclusion

In chapter one, the researcher provides background information on the study. The research problem, brief historical background of the LCCN, and motivation for the study were discussed. In this chapter, the problem that predicated this research was presented, the question and objectives of the study were described. The following topics were also discussed: the geographical location of the research area; the socio-economic life of the people of Todi Diocese; brief historical background of the LCCN; motivation for undertaking the study; statement of the problem, questions and objectives of the study; the structure of the study, research design and finally the conclusion.

Chapter one established that many Nigerians have lost their loved ones to AIDS related diseases. The experience necessitates the urgent need to rise to the challenge caused by HIV/AIDS. It is therefore foreseen that multiple efforts from different sectors both from secular and religious organizations can bring down to the barest minimum the HIV epidemic if not completely eradicated. In chapter two, the researcher will review the related literature.

CHAPTER TWO: LITERATURE REVIEW: STIGMA AND DISCRIMINATION, SEX AND SEXUALITY IN THE CONTEXT OF HIV AND AIDS

2.1 Introduction

In chapter one, the general background of the study was presented. The motivation together with the research questions and objectives of the study were offered. The significance of the study and the structure of the research were given. In chapter two the researcher will be reviewing relevant literature on the following topics: Stigma and discrimination; Sex and Sexuality from the Biblical viewpoint, the modes of HIV transmission; Reducing the risk of infection through safer sex practices from the church standpoint; the gaps identified were presented and finally the conclusion.

2.2 Stigmatization and Discrimination of PLWHIV

Stigma could be defined as a set of negative and unfair beliefs that society, church or group of people have about something or someone.¹⁷ This negative attitude to PLWHIV in Adamawa state will fully be discussed later in chapter six. Stigma is a negative reaction to people infected and affected by HIV.

Stigma is a common human reaction to disease. Pervasive stigma has surrounded HIV and AIDS since the beginning of the epidemic and it has mostly been accompanied by discrimination, affecting transmission patterns and access to care, treatment and support. It negatively affects preventive behaviours such as condom use, HIV test-seeking and care-seeking behaviour upon diagnosis as well as quality of care given to People Living with HIV (Mutalemwa, 2008).

People who are stigmatised are marked out as being different and are blamed for that difference. In Todi Diocese, living with HIV is to become untouchable; the HIV-infected is neither allowed to touch anyone or to be touched by other people, because the virus is mistakenly viewed as contagious through casual contact. HIV is one distinctive infection which many people have fears, prejudices or negative attitudes about.¹⁸ HIV does not signal

¹⁷ See: <http://www.merriam-webster.com/dictionary/stigma> (Accessed on the 16th August, 2015).

¹⁸ What is stigma? <http://www.aidsmap.com/stigma/What-is-stigma/page/1260706/> (Accessed on the 29th August, 2015).

the death of the person living with it, most especially when the person living with the virus starts his or her treatment as soon as possible; it is also not a disease to be transmitted by ordinary touching. Stigma can result in PLWHIV being insulted, rejected, gossiped about and excluded from social activities. Fear of this stigma can lead to people with HIV being nervous about telling others especially medical personnel that they are HIV positive. They may end up suffering and dying in silence instead of getting the necessary assistance they need.¹⁹ These negative attitudes constitute a colossal threat to open disclosure and onward treatment.

Stigma and discrimination play key roles in fuelling the transmission of HIV, and increasing the negative impacts associated with the epidemic; in this way, stigma is closely associated with the denial and violation of human rights that many HIV-positive people experience (Hoare 2008:184). Eradicating stigma and discrimination in Nigeria will translate into a huge breakthrough against the spread of HIV. In Nigeria, the number of people becoming infected with HIV will continue to heighten, simply because there are no laws enacted to protect PLWHIV. If the legislators continue to treat the issue of stigma with laxity, South Africa will soon become second after Nigeria with the largest number of PLWHIV (Agarau and Fashola 2010).

To stigmatize someone living with HIV is to question the integrity and the moral status of the person presumed to be infected due to his or her sexual escapades (Parry 2008:27). Stigma directed at PLWHIV not only makes it more difficult for people trying to come to terms with their HIV positive status and manage their condition on a personal level, but it also interferes with attempts to fight the HIV epidemic as a whole. On a national level, the stigma associated with HIV can deter governments from taking fast, effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV testing, treatment and care which prolongs life.²⁰ AIDS stigma is a global challenge. To quarantine people with a disease that is not transmissible through casual contacts is outright denial of one's human right.

In some communities, people frown at injustices exhibited in all strata of the social order, unfortunately, stigma and discrimination are huge injustices that alienate and annihilate

¹⁹ See: <http://www.aidsmap.com/stigma/What-is-stigma/page/1260706/> (Accessed on the 29th August, 2015).

²⁰ Stigma and Discrimination. <http://www.cabsa.org.za/book/export/html/747>(Accessed on 4/9/2014).

PLWHIV; such injustices stand in the part of faith and call for a complete turnaround for christians who believe in Jesus Christ and are expected to follow His examples when dealing with people who are challenged physically and otherwise (Wamala, 2010:12). The call made by Wamala should not be limited to Christians only, because the fight against HIV goes beyond that. It is a reality that, stigma and discrimination associated with HIV which alienates people does not represent the true nature of Christ that is in his followers, even if there was no Christianity, people were expected to live as an indivisible entity, sharing each other's pain instead of stigmatizing them on the bases of their HIV status and consequently accelerating their death as previously noted by Faghmeda. Stigma and discrimination is sometimes accountable for the death of many HIV positive persons. Stigma and discrimination cause more pain than the HIV itself. Stigma has prematurely killed many HIV positive persons than the virus itself. Even though, the virus does not kill, but the pain associated with stigma is more excruciating than the HIV. In view of what Faghmeda said, it is possible that PLWHIV develop high blood pressure (hypertension) and heart attacks as a result of passionate stigma and discrimination which eventually lead to their untimely death.

Why should HIV be seen differently with other viruses? HIV is like any other virus except that it attacks the immune system, and if people could see that there is nothing mysterious about HIV, we could remove the stigma surrounding it and combat it more openly and effectively (Whiteside and Sunter, 2000:5). Comparing other diseases with HIV, it is a simple virus which is mostly found in the blood and semen and can only be contracted when the blood and semen of the infected come in naked contact with someone who is infected. PLWHIV do not need to be quarantined like patients with Ebola diseases. Therefore, if people living with other diseases are not stigmatized and discriminated against, HIV should be accorded same treatment. I concur with Whiteside and Sunter when they describe HIV like any other virus above, but at the same time I view HIV as a mysterious virus compared to other viruses which are curable. There seems to be mysteries surrounding the epidemic which made it difficult to find a scientific vaccine that cures it; that does not portray the virus as a tool in the hands of God to punish sinners.

Scholars as will be seen below are of the view that HIV is a virus that God uses to punish sinners; others are of the opinion that HIV should be viewed like any other viruses. According to Ibenwa, “God allowed HIV and AIDS to come upon man as a punishment in order to reduce the spate of sexual immorality in man nowadays” (2015:9). Yes God

promised to smite us with the botch of Egypt (Deuteronomy 28:27) as referred to by Ibenwa, but the passage does not include that children are to be punished for the sin committed by their parents. Other scholars like Whiteside and Sunter further argue that HIV is only a virus like other viruses which can infect anybody whether innocent or guilty (2000: 6). Suffice to agree with Tayo that HIV should not be seen as a crime but a virus like any other viruses and the infected should not be treated as criminals or the most sinful persons.²¹ With the ongoing awareness on the HIV epidemic and the rate of civilization in our society, hatred for PLWHIV continues to manifest itself in multiple ways across northern Nigeria, including Adamawa state. Even after gaining access to treatment, HIV-positive women often withhold their status from their families and social networks for fear of being discriminated and treated inhumanly (Rhine, 2009). When stigma and discrimination are properly addressed, ideally, people who are uncertain about their HIV status will seek voluntary and confidential counselling and testing to identify their HIV status without fear of the repercussions (UNAIDS, 2014:1). It is more difficult at times to cope with the irrational fears of society than it is to live with HIV itself as argued by Malloy (1990:115).

It is of necessity for the society to create a supportive and caring environment if we are to have any real hope of controlling the spread of HIV in the future (Dixon, 2010:121). A number of scholars argue that stigma and discrimination against people who are openly living with HIV make it difficult to curb the spread of HIV (Paterson 2011:350; Nord 1997:61; Dube 2003:3; Materu, 2011:96). If the spread of HIV is to be nipped in the bud, effort from all states in Nigeria must be geared towards eradicating stigma and discrimination to pave way for voluntary disclosure of one's HIV positive status so as to enable the infected to start treatment early.

Bayelsa state government in their determination to eradicate stigma, had to promulgate laws that deal with those unleashing anguish to PLWHIV. People who were found to be stigmatizing and discriminating them were prosecuted, and not only that, monthly allowances of 10.000 naira are giving to people who have openly disclosed their HIV positive status.²² If all states in Nigeria will emulate from the above mentioned state, when dealing with people

²¹Nigeria Wakes Up to its AIDS Threat <http://www.ipnews.net/2014/08/nigeria-wakes-up-to-its-aids-threat/>(Accessed on the 5th August, 2015).

²² Bayelsa: Beyond allowance for PLWHIV.
http://www.nghttp://www.nigeriahivinfo.com/inthenews/breaking_news_feeds.php?article=19(Accessed on 5th September 2014).

inflicting more pains on PLWHIV, stigma and discrimination will be eradicated in no distant time in the country. People in state have demonstrated their sympathetic response for PLWHIV in a way that is commensurate to the biblical instruction: “Bear one another’s burdens, and so fulfil the law of Christ” (Galatians 6:2).

The former president (Goodluck) who was the governor of Bayelsa state that initiated the platform of ameliorating the plight of PLWHIV became the President of the 37 states including the Federal Capital Territory (FCT, Abuja). Goodluck did not deviate from his initial effort to stem the evil of stigma and discrimination of PLWHIV in the country. He had unswervingly signed the HIV and AIDS Anti-stigma and discrimination Act which reflected Nigeria’s commitment to removing all forms of stigma and discrimination of PLWHIV.²³ This is a landslide achievement if implemented to the later. Most times Bills are signed into laws, but less attention is given afterwards. Uju argues that, the Anti-stigma law is part of government’s effort to end the AIDS epidemic by 2030; however, the question on the lips of many bothers on the implementation of the law; the Anti-stigma and discrimination law is highly appreciated, but emphasised the need to shift attention to implementation.²⁴ To enact or verbalize anti-stigma and discrimination law is a good start on the part of the government but when such law is not enforced to the later, the aim and objective of such a law is defeated.

AIDS related stigma and discrimination in spheres most especially, in employment, housing, school policies, and services has been widespread. Employers have refused to provide insurance coverage for employees with AIDS; property owners have refused to rent to PWHIV or have evicted them, and PWHIV have experienced unwanted demotions, dismissals, and harassment in their work places. In addition, some PLWHIV have been targets for violent attacks because of their HIV status (Herek and Cogan, 1998:446).

²³President Goodluck Jonathan signs HIV Anti-Discrimination Law.

<http://www.naca.gov.ng/content/blog/president-goodluck-jonathan-signs-anti-discrimination-law>
(Accessed on the 31st October, 2015).

²⁴HIV/AIDS anti-discrimination law and essence of implementation <http://www.nguardiannews.com/2015/04/hivaids-anti-discrimination-law-and-essence-of-implementation/> (Accessed on the 31st October, 2015).

The negative attitudes as presented by Herek and Cogan and other scholars were seen as reasons why treatment of HIV continues to pose a serious challenge and instead the virus continues to spread in the country and particularly in Todi Diocese.

2.2.1 Church and stigmatization

God loves all people, irrespective of their religious affiliation and health condition, without distinction, without limit. He loves the sick including those suffering from AIDS. He loves the friends and relatives of the sick and those who care for them. He loves all with an unconditional and everlasting love. Hatred for people with AIDS often involves alienation and separation between the person with the disease and every surrounding system. We as Christians are challenged to be reconcilers, helping to restore a sense of wholeness to broken relationships between the patient and those near to him or her. We must build a sense of trust and caring. The church which is the body of Christ in an effort to exhibit Christ love must open its doors to all, unconditionally, just as Christ opened the door to all, irrespective of who they were or what they had done. Salvation is given to all by grace, through faith, not because of deeds or behaviour. Today in his church, we receive this new life through the Word and the sacraments. By excluding somebody from these sources of life, the church becomes guilty of the gravest form of discrimination that exists.

Through baptism, we become part of the body of Christ. We belong intimately to Christ and thus to one another, as brothers and sisters in Christ. Whether we are living and affected by HIV and AIDS or not, we belong to the same body and participate in the same communion. Diaconia (service) is part of the very being of the body of Christ. It is the church's body language, how it bears witness in the world: compassionately reaching out to be with and serve all those living with and affected by HIV and AIDS.²⁵ The church should be a place for spiritual support and social healing, where hope for the future is proclaimed and live out. Tragically, local congregations are often places where such persons feel most excluded, stigmatized, or unwelcomed.

The fear of AIDS should not compromise our compassion or our witness. Those who test positive for HIV and who may be sick with the disease should find acceptance and fellowship in the local congregation. They should be comfortable in our church services and be

²⁵ Grace, Care and Justice: Handbook for HIV and AIDS work, Lutheran World Federation, 2007:9

welcomed to participate in all activities of the church: baptism, foot washing and the communion supper. The local church can find many ways to minister to those with AIDS. Church members can join or form a support group and become individually involved in a supportive role to meet the needs of persons and families affected by AIDS

While efforts are being made by different organizations to fight against stigma, for more than three decades, the church leadership has too often contributed to the stigmatization and discrimination to PLWHIV, the LCCN has not always been a safe or welcome place for people living with or affected by HIV. Ideally, it is the duty of the church to create a conducive atmosphere for PLWHIV to find a shelter, however, reverse is the case. PLWHV prefer to find solace in the society than the church (Noko, 2005: 3).The impression church members get from the religious leaders is that the HIV infected persons are carrying their “crosses” which they themselves had designed for their failure to live righteously and thereby stigmatizing them by creating a barrier between those living with HIV and those who claim to be HIV negative.

AIDS is not something that happens outside of the church, Mosque or Temple and even our homes. Christians and non-Christians are not exempted from the reality of the epidemic (Archbishop Tutu Emeritus 2010:9). HIV subject does not only cross religious boundaries but international boundaries as well. All humans irrespective of their religious affiliations, geographical locations, economic status and positions in society are either infected or affected. In Todi Diocese the people called HIV in Hausa²⁶ language “kabari, sallama alaikum”, literally translated as, “Excuse me, grave, I am coming”. This is referring to people who are living with the virus not even AIDS, reminding them that their death is immanent. Language of this nature is stigmatizing and it does not give any hope to those living with HIV. This made PLWHIV to live in bondage of fear believing they will only be alive for a short period of time, for that reason those who are farmers become sceptical and apprehensive of doing anything, thinking that another person will eat the fruit of their labour. The causes and the consequences of stigma and discrimination will further be explained in a more elaborate manner in chapter six.

²⁶Hausa is one of the three major languages spoken in Nigeria, most especially in the Northern part of the Country.

2.2.2 The impact of stigmatisation and discrimination on treatment in Todi Diocese, Adamawa state

Because of stigma and discrimination many people in Todi Diocese do not like to know their HIV status, using an adage that supports their reluctance to go for the HIV testing: “Da mugun rawa gara kin tashi”²⁷ This is why only few people in the Diocese know their HIV status. No body desired to face a quick agonizing death or being ostracised from family members. The few per cent (15) who dare to know, for the same reason, are very hesitant to disclose their HIV positive status as described by Biyamugisha (2009:90). One other difficulty about HIV prevention is that only few people know their HIV status. The percentage of those who know their HIV status as pointed above is very little which indicate that, the remaining 85 per cent are unaware of their status, and for those who are HIV positive will continue to infect others unintentionally. Declining to go for HIV testing does not portray the paucity of testing materials, but the outcome of the result which is stigma and discrimination deter people to seek for voluntary test. It is undoubted that stigma amplifies the complexities of HIV. When stigma and discrimination is eradicated, people would voluntarily disclose their status and seek for early treatment.

The key to effective treatment for HIV infection is early detection and intervention (Ramaiah, 2008:79). It is of great significance when HIV is detected early before it damages the immune system. Quite a number of people have their HIV resulted to AIDS because some people carry the virus in their bodies for years without any knowledge of it which led to other infectious diseases. According to McCain, within few days of entering the body, HIV actually alters the body’s DNA, and to this point, scientists have not figured out a way to reverse that process. Therefore, the disease remains incurable and it will remain that way for the unforeseeable future. Fortunately, medical scientists have done a good job at creating anti-retroviral drugs that boost the immune system and hold the disease at bay for a while (2008:234). Grodeck, furthers the above argument and contends that people with HIV in developed countries because of their knowledge about the epidemic are no longer dying of AIDS related diseases as long as HIV treatment is started correctly (Grodeck 2003:1). In collaboration to this, Usdin posits that living positively with HIV becomes even more of a

²⁷ Da mugun rawa gara kin tashi, literary means, if you know that you will not dance well, it is better you remain sitted; those who know that they cannot bear the repercussion of knowing and openly disclosing their HIV positive status should not even bother to go for test, let alone disclosing their HIV results.

possibility with ARVs which-although not a cure-slow down the replication of the virus, thereby extending the length of life (2003:24; Robert, 1991: 22).

New treatments have revolutionized the outlook of millions of people with HIV and AIDS. Many people in Africa 10 years ago might have been expected to live only five years on average after testing positive for HIV. But today, with earlier testing and better treatment, many people are now enjoying 20 years or more of healthy life after first knowing their HIV status. So HIV has changed from a warning of possible early death to diagnosis of a chronic condition, which can be managed to allow a relatively normal and active life (Dixon, 2010:131). Some people with HIV infection who are on drugs are now living fulfilled lives unlike in the past when anti-retroviral drugs were only within the reach of wealthy people. Dixon further notes that “an anti-retroviral treatment now means that up to 99 babies out of 100 born to mothers with HIV will grow up totally free of the virus, hopefully to lead completely healthy lives” (2010:131). These days, many babies in Nigeria are born HIV positive because their mothers lack basic knowledge on the effectiveness of ARVs. According to Ryan, the development of anti-retroviral drugs has made progress possible in the postponement of death and the control of opportunistic diseases in HIV positive patients. Many HIV positive people are now living reasonably healthy lives and have acceptable life expectancy (Ryan 2014:2 48). Those who were infected can only have a positive living when stigma attached to HIV and AIDS is finally eradicated, people will develop interest in having their HIV testing voluntarily like any other diseases, then in Nigeria we can confidently say, we are winning war against HIV. When PLWHIV have access to treatment, the spread of the virus will be halted significantly. But this cannot be achieved unless stigma and discrimination is eradicated so as to pave way for testing and consequently treatment.

According to Mangwane, providing care and treatment for PLWHIV will help improve greatly the lives of many people. Treatment will promote better access to HIV testing and counselling, as medicines for opportunistic infections caused by HIV become available (2001:60). Many HIV infected persons in the LCCN will continue to delay their treatment for fear of being exposed and stigmatized and those whose health conditions deteriorate will continue to borrow drugs from their fellow patients (see: chapter six) which is dangerous to their health as long as PLWHIV continue to face stigmatization and discrimination.

2.3 Understanding sex and sexuality from the religious perspective

Sex refers to the biological and physiological characteristics that define men and women. It is the term often used to describe the physical or genetic markers of gender.²⁸ Ellens does not see sex as only something that is limited to humans, but also view God as a sexual being. Ellens observed that the issue of sexuality is not only limited to humanity but to God's divine nature as well. God Himself is sexual; gender and sexuality are of God and are reflective of the very nature of God in humanity. Therefore, being made in the image of God, sex is God's thing which means God reproduced Himself and made us persons who have the capability to produce ourselves (2006:14).

In corroboration to this biblical standpoint, complementarity is the idea that men and women possessed different natures, which are designed by God to complement each other. For men and women who love each other and seek unitivity, then, sex fulfils God's theological design by uniting these two differing, incomplete pieces into one whole being (Ruddy, 1997:116). If sex is purposely designed by God, it must therefore be held in high esteem. Sex, is a gift from God that makes us live in association with others and appreciating each other instead of living in isolation. According to Sherman, "sex is an outward manifestation of an inward reality; Sex is never just a physical act, it is the meshing of the mind, soul, emotions, and spirits of two people" (1999:77). Sexuality is the human drive toward intimate communion. It goes beyond ordinary physical itch that needs scratching, it urges us to experience the other, and to enter the other's life by entering the vital membrane of his or her body (Merill1994:110). Sex drives people to find fulfilment either in the opposite sex or same sex.

Sex and sexuality plays a significant role in the life of an average African man or woman. No any human pleasure can be likened to sex. It is above anything else; since sexuality performs such a large and important function in human life, it is perceived by all Africans as the heartbeat of the society (Amanze, 2010:83). If human sexuality occupies a central position in Africa, it must therefore, be talked about more than any other subject of discussion. If sex is considered as a precious gift given by God, it must therefore, be highly appreciated by freely talking about it, except otherwise. The misconception by some Christians who view sexuality based more on the body as enemy than as a gift has contributed to the huge silence around sex and sexualities. This view suggests residual

²⁸See: <http://www.who.int/gender/whatisgender/en/> (Accessed on the 18th June 2014).

influences of Gnostic dualism, in which the spirit was viewed as good and the flesh as the unfortunate evil container of that good spirit (Dahl, 2011:745-746).

A dichotomy is created between spirituality and sexuality in the church, and this is the reason why spiritual matters are encouraged to be discussed in the church while issues of sex are preferred to be discussed outside the four corners of the church. In response to people who make distinction between sexuality and spirituality, Nicolson noted that “the negative view about sexuality is based on a wrong understanding of human nature and a wrong understanding of sexuality. We do not have two natures, a higher and a lower, but one nature in which the human spirit exists in a human body. Therefore, our sexuality cannot be divided off from our spirituality. Sexuality is not confined to the genital; it is part of who we are and thus part of our whole personality” (1996:107). When we try to make distinction between the spirituality and sexuality, the church end up losing the meaning and the reason for which sex was created or invented by God.

Most Christians and religious leaders in Nigeria do not see the need for sexual Education (Adepaju, 2005:10-11). If Christian denominations in Nigeria will have a common front on the topic of sex and allow it to be included in the curriculum in various institutions of learning, the youth will have a better understanding of sex and sexualities. Communication on sexual issues remained elusive and almost unachievable in the country (Nigeria), thereby making the effective implementation of sexuality education inaccessible. Alternatively, Nigerian youth resort to Nigerian films or Nollywood only to be led astray by learning negatively on sex and sexuality (Adepaju, 2005:12).

On matters of sex each religion is an entity, and it is a serious challenge to the nation. This is relatively accountable for reasons youth in the country alternatively turn to internet to learn about sex and sexualities. The religious leaders and parents who do not see the need for sexual education turn out to blame the youth for not exercising self-control over their sexual urge. The Negative and discriminatory mentality or concepts we hold about particular expressions of sexuality may indeed influence the way we read and interpret our bible and other sacred texts, rather than allowing sacred texts to influence the way we think and respond to sexuality. This negative attitude can totally becloud our vision towards sex and sexualities, rendering us incapable of responding positively and productively to anything which might engage with matters of sex and sexualities (Chitando and Nickels, 2010:78). So

much negative notions on sex have caused backwardness in the effort to stem the spread of HIV. Both the two major religions in Nigeria have different connotations and approaches to sexual matters. These negative notions are leaving our children growing without sexual education. If the religious leaders continue to respond from the stand point of judgmental born from our negative images of sex and sexualities, the church including the LCCN will continue to drive the stigma, shame, denial, discrimination, inaction which render all interventions on HIV prevention, treatment, care and support significantly less effective than they can and should be (2010:78). The researcher strongly considers that the key to eradicating stigma and discrimination lies in the hands of religious leaders.

The language used in everyday discussion by Africans and church leaders on matters pertaining to sex and sexualities blurs the message to such an extent that it does not reach its intended recipients; if the youth in the church and the society at large are faced with the naked truth pertaining to sex and human sexuality it will empower the young ones to live a healthy life free of HIV infection (Amanze, 2010:89-90). Considerably, the church assumes that sex topic should be treated outside the church and the topic should also be reserved for the matured and old, but not for teenagers, and therefore any language around it should be shrouded in secrecy. The teenagers therefore struggle on their own to unravel what is it that the elderly do not want them to know? By trying to find out the meaning themselves they end up plunging themselves into what the church leaders dreaded most.

There are places in Northern Nigeria, where it is still difficult to talk about sex. And many northern states resisted the implementation of the Ministry of Education's HIV and AIDS curriculum because it was viewed as sex education and many parents did not want their children exposed to sex education in the schools (McCain, 2008:237). Religious leaders need to move beyond the negative views on sex and sexualities which is always emphasized in most of the various church denominations, towards embracing sex and sexualities as a gift from God. Youth in the north, particularly in Adamawa state finished from various institutions without sex education, and the church cannot deny the fact that their teenagers are having sex and therefore need to be well informed on the subject matter. Sex education needs to be given appropriate responsiveness if the church is ready to safeguard the future of their youth. Since HIV and AIDS is linked to social taboos such as sex and sexualities; there are enormous level of ignorance, denial, fear and intolerance in most communities; it is these

prejudices that lead to the stigmatization and discrimination of people living with HIV (Gennrich, 2004:18).

Christian religious Studies (CRS) has been one of the school subjects in Nigeria, and instrument of impacting knowledge to children at tender ages. CRK is a compulsory subject by the school curriculum for students in primary and junior secondary schools. The subject is also taught at the senior secondary school level (Falade, 2015:2). My argument is that if CRK is made compulsory in schools for youth to learn about their fundamental religious beliefs, there is no justification for excluding sexual education from their curriculum. For a child to become a responsible and reliable man or woman and to ultimately and responsibly determine his or her own way in this world needs help from an adult to become sexually educated in order to know what is expected of him or her as he or she grows up (Van-Rooyen, 1997:28-29).

God's people must take up the challenge to develop and implement wholesome teachings about human sexuality for our children, our youth and our adults. If we do not, the understanding of our people about human sexuality is going to go by default to those who are teaching openly and publicly through the public media and to the incomplete and distorted views of their peers (McCain, 2008:54). Teaching is not the same as warning. The researcher views teaching, as giving youth the opportunity to choose what is good for them; unlike using the epidemic to inculcate fear to the youth. LCCN leaders need no to limit themselves to mere warning about the danger of sex alone, but also on the benefit and importance of sex as also suggested by Nicolson; "Our sex education should go beyond merely warning against AIDS, or against premarital pregnancy or any other dangers" (1996:107). Sex education needs to be about more than what we must avoid. Children need to be brought up with healthy sexual attitudes from the beginning; they need to learn a positive attitude towards their bodies and themselves, and not merely be warned against the dangers of sex in their teens (Nicolson, 996:100). Children need to know the necessity of sex education. It is not everything about sex and sexualities that our young ones need to know at tender age, but the most fundamental things about human sexuality.

McCain corroborates this by asserting that "primary school students do not need to know all the details of human sexuality; they need to learn the right and the wrong associated with sexuality" (2008:70). McCain strongly suggests that we cannot educate about HIV and AIDS

without teaching about sex. In his words: Sex is a sensitive subject, and that many Nigerians are still convinced that the school should say nothing about sex and certainly should not be involved in any kind of sexual discussion. They believe that children should learn about sex from home or other places other than school. It is commonly thought that introducing young people to sex education too young would create curiosity in them and will actually encourage them to experiment sexually (2008:123). Only few parents today can confidently and without shame discuss issues of sex with their children. If therefore parents, church and schools cannot openly talk about sex, the only options left are the media and peers who are out there to give our children a distorted version of sex and sexualities.

The significance of introducing issues of sex in children cannot be over emphasized. Knowledge and attitudes toward sexuality instilled in early life influence perceptions about sexual needs and feelings throughout life (Janice et al, 2002:255). Emphasis on sex education of young adults cannot be over stressed. Usdin asserts that most people around the world find it difficult to talk about sex, especially to younger people, and therefore are not able to protect themselves or equip the youth to do so (2003:11). If adults cannot protect themselves and their children as well, that portrays a danger of the extinction of future generations. Knowledge is power, and to be informed is to be forewarned. When information on sex is acquired, people will no longer live in ignorance that leads to the spread of HIV through sexual misconduct which includes unprotected sex. McCain was right when he suggests that, teaching and encouraging people to practice the religious principles related to sex will greatly assist in preventing the spread of HIV both among Christians and Muslims in Nigeria, since one of the highest motivations in life is religion and the two major religions agree on sexual abstinence either before or after marriage. If we do not come together to create a God-centred agenda for AIDS through sexual education, the society will create one for us, and we probably won't like it (2008:60).

As earlier mentioned above, the religious leaders in Nigeria hold the key that opens the gate leading to the open discussions of sex related issues. This, consequently leads to open discussions on HIV and AIDS; with open discussion on the aforementioned, definitely the stigma and discrimination associated to HIV and AIDS will totally be eradicated. Below are the literatures discussing the relationship between sex and sexualities in the context of HIV and AIDS.

2.4 The Concept of Sex and sexualities in the context of HIV and AIDS

The connectivity between HIV and AIDS and sex and sexualities has made the battle against the spread of the epidemic complicated (Kunda 2008). In the absence of a cure for HIV now, attention must shift to disseminating adequate knowledge on sex and sexuality. Sex is a pleasurable motion and a good thing to have if managed properly. The problem is the misuse of a good thing (Eckman, 2006:18). When sex is “properly managed” the spread of HIV will be minimized. Lack of proper management of our sexuality has made the epidemic to be an agent which causes premature death, cutting the expectations of many people short, most especially when done recklessly. Proper management in this sense could mean proper protection during sex which goes a long way in minimizing the spread of the HIV. It is worthy of lamentation that human sexuality which was created purposely for our enjoyment and procreation has now become a death trap not only for those who engage in sexual promiscuity, but for the innocent babies and children who are born HIV positive or are orphaned and left behind to fend for themselves. It is conspicuous that the survival of African families is threatened because the epidemic has reached an alarming rate in the continent (Mosue, 2001:30). HIV does not target a particular age group; all and sundry are potential victims when carelessly exposed to the virus.

Some cultures in Todi Diocese place a taboo on sex and sexualities which makes any discussion around HIV and AIDS almost impossible. Patterson argues that “religion tends to reinforce those taboos rather than resist them; thus the conflict between the private and the public especially over sexual issues has become a stumbling block to the ability of religious organizations to engage with HIV related stigma” (2011:356). The leaders of Churches affirmed their silence on the subject of sex and sexuality. In November 2001, African Church leaders meeting in Nairobi confessed categorically and “Regrettably”²⁹ their inability to address the issues of sex and sexualities which has constantly made it difficult for them to engage in honest and realistic ways with matters of sex education and HIV prevention (World Council of Churches, 2001:5). Mere acknowledgement of the silence by the church is not enough; WCC which is a respected body should further use its highly esteemed office to influence other church denominations to break the silence surrounding sex and sexualities in order to fight spread of HIV and escape the preventable deaths.

²⁹“Regrettably” The Church leaders’ meeting showed a great sense of remorse for their silence over the years, which led to the untimely death of many Church members. However, that attitude of negligence on sex issues is still seen in their leadership characteristics.

A document on AIDS from World Council of Churches quoted by Adam in Nicolson cited Adam who argues, “for many Churches, though sexuality is tolerated as a means of perpetuating the human race, the subject remains a taboo; in many Christian communities to talk about it is to risk being regarded askance, as someone of doubtful morals. This theology and this attitude pose a problem when it comes to the preventive measures necessary in the fight against AIDS” (1996:106). In the LCCN if you want to be seen as a highly respected person, keep your distance from discussing sexual issues, and also pretend as if sex is of no significant value to you, then you will be rated as a person of integrity. In one of the Church Executive Council meetings, the Archbishop, Babba asked council members to tell him, “Why did God create penis and vagina that the LCCN is shy to talk about them”?³⁰ He used Hausa³¹ language (Bura da Duri) which makes the question more embarrassing than using English terms. Almost all council members buried their heads in shame, and asking why would someone of his position chose to ask such a question calling men and women private parts as if he is not a leader of the church. Women among us took a long time before they could freely participate in the deliberations. Mentioning of the genitals alone was not enough; hence the leader (Archbishop) saw how people reacted negatively to his comment; that should have afforded him the opportunity to instruct all Diocesan bishops who were all present to swing into action by teaching on sex and sexualities so as to reduce the silence on sex in the LCCN; it was not enough to just make a passing statement. In the LCCN, if you want your respect, never make a mistake of mentioning the above names in public or on the pulpit. You can talk about sex but indirectly, using names that are closer to them (such as gindi,³² asiri³³, pegele³⁴ e.t.c) but not directly calling them by name.

Drawing from the above perception, in this era of HIV and AIDS epidemic, indirect languages (euphemism) used in matters of human sexuality which is common in African society is a serious barrier towards effective sex education designed to save the lives of many people in Africa (Amanze, 2010: 8). The older men and women resort to using euphemism in an attempt to hide the meaning of what is being discussed, and by doing that sex and sexualities continues to be shrouded in myth. When sex is shrouded with myth the

³⁰ Executive Council meeting held in September, 2013

³¹ Hausa is one of the lingua franca, and one of the major languages spoken in the Northern part of Nigeria.

³² Gindi means buttocks

³³ Asiri means secret

³⁴ Pegele means a big thing that does not need to be mentioned publicly

understanding for what it is becomes difficult and the youth who struggle to find out what sex is, end up learning it erroneously (2010:8).

McCain was right to reiterate that whether we like it or not, circumstances have overtaken our concerns. The AIDS epidemic is forcing us to talk about sex than we are comfortable with. And we are being forced to talk to our children at a younger age than we would have preferred. We cannot ignore the problem and continue to say nothing to our children about sex. This will mean that they will continue to learn from their peers and become more and more vulnerable to potential HIV infection. Or we can swallow our concerns and embarrassment, and teach our young people about their sexuality in a sensitive and correct manner and in so doing, preserve many of them from the HIV infection (2008:123). McCain uses the word “force”. The researcher is not in agreement with McCain’s standpoint that the church should be forced to talk about sex and sexualities simply because of HIV and AIDS. The LCCN leaders should not only be compelled to talk about sex and sexualities primarily because of its relationship to HIV; we are aware that the scientists are working tirelessly to ensure that the HIV epidemic is overpowered in no distant time. Therefore if the church is only forced to talk about sex and sexualities because of its affiliation to HIV and AIDS, as soon as the epidemic is wiped out, the church would go back to its shelf of silence, simply because what it dreaded is no longer existing. I concur with Fassin in his opinion that, “Even when AIDS has not struck, sex remains the factor to be explored” (2007:150). Discussion about sexual matters should not be predicated on the ground of its relationship to HIV.

Nord argues that Sexual spontaneity and desire have decreased simply because it is primarily attributed to HIV (1997:184). Sex today is loaded with so many uncertainties, owing to its relationship with HIV, except between faithful partners who are fully sure of their HIV status, or else the joy accompanying sex is diminished. HIV and AIDS have drastically reduced the excitement that accompanies the sexual ecstasy. When one is conscious of the fact that he or she is risking his or her life or that a particular intercourse may cause his or her health hazards for the rest of his or her life, automatically, the joy and excitement are no longer complete. Effort must therefore be geared towards eliminating HIV from the face of the earth so as to restore the joy associated with sex.

2.5 Modes of Transmission

HIV is not an air borne disease that can easily be transmitted haphazardly. It is not a contagious disease and therefore, the virus is hard to be transmitted casually. In order for a

person to be infected, the virus has to enter the body in large or sufficient quantities; it must pass through an entry point in the skin and/or mucous membranes into the blood stream (Whiteside and Alan, 2000:10). There are four bodily fluids that contain high HIV concentrations in an infected person and show evidence of transmission: blood, semen, vaginal fluid and breast milk. But tears and saliva, perspiration and urine have low HIV concentrations and there is no evidence of transmission. For HIV to be transmitted through them, they need to be present in large quantity, e.g. seven gallons of saliva (Magezi, 2007:17).

2.5.1 Transmission of HIV through sexual intercourse

The chief route of transmission is via sexual activity, homosexual and heterosexual anal intercourse is an efficient means of transmission, due to the presence of both potentially infected semen and small amounts of blood, which are common in penetrative rectal intercourse (Robert 1991: 18; Dyk, 2013:38).

According to Adamu, saliva contains very low level of HIV. Therefore, it can only be a route of transmission under the following conditions:

- i. “During period of high infectiousness,
- ii. In the presence of sores/cuts, bleeding gums/mouth, and
- iii. Prolong continuity of saliva during wet kissing and fellatio” (2001:42).

2.5.2 Transmission of HIV through blood/blood products

There are several methods that HIV can be transmitted from one person to another. The transmission could either be horizontal or vertical, depending to the situation. Horizontally, the virus can be transmitted through unprotected sex while Mother to Child Transmission (MTCT) is regarded as vertical transmission. The ‘vertical transmission’ is the term used to depict MTCT of HIV. As the number of maternal mothers with HIV increase, the number of children infected with the virus from their mothers also increase (Tyndall et al, 2011). The virus has a way of crossing the placenta from the mother to the infant before delivery. Placenta is a flat cake-organ that has a large number of blood vessels. The unborn baby in the mother’s womb receives oxygen and other nutrients through the placenta and excretes carbon dioxide and other wastes through the placenta (Ramaiah, 2008:40). This is an indication that HIV-infected blood becomes a high risk when passed into the body in the following ways as outlined by Adamu:

- i. Through blood transfusion
- ii. Blood products transfusion, e.g. plasma, concentrate of white blood cells, or platelets and clotting factor,
- iii. Surgical and dental procedures,
- iv. Attending to bleeding wounds and injury sites,
- v. Childbirth
- vi. Laboratory and clinical handling of blood specimens and bleeding sites including needle stick injuries to health care workers,
- vii. Traditional blood handling practices,
- viii. Organ transplant
- ix. Bone marrow transplant,
- x. Insemination (2001:38-39).

2.5.3 Mother to child HIV transmission

During pregnancy and most especially at the time of delivery, women who have no knowledge at the early stage of the pregnancy, if they can have access to ARVS there is possibility that their children will be born HIV negative, however, out of ignorance some women abort the babies.

Llewellyn-Jones suggests that, if a woman who has HIV becomes pregnant, and her baby infected, she may choose to have an abortion, but if she wishes to continue with the pregnancy, she will be given the drug zidovudine (AZT), from the 20th week of the pregnancy. This has been shown to reduce the risk of the baby being infected by two-thirds (1998:375). This kind of misinformation as suggested by Jones has caused many mothers to lose their children who should have been born without being infected. Some women in Todi Diocese as would be discussed in chapter six who were counselled to abort their children or born them HIV positive resort to aborting their pregnancies for fear of giving birth to HIV infected children. Upson in contrast to Llewellyn-Jones' submission argues that There is now a drugs available in many parts of Africa countries that reduce the risk of HIV transmission to the baby by around 50%. It only needs to be taken by the mother while in labour and given to the baby when born; therefore, there is no need for committing abortion or refusing to be pregnant for fear of being infected with HIV (2004:21). The risk of MTCT during labour and vaginal delivery is high due to contact with the mother's blood and mucus in the birth canal during the birth process. The infected women do not need to either abort the child or go through the normal delivery, but can choose other method (caesarean) as noted by Upson:

some of the risk of HIV contraction to the baby is due to blood exposure during delivery; the safest way to have their baby delivered without getting infected with HIV is through caesarean service. This measure, along with the anti-retroviral drugs and formula feeding, helps make the risk to the baby as low as possible. The cost is often prohibitive, but if patients are able to choose caesarean section birth, they can feel more secure about their babies' opportunities for the future (2004:22-23; see Van Dyk 2012:47).

Nigeria unlike Cuba is far away in the prevention of MTCT. World Health Organization reports that Cuba in its effort to prevent MTCT has worked tirelessly to ensure that pregnant mothers have access to prenatal care, ensuring that both partners are tested to ascertain their HIV status. Other health facilities are made available to women who are living with HIV, including free Caesarian services during delivery.³⁵ The success recorded by Cuba demonstrates that prevention of MTCT is possible by Nigeria; Cuba's achievement serves as an inspiration for other countries including Nigeria to intensify effort towards eliminating MTCT. It has been reported that Nigeria has made slow progress in the Prevention of Mother-To-Child Transmission of HIV, with 30 per cent coverage by 2013 due to a number of structural challenges, including inadequate services at Primary Health Care level, poor attendance of pregnant women at antenatal services, and many women especially those in rural areas preferring to go to traditional birth attendants, churches and mosques to access antenatal and delivery services (Aderele, 2014). Some women in Todi Diocese have resorted to traditional practices of giving birth to children because of the poor antenatal services and the incompetency of the health workers to keep the HIV status of pregnant women who are HIV positive confidential.

The purpose of this section is to argue that MTCT is preventable when stigma and discrimination of PLWHIV is totally eradicated and medical attention is adequately administered. In chapter six, the researcher discovered that many HIV infected persons in the research area were demanded against their desire and under deception by medical professionals to commit abortion so they can get rid of the HIV infected children which they presume will result into family stigma and discrimination. Many LCCN members in Todi Diocese have lost innocent children who could have been born HIV negative but were

³⁵WHO validates elimination of mother-to-child transmission of HIV and syphilis in Cuba <http://www.who.int/mediacentre/news/releases/2015/mtct-hiv-cuba/en/> (Accessed on the 4th November, 2015).

aborted due to ignorance. Below are few practices that can potentially reduce the spread of HIV in Nigeria and particularly in Todi Diocese when adhered to.

2.6 Reducing the risk of infection through safer sex practices from the Church's standpoint

Emphasizing safer sex techniques is essential because the epidemic drivers have shifted to heterosexual sex, unsafe or unprotected sexual practices. Hence since it is obvious that the most sexually active age group in society are the youth and they are more vulnerable to the epidemic, there is need for the safer measures to be put in place to reduce the high rate of infection among the youth and other age groups as well. There are various safer methods that can reduce the spread of HIV, two of these methods to be discussed are: abstinence and the use of condoms.

2.6.1 Abstinence

By definition, to abstain means to refrain from indulging in an appetite or desire especially for alcoholic drink or sexual intercourse³⁶. Abstinence implies the wilful avoidance of pleasures, especially of food, drinks and sex thought to be harmful or self-indulgent.³⁷ Abstinence is viewed according to Obisesan to be 100 percent risk-free from HIV infection and other sexual transmitted diseases. He sees it as the only life-saving decision; it is also a life of moral excellence (2010:41). Abstinence from sex either pre- or extra-marital does not predict that one can never get infected with HIV; however, the risk of getting infected through sex is reduced significantly. The researcher observes that, the price one pays to live a life of nearly free from HIV infection is a life of self-discipline to abstain from sex before entering into a matrimonial home and after the marriage vows were swapped. This is in agreement with Johnson's position which states that "one benefit of postponing sex is that you won't have to worry about HIV and other STDs, and pregnancy. The "safest sex," of course, is no sex at all. Abstinence –not having sex at all is a very responsible and difficult decision. If you decide to put off having sex, that's great; if you decide to have sex, make a conscious decision to be responsible about it, but preferably, if you can wait, don't do it, wait" (1992:54). However, hence not all people are in the position to abstain from both premarital and extramarital sexual intercourse; therefore, condoms are the next possibility (Moyo, 2015:156).

³⁶The Free Dictionary.<http://www.thefreedictionary.com/abstinence>. (Accessed on the 20th September, 2014)

³⁷The Free Dictionary.<http://www.thefreedictionary.com/abstinence>. (Accessed on the 20th September, 2014).

To make a conscious decision and to be responsible about having sex is to be protected by any available means such as condoms and other barrier methods which go a long way in halting the spread of HIV. In the same vein, Ryan is of the view that the only reliable method of achieving complete protection from acquiring HIV or becoming HIV positive lies, as it did when AIDS was first diagnosed, is abstinence from sexual activity or fidelity to an HIV negative partner, because even the scientific community is not unanimous about the efficacy of condoms in preventing infection (2014:248; see Madunagu 2005:8; Williams and Smith 1998:35).

Abstinence from sex does not guarantee that one cannot be infected with HIV as mentioned earlier. Quite a number of people have chosen the path of abstinence, unfortunately ended up being HIV positive. Garland and Blyth report the case of a girl (Sarah), who abstained completely from premarital sex to keep with the rules of the church but ended up being infected when she finally got married to the man of her dream. With all the effort she had made to stay away from HIV infection proved abortive (2005:36-37).

Now, Sarah in her frustration was asking, why is it that after choosing to be abstinent as always promoted by religious leaders and still became positive? For reasons like the above mentioned scenario, Dixon argues that there can be another challenge or problem with abstinence-only programmes. Many people have been abstinent before marriage and faithful since their childhood, but have still got HIV through their partners, so prevention of sexual transmission of HIV is more complex than abstinence and faithfulness alone. It is almost impossible to prove that one method is better than another (2010:37). The LCCN needs to shift away from sticking to abstinence alone as the only methods of stopping the spread of HIV in the Diocese, and embrace other barrier methods which may not be hundred per cent safe but when used effectively can reduce the high rate of infection to other people.

Fox contends that “safer sex refers to a set of strategies adopted for reducing or eliminating the risk of transmitting HIV through sexual contact; it involves minimizing contact between the potentially infective bodily fluids of one sexual partner and the porous areas, such as mucus membranes or broken skin, of the other sexual partner” (1998:433). There is therefore need for the preventive measures such as condoms to be put in place to reduce the high rate of infection among the youth and other age groups as well by educating them.

Obisesan asserts that over 80 per cent of people living with HIV in Nigeria got infected through reckless or unprotected sex (2010:28). The researcher agrees with those who posit that sex without any barrier is more natural and fulfils the divine purpose for which it was meant for. However, the situation at hand has called for the need to protect oneself from the danger of getting infected and dying before one's appointed time. Allen, et al, give two reasons why it is vital to practice safer sex if you are HIV positive, "to protect other people; obviously, you would not want to expose someone else to a serious illness; to protect yourself. Even if you are already HIV positive, you could be infected with new, possibly more dangerous strains of HIV. The infected could be re-infected with new HIV that is resistant to anti-HIV drugs. You will stay healthier and live longer if you can avoid any new HIV infection" (2005:9; see also Critzer 2004:122). It is a display of ignorance for those who are living with HIV to assume that once one is infected; there is nothing to fear any longer.

Johnson contends that every time one has unprotected sex with someone, it's as if one is also having sex with everyone the person has had sex with. And since in some cases it can take up to ten years from the time someone is infected with HIV until he or she feels or looks sick, you have to be concerned about anybody your partner has had sex with in the last ten years; when someone has sex with you, he or she is having sex with everyone that you ever had sex with anytime in your life (1992:56). Behavioural adjustment is necessary; education alone in a narrow sense is not enough to change behaviour; many people have good information about HIV, They know the disease is sexually transmitted and that condoms significantly reduce the likelihood of infection. But knowledge alone is insufficient. Attitudes must also change. Health care providers must relate friendly to their clients, especially younger ones (Bermudes and Da Cruz, 2004:136). In an effort to combat the HIV epidemic, knowledge and behavioural change must be combined together.

Safer sex is not completely without failure sometimes, most especially when it is used ineffectively. Virginal intercourse, even with a condom, is a high-risk behaviour in terms of HIV infection, but condoms with spermicide are not only effective in preventing pregnancy but are also the only protection for HIV prevention through intercourse (Sellgson and Peterson, 1992:256). The ineffectiveness or the weakness of condoms does not render it completely helpless. Effective use of condoms reduces the spread of HIV; however, Malloy was right to say that, "even though there are recommendations for safer sexual practices, the

only safer sex is sex within a monogamous relationship where partners can trust each other's sexual history" (1990:100). Condoms have been demonized owing to the fact that it is related to sex and sexualities and HIV and AIDS.

2.6.2 The significance of Condoms

I align myself with McCain, who views condoms as one method that saves lives. He acknowledges that when people are fighting the same battle he is fighting, he is certainly not going to fight them. He will not see himself as the enemy of those who promote condom use as a means of fighting the spread of HIV. An old proverb says, 'the enemy of my enemy is my friend'. Those who are fighting HIV, even though using different means and presenting different messages must not fight each other (2008:176). Strategies that are aimed at preventing HIV transmission have been demonized by the church. The discussions in (chapter seven) have shown how LCCN pastors abhor the use of condoms, arguing that such idea is ungodly and promotes promiscuity among the youth in the church. When LCCN members are well informed of the effectiveness of condoms, there would be drastic reduction in the spread of HIV in Todi Diocese.

Condoms have also become stigmatized by church leaders because of the connotations of HIV and AIDS associated with them. It is pathetic that some LCCN leaders were found to be using condoms to protect themselves from sexually transmitted diseases, but failed to create awareness among its members, most especially to those who are sexually active to do same. This is in consonance with the proverbial phrase that says, "Do not do as I do, but do as I say." Wanting to use condom is also seen as a lack of trust between partners. Partners are often asked to express their love and trust by having unprotected sex. The stigmatization of condom by church leaders is primarily attributed for reason members of the church (LCCN) were not taught its significance in the era of HIV.

McCain further argues that, sometimes we give people wrong information. We do not state that condoms fail. We do not state that they can tear or slip off. We do not say that condom can deteriorate through being improperly stored. Because sex is something that is practiced in a highly excited state, condoms are not hundred percent reliable. The recognized breakage rate of condoms is 7percent. In addition, condoms slip off of the penis approximately 4 percent of the time. The recognized rate of failure of a condom to prevent pregnancy is between 12 and 15 percent. Therefore, a conservative estimate of the failure rate of condom

either because of defects or improper use is about 10 percent. In light of these facts, the message that sex with a condom is “safe sex” is misinformation. It can certainly be argued that using condoms is “safer sex” but not “safe sex (2008:176).

Knowledge about condom must be all encompassing. Despite the fact that the effective use of condom greatly helps in winning the battle against HIV. Adding to this notion, Dixon acknowledges that while condoms, offer good protection, they do sometimes fail, as we know from the fact that few women in every hundred become pregnant each year, even when condoms are used every time they have sex, they may be damaged during use, as people fumble to put them on in the dark. They may be of poor quality, old stock or damaged by heat. Research shows that if used carefully, condoms can reduce the risk of HIV infection or a pregnancy by up to 95 per cent (2010:42).

A condom is not entirely without deficiency, but for now it is the best alternative to HIV prevention. Grodeck argues that, it is undeniable that condoms don’t entirely stop the transmission of STDs, but to an extent, they spin the odds in your favour, and gives some reasons why condoms are essential when considering having sex with someone whether HIV positive or not: Condoms offer you protection from a long list of STDs that can damage your immune system and may shorten your life; It can reduce your chance of getting or giving genital herpes or genital warts; condoms prevent you from getting other strains of HIV that may be worse than the one you already have (2007:103).

Condoms should not be seen as the only solution to HIV prevention and undesirable pregnancies. There are other practical challenges associated with condom use. There is need to diversify our preventive messages. Dixon posits that, there is lack of access to condoms due to poverty and cultural issues. The cost of condoms is a challenge in many nations. Very low-income countries cannot afford to provide them for everyone who needs them. Donors do not have enough funds to provide enough of them, and hundreds of millions of people cannot afford to buy a new condom each time they have sex. Therefore, it is not realistic, nor sustainable, for government workers to give out messages that the only answer for everyone at risk of HIV is for them to use condoms. Prevention messages need to include other options that are appropriate to each person’s situation. Even where condoms are available and affordable, a major problem with condom use is that in many cultures a woman may risk a severe beating if she starts suggesting to her husband that they should use a condom. And he

may not be prepared even to think about suggesting it to his wife-as it could mean admitting that he has been unfaithful (2010:42).

Poverty and cultures are hindrances to the noble role that condoms play. If preventive measures are only centred on condom, people in the rural areas and are living in abject poverty may find it difficult to access it. The well-to-do in the society may not even buy the idea of using condom on cultural ground, because some people see condom as culturally unacceptable especially in the area of the research. For the few who desire to use condom do not have access to them. Gender is a barrier to safer sexual practices. Although the promotion of condom use by various intervention programmes aims to empower people with a means of protection against HIV and STDs, often the simple access to free condoms does not automatically translate to consistent use (Bermudes and Da Cruz, 2004:145). This boils down to the fact that condom should not be seen as the only remedy in curtailing the spread of HIV. Historically, condoms have played a significant role in curtailing the spread of sexually transmitted diseases.

The use of condoms is very old and it can be traced back to around 1000 BC when a linen sheath was used by the ancient Egyptians to protect them against diseases. Condoms were also used by the Romans from 100 to 200 AD. The syphilis epidemic in the 1500s gave rise to greater popularity in condom use and its usefulness for the prevention of pregnancy and diseases. The consistent and correct use of latex condoms is one of the most effective ways of combating the spread of HIV (Van Dyk, 2013:166).

Safer sex is a concept that arose from the reality that sex is a normal part of life that will continue even amid the AIDS epidemic. Given this realization, education targeting HIV-risk reduction has become a major challenge. Religious and political concerns are also important factors in safer-sex education (Smith 1998:437). Smith further asserts that a safer-sex program teaches that there are many options ranging from total abstinence to using condoms every time one has sex and these options should therefore be explored (1998:437). Discussion on sexual issues should no longer be seen as an encouragement to youth as noted by Dixon, Church leaders often worry that discussing or encouraging the issues of condoms actually boost inappropriate sexual activity. This is usually a fear about corrupting the innocence of the young. But sadly, the reality can be that the innocence of these youth has already been corrupted by friends, films, Television programmes or the internet (2010:37).

One of the questions of this study is; what does the LCCN need to do to be a HIV competent church in the context of Nigeria? Among other things as will be discussed in chapter seven, safer methods, especially the effective use of condoms can be part of the LCCN answer to the spread of HIV. The LCCN can play a positive role in upholding the use of condoms to save lives in the perspective of wider health messages that include abstinence and faithfulness.

2.7 Luther's approach to epidemic (bubonic plague)

The Black Death can be likened with HIV and AIDS epidemic today. Observing the number of people killed by these two epidemics, it will not be out of place to marry the two as identical twins in its horror. According to DeNoon, the black death , known as bubonic plague exterminated about 40 million people without age barrier, both young and old, men and women were casualties of the plague (DeNoon, 2002). In the other hand, statistically, AIDS has claimed the lives of about 39 million people which indicate that currently HIV is the world's leading infectious killer. The two epidemics in the history of humanity have captured the widespread imagination than other diseases that had ever existed the world over.

The Black Death had killed many people indiscriminately: men and women, Pastors and church members alike, many productive and talented people in the society had their lives terminated as pointed out by Barton in his article. He said, The Black Death did not only kill peasants, but every class and social order was devastated. Even the King's daughters and sons succumbed to the Plague. The church was not immune and lost many of their priests and clergy; replacing the priests was not an easy task and newer less educated and less devoted men entered the hierarchy of the church ranks (2015). But the good thing about the church at the time of Black Death was that, compassion became the watchword of both Priests and members of the church to those who were infected. Many gave up their lives to die with those in pain, not being mindful of the nature of the epidemic which was contagious through casual contacts unlike HIV.

Luther on whether one may flee from deadly plague, which he branded a “fight or flight” is a dilemma all creatures share. When plague stroke in the Northern Germany in the late summer of 1527, as devastating as the situation was, on the 10th of August, Elector John of Saxony ordered Luther and his family to leave the city, but Luther determined to remain with other

few pastors who continued to minister to the sick and the dying. Fear of the plague began to spread in the city, Luther spoke out in pulpits, admonishing Christians as commanded in the Bible to show love for their neighbours. Luther also rebuked those who left their wives or husbands because of the plague (Brill, 2007:223). Luther in his quest to ameliorate the plight of Christians without stigmatization or discrimination, called his home a hospital, offering a paraphrase of Matthew 10:38, putting Christ's words before his readers: Whoever disown before mere men, I will equally disown before my Father in heaven (cited by Brill, 2007:223).

For Luther, failing to sympathize with those in pains was an outright denial of Christ. Luther turns to a lengthy discussion of the fears people have of caring for plague victims. Luther contends that no risks of harm can withstand the enormous and sure resources of God, however, for those who refused to take their drugs were labelled as those tempting God and were tantamount to suicide (cited by Brill, 2007:235). For the LCCN to be HIV competent it must be a church that does not only visits its members who are living with HIV, but make their homes hospices for people to come in and pray along with them no matter how deteriorating their conditions become. Both pastors and members need to offer their homes to PLWHIV. Luther was certainly aware that in an epidemic of that nature which was contagious, there were those who as a result of their immorality contracted the virus. To them Luther warned: "Those who sin on the other hand are too reckless, tempting God and disregarding all that might insulate them from getting infected by the plague; they do not avoid places and persons that are infected and overcome by the plague, they are not doing justice to their health (Cited by Brill, 2007:250).

2.8 Theoretical frameworks underpinning the study

Below are two theological frameworks which underpin this study: The theory of a HIV competent church and liberating theology. The theoretical frameworks; theory of an HIV competent church; theory of liberation theology; research design; research methodology; qualitative empirical research; the research site and the procedure to gain access; procedure for data collection; methods of data collection; research participants, procedure for data analysis, methods of data analysis and ethical considerations.

2.8.1 The theory of a HIV Competent Church by Sue Parry (2008)

This study employed the framework of an HIV competent church to investigate why LCCN leaders and members who preach and promote love, stigmatize and discriminate PLWHIV. To be an HIV competent church envisages that there is something peculiar about Christians and they must therefore act differently. Christians' responses in the time of HIV and AIDS should be seen different than the secular world or the society, this is because of our deep spiritual values that arise from our faith in Christ Jesus. Fundamentally, Christians are admonished to commiserate with those who are challenged with all kinds of sicknesses and accompany those who are assaulted by the enemy, giving hope to the hopeless. Failing to do the aforementioned as Christians indicates that we cannot tackle the menace of HIV and AIDS (2008:21).

Standing in solidarity with those who are assaulted by any kind of affliction is a clarion call Christians were called into (see: Matthew 25:30-46; Galatians 6:10). Suffice to say with Moyo that, If we (as a church) accept and treat the sick with dignity, we are actually accepting and treating Jesus with dignity. Jesus is located amongst the HIV infected and if one stigmatizes them one will equally be stigmatising Jesus; the sick are embodiment and personification of Jesus; today the actions of stigma and discrimination in the church are a contemporary sign of misunderstanding Jesus (Moyo, 2015: 151). Parry identifies some cardinal obligations of an HIV competent church; first, a HIV competent church must be a Church that has primarily developed an inner competence through internalization of the risk, impacts and consequences and has accepted the responsibility and imperative to respond appropriately and compassionately. Except the church accepts the fact that HIV is in the church, and sympathise with those living with it, its responses will be very minimal. The church must acknowledge that the epidemic is wreaking havoc in the body of Christ and that all Christians

are affected; by thinking along this line shows that the church has internalized and personalized the plight of PLWHIV (2008:20).

Besides developing inner competence, the church is obliged to similarly develop an outer competence by developing theological competence on HIV in order to ensure social cohesion; advocate and reclaim the prophetic voice of the church and to restore the dignity and hope with compassion to all who are infected and affected with HIV (Parry 2008:20). Bearing one another's burden is fundamental to Christian faith. To bear one another's burden is to compassionately attend to the need of others around and deal with the stigma and discrimination of people who were infected with HIV. Central to Parry's theory of an HIV competent church is the compassionate attitudes that need to be exhibited by the church. When these compassionate attitudes are demonstrated among Christians, certainly, stigma and discrimination will be consequently eradicated.

When the LCCN is compassionate enough to those infected with HIV, stigma and discrimination will soon be eliminated and PLWHIV will find relief by openly divulging information regarding their status. Christian faith is relevant only when it recognizes that suffering with those who are suffering, then it is in the right direction to fulfil one of its cardinal obligations to humanity. According to Parry, In order to halt the spread of HIV, responses from the Christian faith must be practical as well as sensitive (2008:29). It is the Christian's individual responsibility to demonstrate love, forgiveness and compassion towards PLWHIV; it is through love that stigma and discrimination can be overpowered which will consequently pave way for early treatment.

This framework is relevant to this study because it will help the LCCN leaders and members as well to see those who were assaulted by health hazards especially those who are living with HIV and were alienated by the communities around them. This theory will be of great help to the LCCN which can serve to motivate it to commiserate with those who are vulnerable to the devastating effects of AIDS-related diseases; feeling their pains because of our inter-relatedness. Parry's theory will help the LCCN to live a life of inter-relatedness, and it will awaken the LCCN to its God-given responsibility to care for the needy. Groody cited Martin Luther King Jr. as saying that, all human beings are all unified. We all have the same destiny; anything that distresses someone, directly or indirectly affects us all (2008). This is also substantiated by a biblical passage, which records that If one of us is challenged, we

partake of that challenge; if one member is promoted, all rejoice together (1 Corinthians 12: 26). Christianity is not practiced in isolation. A pain to one is pain to all, irrespective of one's religious affiliation. Olivier and Paterson citing Siegel and Eric assert that, religion is frequently posited as a positive force that provides coping strategies and support for PLWHIV regardless of their religious backgrounds (2011:39).

When the church of Christ responds effectively to the plight of PLWHIV, it is therefore demonstrating that the church is the body of Christ. In the body of Christ, the church will speak out on behalf of the downtrodden and the marginalized. Those who have no voice, the church speaks for them, defends them and equally brings succour to them. In responding to HIV infected persons, compassion has a significant role to play without which any assistance rendered would be incomplete. To love PLWHIV is to be compassionate enough and visit them in their ostracised places either in places where they are receiving treatment or homes where they are secluded by family members as will be seen in chapter six. Those who are under the yoke of HIV epidemic are already suffering enough without Christian people heaping further guilt and abuse on them. McCain contends that we must exercise the same kind-heartedness and understanding that Jesus had towards them and use our time and resources to assist them. Therefore, to fail to demonstrate compassion to those who are weak and sick is not only to ignore their fundamental human rights to being treated as human beings but is to ignore the plain teachings of the Bible (McCain 2008:18). Becoming infected with HIV does not deny one his or her fundamental human right to be loved and cared for. The Bible does not give us conditions on which love can be predicated.

Cox rightly asserts that, HIV and AIDS has robed people, most especially Christians of their love for one another and has also robbed the church of their collective memory of the compassion of Christ Jesus, the Saviour of the ostracized, the prophet of people who are pushed to the periphery (2010:94). The church has not lost the ability to be entirely uncompassionate. However, HIV became an opportunity for the church to demonstrate its compassion, unfortunately the church was found wanting. If the church truly believes that the love of God is unconditional then the person who has committed the worst sin should be accepted. The church must learn to accept that God's grace is sufficient for the person infected with HIV, and the church should be the vehicle of God's grace to that person, which means that the righteousness of the church must be set aside; that does not entail that the church has accepted their sexual misconduct.

In a situation where the infected were found to be responsible for their infections, the church should not take the place of God as argued by Nicolson, the church needs to change the attitude of looking for reasons why they were infected, but rather, what can God's grace do to transform the situation. Jesus is a perfect example who showed love regardless of the sin committed. Jesus acknowledged the sin and did not pass it over, but he did not see sin as a reason for not loving; he is reported to have said that sinners were closer to the kingdom of heaven, and that those who had been forgiven most also loved most. The general perception of many both inside and outside the church is that church is the enemy of sinners. The opposite should be the truth. Like Jesus the church should be the friend of sinners (1996:38).

For the LCCN to respond appropriately and compassionately as stated above by Parry, the church must acknowledge that, we all have AIDS because we all share in creating an environment for AIDS even though we may not ourselves be involved in sexual promiscuity. In one of my preaching engagements, I said to the LCCN Cathedral in Todi Diocese that I did not know that "Jesus is HIV positive" (Moyo 2006:11) until I went to a South African University and I discovered also that I have been living with HIV without knowing. This threw the whole congregation into confusion upon hearing that. Even after taking time to explain to them what I meant, some people still believed that there must be something about my HIV status that I did not want to disclose to the congregation. Moyo articulates this point thus: "the Church is the body of Christ, and if one part of the church is infected with HIV the body of Christ is infected as well. If the body of Christ is infected every professing Christian is without exemption infected" (2006:211).

In his argument, Noko poses challenging questions to fathom the roles that are played by the church as their contribution to stem the spread of the HIV epidemic: Is the church lacks theological acumen to deal with the stigma and discrimination? Is the church really a caring community and using its God's given resources to ameliorate the plight of PLWHIV? When can it really be said that the church is competent enough to tackle the challenges of HIV and AIDS (Noko 2005:3)?

The church cannot run away from the fact that it will either be a solution by halting the HIV from circulating or a problem by fuelling the spread of the virus by promoting stigma and discrimination. The LCCN is not competent enough to profess that it follows the footsteps of

its master Jesus Christ. The church can only begin to be effective in its combat against the HIV and AIDS epidemic when it recognizes that AIDS is not confined to those outside the faith, and that people within the church community are infected by HIV (Gennrich, 2004:56). HIV and AIDS should not create a demarcation among Christians as noted by Usdin: HIV and AIDS has divided humanity into ‘them’ and ‘us’ and this is one of the most dangerous repercussions of stigma. The irony is that the ‘us’ who discriminate may well be ‘them’ but don’t know it yet, because they have not been tested (2003:62).

The rampant advance of HIV, and all its side effects, present a huge challenge in the field of coping, caring and understanding. It is by doing this that the church communities are operating and are expected to play a major, constructive role in alleviating the plight of those living with HIV (Ward, 2009:158). Ward further contends that rejection by the church seems to be one of the areas of greatest needs. What the church needs to do in times of HIV is to make the church a home for PLWHIV to share their anguish, their stories, in return, be accepted and loved; instead, most are ejected from the church community to live a life of anguish, loneliness, and total rejection (2009:158). PLWHIV can hardly share their anguish with the church when the environment for doing so has not been created; instead, they decide to remain mute and endure their pains.

Sunderland and Shelp argue that as individuals and as a community of faith, we do not have the power to cure HIV or any other diseases, we are embodiments of love, empowered by God whom we characterize as Love, and called to be agents of God’s love for all humanity irrespective of their creeds. The question before us as God’s people is whether we will freely give the love that we have freely received. If we will do so in the midst of AIDS, we, the people of God will relieve some of the suffering caused by AIDS and we will be an example for others to follow (1990:15). The power to cure the church does not have; however, the church has the power to heal PLWHIV. Compassionately identifying with people living with HIV is a healing to the mind and spirit as well.

Viljoen postulates that it is in caring ministry to the suffering that the church comes to its full right, and has the greatest impact. The reasons for this are not hard to find. Firstly, the church’s wealth of social teachings, born from teachings of Christ, impels its adherents to show compassion and care for their suffering fellow-humans. And secondly, the church is present in the remotest and most marginalized communities of the country. Through its parish

networks, the church has better access to these communities than even the government (2001:63). The LCCN in most communities in Todi Diocese is strategically located and have better access to people and it can play a significant role in combating the spread of HIV through its ministry to those infected. The Prophet Isaiah speaks of God dressing people's wounds, and healing the scars of the blows they have received (Isaiah 30:26). This task of love is now the church's responsibility. This is not to say that the task of dressing people's wounds is without pain. At times, to say, dress people's wounds, or bath people whose condition has degenerated to AIDS and are no longer strong enough to go to toilet is easier said than done. However, in many parts of Southern Africa the church has been providing Home Based Care to people living with HIV (see: Richardson, 2006:38; Paterson 2011:35).

As followers of Christ, as noted by Mota, we cultivate in PLWHIV spirituality of hope that provides them with reason to live in vigour and joy; it is from this perspective that the Christian communities is trying to be in solidarity with people living with HIV (2001:37). Mota further suggests that, this is the responsibility we are called to; we are called to embrace our people living with HIV with empathy and love. Must the whole generation be wiped out before the church develops a compassionate attitude towards PLWHIV? Flynn rhetorically asks a pertinent question, which needs a serious attention. "How many people must die of AIDS before our government and churches and every person faces this epidemic with courage and compassion" (2001:41)? In the same manner, the question to the LCCN today is, how many of its members are expected to die before it can respond appropriately and compassionately? As previously established by Parry, the LCCN must develop an inner competence through internalizing the risk and accept the responsibility to respond appropriately and compassionately.

2.8.2 The theory of Liberation Theology by Gustavo Gutierrez (1988)

Liberation could be defined as a process of setting someone free or something from another's control. The theory of Liberation Theology according to Gutierrez is a "critical reflection on praxis in the light of the word of God" (1988:11). Gutierrez explains that "liberation theology recognizes a need for liberation from any kind of oppression, be it - political, economic, social, sexual, racial, and or religious" (1988:11). Christians need to be involved in the liberation process. According to Gutierrez, "there is an urgent need for Christians to involve themselves in the work of emancipating the oppressed, by establishing real commonality with oppressed persons who are the victims of circumstances (1979:29).

Gutierrez's theory of liberation may not be related to the context of HIV, but his struggle and theory of liberating people who are under the yoke of oppression finds resonance in the contemporary challenge of the HIV epidemic which leaves those infected in the LCCN in perpetual captivity. Socio-economic and political liberation of society is as important as salvation; liberation theology is grounded in the life of Christian discipleship in solidarity with the poor and the marginalized (Kurian 2001:455). HIV as will be discussed in chapter four is seen as the disease of the poor; it does not only infect the poor but those living in abject poverty are more vulnerable to the epidemic.

In corroboration to Gutierrez point of view, Boff and Clodovis explain that "liberation theology is found at the base, among the ignoble, in organic communion with the people. It has to articulate the discourse of society, of the oppressed. They hear the problems brought by the people, listen to the plight of the members of their communities and making effort at meeting their needs. The theology should not be an executive one, where theologians have the head knowledge but devoid of being in touch with the downtrodden (1987:19).

Liberation theology needs to have an open and positive relationship with the social teaching of the church. Liberation theology places itself fully in line with the requirements of the teaching of the church. A theology that is not aimed at liberating its people from any kind of bondage and void of giving hope to the depressed is not qualified to be labeled as liberation theology. Liberation Theology must be a life giving one and the church instead of passing judgement to PLWHIV must move from retribution to a life giving theologies (Hove, 2013:35). The Church and the community need to avoid its judgmental attitudes towards those infected with HIV. The church should also stop seeing the HIV infected persons as the most sinful men and women who are architects and designers of their predicaments. Hove further argues that "in order for our theological discourse to be life affirming, we must reach out and allow ourselves to look into the eyes and heart of those infected or affected by HIV; we must locate them from their hiding places of shame and disgrace and give them messages of liberation" (2013:35). Locating PLWHIV from their hiding places of shame and disgrace for the purpose of liberating them is a serious challenge the LCCN leaders and members as well must overcome.

Gutierrez' theory of theology of liberation is of relevance to this study because the theory emphasizes the imperativeness to emancipate the LCCN members who are living with HIV under the clutch of stigma and discrimination. If the LCCN must be a HIV competent church, it must ensure the liberation of its members who are in bondage of isolation and economic hardship, especially to PLWHIV. Economically, PLWHIV in the LCCN are living under the oppression of poverty. Stigma and discrimination in the LCCN has prompted many HIV infected persons to turn their homes into prisons, hence they were been ostracised by the church and the community members at large. These people need to be liberated from the shackles of this self-imprisonment and be brought out from their hiding places of shame and disgrace and give them message of liberation as stated above by Hove. For the purpose of this study, HIV and AIDS epidemic is perceived as oppressive because of the stigma and discrimination attached with the epidemiology of the disease and these impacts negatively on PLWHIV in Todi Diocese. Many who are infected with HIV cannot go to public gatherings for fear of being derogatorily laughed at. Sunderland and Shelp rightly observed that people, who discovered that they are HIV positive, often retreat into a fear-filled and threatened world, withdrawing from people to whom they have been closed (1990:88). Such people are living in bondage of sickness, financial disability and need to be urgently liberated or emancipated so they can inhale the air of freedom once again.

2.8.3 The Gaps

Literature confirms that Nigerians stigmatize so much; to my knowledge, literature does explain the causes of the resilience of stigma and how stigma is affecting people living with HIV. However, literature does not explain why Christians who are expected to love their neighbours as they love themselves and also to be their neighbour's keeper, stigmatize and discriminate against PLWHIV. Christians with the teaching of love should be leading by example to the outside world; in essence, Christian attitude towards those living with HIV is a huge setback to open disclosure of one's HIV positive status and onward treatment. Secondly, the literature defines what sex is, and the secrecy surrounding it, but does not explain how people can move away from seeing sex as a taboo in Nigeria and openly making it a topic of public discussion. Thirdly, the literature does not show why the LCCN leaders keep their distance from sexual matters and more so viewing HIV as an off-shoot of sexual misconduct which in itself continues to promote stigma and discrimination among its members. To contribute to the body of knowledge the study will seek to stimulate a

proficient Church response to HIV and AIDS health crisis by exploring the concept of sex and sexualities in the LCCN; and possibly eradicate stigma and discrimination of PLWHIV.

2.9 Conclusion

Chapter two provides the various literatures that were studied for the purpose of the research. Materials for the chapter are from published resources, internet, and the empirical knowledge of the researcher. Stigma and discrimination which is one of the leading causes of the spread of HIV in Todi Diocese was discussed. The chapter thrives to unpack the understanding of sex and sexualities from the religious viewpoint and looking at the co-relation between sex and sexualities in the context of HIV and AIDS. The modes of HIV transmission and the various safer sex methods aimed at reducing the spread of HIV were explored. The negative views the church have on condoms; Lthers attitude towards people challenged by epidemic in his time, the two theoretical frameworks, the gaps discovered were also presented and the conclusion was drawn. Chapter three will discuss the research methodology and methods employed by the study.

CHAPTER THREE

RESEARCH DESIGN, METHODOLOGY AND METHODS

3.1 Introduction

The previous chapter dealt with what the existing literature say about the prevalence of stigma and discrimination with its devastating effects. Other concepts discussed were: Sex and sexualities from the biblical context; sex and sexualities in the context of HIV and AIDS, the modes of transmission of HIV, Various methods of safer practices were discussed from the biblical point of view: Abstinence; the use of condoms; Luther's response to epidemic, the research gap and conclusion. Chapter three deals with the research design, methodology and methods employed by the study. According to Reynolds, chapter three provides direction serving as a sign post on how the study was executed (2012:112). Dawson asserts that the research methodology is the coherent group of methods that supplement one another and have the good gift to supply data and results that will have a direct reflection of the research question and suit the research purpose (2002:36). Chapter three deals with the research design, the methodology and the methods for this study.

This chapter is structured into the following sub-sections:

3.2 Research design

Kumar defines research design as a procedural strategy that is embraced by the researcher to answer questions validly, objectively, precisely and economically (2011:94). It is through research that researchers make their decisions known regarding what study design he or she proposes to use, how the researcher will collect information from respondents and how the information collected will be analysed and how the researcher will communicate his or her findings. Durrheim, et al contends that a research design could serve as a bridge between research questions and the implementation of the research. Research design provides a plan that specifies how the research is going to be executed in such a way that it answers the research question (2010:34). The function of a research design is to ensure that the data obtained enables the researcher to answer the initial question as unambiguously as possible.³⁸

³⁸ What is research Design? New York University.<http://www.nyu.edu/classes/bkg/methods/005847ch1.pdf>(Accessed on 28th 2014).

A research design is a comprehensive outline of how a study will take place. A research design will typically include how data is to be collected, what instruments will be employed, how the instruments will be used and the intended means for analysing data collected".³⁹

3.2.1 Qualitative empirical research

Empirical Research is research that is based on experimentation or observation, such research is often conducted to answer a specific question or to test a hypothesis.⁴⁰ Qualitative research does not deal with numbers, but rather deals with ‘interpretive’ social realities, and is considered ‘soft’ research (Martin, et al, 2000:7). This study will only use numbers when necessary to indicate the enormity of the epidemic. Coombes notes that, “Qualitative research often lends itself to small- scale research where the researcher is engaging in unstructured interviews, focus-group discussion, life histories and observations” (2001:30). Coombes further explains that, if the researcher is involved closely with a single or a small group of individuals in the process, one-to-one personal qualitative research helps to cultivate a good interaction and understanding of the experiences that have taken place. In a qualitative research process the researcher tries to interrelate with those the researcher studies, a relationship is fostered and personal interaction takes place. The researcher may lay their own values and biases on the information gathered (Coombes, 2001:30). Making sense of people’s experiences by interacting with them and listening carefully to what they say (epistemology), and making use of qualitative research techniques to collect and analyse information (Martin, et al, 2000:274).

Based on the above understanding of what qualitative research is all about; this study will use qualitative research. Proper consideration would be accorded to participants’ views, and cultural values that influence the construction of such multiple realities. So far no research has been conducted on this topic (Sex and sexualities in the context of HIV and AIDS) in Todi Diocese and the LCCN at large, and therefore, a qualitative study is most appropriate. Creswel substantiates this and contends that qualitative investigation is the methodology of choice when not much has been done or written on the topic being studied in a particular area, and the researcher seeks to listen to participants and build an understanding based on

³⁹ What is research design? Definition and meaning. <http://www.businessdictionary.com/definition/research-design.html>(Accessed on 28th September2014).

⁴⁰Sociological Research Methods: Empirical Research <http://guides.library.uncc.edu/c.php?g=173030&p=1143848> (Accessed on the 6th August, 2015).

their ideas and experiences (2003:30). The Qualitative research is suitable for this study because it will furnish the researcher with information relevant to the topic which needs to be unveiled and brought out to public knowledge. This method will enable the researcher to find out from the participants the reasons why stigma and discrimination are still resilient and to understand how sex and sexualities is conceptualized or understood by church members in LCCN Todi Diocese. Participants would be given due attention and build an understanding based on their views.

3.2.2 The research site and the procedures to gain access

The research is predominantly located within the four Divisions (Deaneries) of Todi Diocese. These Divisions are as follows: Benue, Kpasham, Bille and Bronnum Divisions. For easy communication and to carry every one along during the focus group discussion, two languages were used, namely: English and Hausa language. The questions which were initially in English were translated in Hausa for those who could not respond in English. The purpose was to facilitate a smooth flow of communication among all the participants. Participants were approached through different channels of communication: first of all, the Bishop (RT. Rev. Clement Dogo) was contacted telephonically to allow the researcher access to his Diocese to interact with members who are living with HIV, Youth group, Executive Council members, Pastors in the Diocese for the purpose of the study. Without hesitation, the Bishop acknowledged his profound gratitude that the researcher is doing a study in his Diocese which is the first of its kind, on the topic HIV and AIDS, the Bishop confirmed to the researcher his interest that he is glad that people will come to know what it is to show love to those infected instead of the stigma and discrimination which is causing serious challenge to the control of the virus in the Diocese “a deadly disease that is finishing my people.”

The rationale for choosing the participants aforementioned was that, the validity of the information needed from them would be more reliable and would represent the true picture of the situation on the ground. After this time, the Deans chose pastors, and Pastors on the other hand chose the participants from the parishes. The congregational leaders within the Diocese were contacted on phone who arranged for our scheduled meeting with participants. The pastors who know the capability of the executive members contacted those who were to participate in the focus group discussion. As soon as the pastors contacted those needed, arrangements were made to see the people contacted together with pastors and congregational

leaders we arranged for appropriate dates and times. The researcher and the participants encountered few challenges on some of the scheduled dates due to Boko Haram's attack in Todi Diocese which left some of the participants affected and displaced. After two weeks, when the security in the area improved, new dates were agreed upon. In fact, the researcher had to commend some of the participants who took risk on the date the participants were informed that the Boko Haram group had planned to attacked people from this geographical location, due to the limited time I had, the participants summoned courage to converge the meeting against all odds.

A research methodology in which the participants assemble together to deliberate on a specific issue with the purpose of generating data is called a focus group.⁴¹ Wong Li Ping further maintains that for any group discussion to be effective and meaningful the number of participants must be sizeable or else the discussion will lack direction.⁴² There were few who were not Christians but are in Todi Diocese who also have useful information on the topic but agreed to interact with me on individual basis so as to maintain the closure of their identity. Our time together was fruitful, just that they asked the researcher if he will be of help to them and meet them in their homes and explain what it is, because many of them were not enlightened on how the HIV spread.

The primary method of data collection in this study was the focus group discussions. However, literatures from other researchers were relied upon because the participants did not have all the information required, therefore, related literature from other sources were sought.

3.3 Research methodology

This section explains the method that is employed in carrying out this research.

3.3.1 Procedure and methods of Data Collection

3.3.1.1 Procedure of data collection

In the first place, the research question was formulated; participants of useful or relevant information needed for this study were sought. In making preliminary contacts to get in touch

⁴¹Wong Li Ping, 2008. Focus Group Discussion: a tool for health and medical research http://www.academia.edu/3326356/Focus_group_discussion_a_tool_for_health_and_medical_research(Accessed on 8th August, 2014).

⁴² Wong Li Ping, 2008. Focus Group Discussion: a tool for health and medical research http://www.academia.edu/3326356/Focus_group_discussion_a_tool_for_health_and_medical_research(Accessed on 8th August, 2014).

with the participants, two channels of communication were employed: phone calls and text messages. For the Diocese Church Executive Council Members, the pastors arranged my meetings with them. The pastors were met during the National Convention to schedule convenient dates for the group discussion. Different dates were agreed upon. Some participants who initially agreed to be part of the discussion later claimed to have no knowledge on the topic and had nothing to contribute decided to discontinue. Two other participants among pastors acknowledged that they cannot freely and openly discuss on the topic of sex and sexuality, because sex is culturally a shameful thing to talk about.

Out of fourteen participants living with HIV, six of them later decided to opt out from the discussion, leaving only eight; according to them, they were prohibited by their partners, believing that the members of the focus groups will also know about their HIV status and subsequently spread it to the church members and the community at large.

3.3.1.2 Methods of Data Collection

For the collection of data for this study, the following methods of gathering relevant information would be used: Literature review, archival study, and field research.

Analysis of Existing literature

This part of research will concentrate primarily on the existing body of knowledge found in various literatures which are related to theories and methodology (e.g. Books, journals, periodicals, newspapers, magazines, etc.). In dealing with the topic (Sex and sexualities in the context of HIV and AIDS), few libraries will be frequently used: The University of Kwa-Zulu-Natal, Lutheran Theological Institute (L.T.I), Scottsville and Pietermaritzburg.

Archival Research

The LCCN Todi Diocese archive as well as the LCCN Headquarters archive would be used to get some vital information which will help in facilitating the research. Relevant minutes and some resolutions reached on certain issues regarding policies and effort of the Church Executive Council members particularly on the effort made on eradicating or reducing stigma and discrimination of people living with HIV among its members will equally be consulted.

Field Research

The focus group for this study is appropriate since the study seeks to investigate the reason why Christians who are supposed to love their neighbours as they love themselves stigmatize and discriminate PLWHIV? In the field research, the structured questions for the focus group discussion were used. The questions were designed for all the four groups: Executive Council members, Pastors, youth groups, and HIV infected mothers and fathers. The focus group approaches accorded the researcher the true picture of the context of the study as it has created an avenue for good interaction with the participants. Some participants have given their consents to use their real names, but for ethical reasons, the researcher decided to use pseudo names viewing the topic as a sensitive one. With the consent of the participants, digital recorder was used to record their responses.

3.3.2 Tool for Data Collection

In this section, tools for data collection would be discussed.

3.3.2.1 Focus group discussion

Group discussion evolved over the past few decades, and has taken on a set of characteristics that are distinctive from other experiences. To ensure effective interaction and free flow of information, as Kumar suggests that the group should neither be too large nor too small, approximately eight to ten people (2011:127-128).

Henning corroborates Kumar's notion and adds that focus group discussion as a unique method of qualitative research that involves discussing a specific set of issues with a pre-determined group of people. The essential purpose of focus group research is to identify a range of different views around the research topic and to gain an understanding of the issues from the perspective of the participants themselves (2007:4). The aim of the focus group is not to reach a consensus on the issues discussed, but to encourage a range of responses which provide a greater understanding of the attitudes, behaviour, opinions or perceptions of participants on the research issues (Henning, 2007:4). The researcher was not seeking for an undisputed view on the subject matter but rather variety of opinions to ascertain various rationales behind stigma and discrimination of PLWHIV which is so prevalent in the research area. In focus group discussion according to Martin, et al, a debate is open and accessible to all; the issues at stake are common concerns; inequalities of status between participants are

disregarded; and the debate is based on rational discussion. The debate is an exchange of views, ideas and experiences, however emotionally and illogically expressed, but without privileging particular individuals or positions (Martin, et al, 2000:49).

Focus group discussion is vastly different from a group of people talking. The former involves a limited number of people carefully recruited to satisfy a known set of characteristics and demographics. The primary objective of a group discussion is to cover the subject matter being explored logically and comprehensively and in a manner that produces valid and replicable findings. The purpose is to gather data that contribute to information and problem solving (Foos and Blum 1986:225). PLWHIV may be living with the same infection but might have encountered different experiences; these experiences can be shared during the focus group interactions, and that will be of immense importance to the researcher for the purpose of this study.

3.3.3 Research sample and participation

Sampling refers to set of techniques for achieving representativeness. The key requirement is the sampling frame that operationalizes a population. It is a concrete list of units that are considered for selection. The aim of sampling is the understanding of the life of the respondents. This may contribute to a number of different research endeavours. It may be an end in itself, providing a ‘thick description’ of a particular social milieu or location. It can be used as a basis for generating a framework for further research; it may provide empirical data to a test expectations and hypothesis developed out of a particular theoretical perspective (Martin, et al, 2000:39).

The research sample for this study was drawn from all sections of the church, within the Diocese so as to give the general picture of the LCCN in terms of their effort in confronting the HIV epidemic. Different categories of church members were represented. Different age groups that cut across gender were also duly represented. The participants in focus group discussion emerged from different educational backgrounds, ranging from secondary school dropped out to Master’ level. The participants have different levels of exposure to the topic. While some participants viewed the topic as scaring because of its sensitive nature, others are of the opinion that the topic is needed by the youth who have difficulty in controlling their sexual urge. The levels of the participants differed due to their different backgrounds. Looking at the level of knowledge of the participants, their experiences in the church will

immensely help in explaining some of the factors responsible for the responses they gave during the focus group discussion.

The researcher has used purposive sampling coupled with snowballing (Cohen and Manion 1994:89; Browne, 2005:7) for people living with HIV. Purposive sampling will be the ideal sampling style since the researcher has a specific closed target group (Salganik and Heckathorn 2004: 200). There are support groups in some of the Divisions in the Diocese, who formed a group after several meetings in the hospital for ARVs. Potential participants were informed about the formation of a focus group as this compromises confidentiality. Participants were told about shared confidentiality within the solidarity of the group. With permission from the participants the researcher used a voice recorder to gather the data. The use of a voice recorder will ensure that the researcher captures the exact words of the discussants. The identities of the discussants were kept anonymous for ethical reasons as stipulated in the attached consent form (see appendix 2). The researcher has also made an agreement with 3 pastoral counsellors who are willing to do pastoral counselling in case there is secondary traumatization as a result of the focus group discussions (See Appendices 5a, 5b and 5c).

In this study four groups will be involved in the discussions: (1) The youth, both males and females (age: 25-40), (2) the Church Executive council members (age: 40-65); (3) the ordained Pastors (35-70) (4) people living with HIV (age: 40-60). The youth-males and females refer to the LCCN youth within Todi Diocese. The Ordained Pastors are Ministers in the LCCN who are In-charge of various Districts, Divisions and Diocese, and people living with HIV within Todi Diocese; the researcher will also interact with them for the purpose of understanding the position and experiences of the participants. The researcher in choosing Participants out of many that were presented by church leaders, few individuals were nominated, those whom the researcher thought would make good participants. Those who openly say they were not familiar with the topic or are not comfortable to participate in the discussion were relieved. Those who seemed to have useful information were selected randomly (Eliot and Associates, 2005:4).

To ensure effective interaction and free flow of information, as Kumar further suggests that the group should neither be too large nor too small, approximately eight to ten. These group discussions will be six to eight persons from each group, and 30-45 minutes will be allotted

to each group discussion. Few issues of relevance to the topic will be identified and discussed. The focus group discussion would give the participants an opportunity to speak out their minds on the topic rather than individual interviews. Looking at the relationship between the researcher and the participants who are members of the church and hold the researcher in high esteem, the participants may not want to say anything that is not in tandem with what the researcher demands if it were to be interviews. Unlike focus group, everyone is free to speak out his or her mind on the issue at hand. Therefore, the researcher considers only focus group discussion to be the best way of getting information from the respondents.

Focus Group with Ministers

The first category of my sample consisted of pastors of whom some are the Executive members of the church. In choosing participants for this group, attention was given to those who seemed to have the knowledge of the topic of discussion. The selection was therefore done randomly. Some of the pastors have attended different institutions of learning, while some have not even completed their primary school education, but went through a “Short Course”.⁴³ The choice of these Pastors was to find out from their wealth of experiences if they have any knowledge of policies on HIV and AIDS stigma and discrimination in the Diocese have ever been formulated but possibly not implemented. Among the six pastors two of them were former executive Council members who were saddled with the responsibility of making Church policies during their tenure. Some of these pastors were assumed by the researcher to be in a better position to know why stigma and discrimination against PLWHIV continues to thrive unabated. Out of the thirteen pastors chosen, three of them confided in the researcher to be HIV positive, and therefore cannot be among the participants for group discussion as their status would be made known were relieved, leaving only ten (10). This group were selected by the Deans who were in charge of various Divisions (Deaneries). Among those selected, only eight of them had Diploma in theology; the rest of them had their first Degree in theology.

⁴³ A Short Course was introduced by the General Church Council for those who have not gone to the Seminary, but have the commitment and the zeal to serve in the church. They were therefore enrolled into the short course for one year and after that they were ordained as pastors. These pastors, sometimes referred to as Seminarians as “Vernacular Pastors”

Table One: LCCN Pastors

S/N	Academic Qualifications	Gender	Ages
1	Masters	Male	45-70
2	B.Th.	Female	40-60
3	B.Th.	Male	40-60
4	DCM	Male	45-58
5	DCM	Female	45-58
6	DCM	Male	45-58

Focus Group with Youth

The second category of respondents in my sample of research was the youth in Todi Diocese who are the most vulnerable in the area of my research. The researcher must really acknowledge the fact that more time was given to the youth than other groups. The choice of these youth is to know if they have any knowledge regarding sex and sexuality, and safer-sex methods. The youth from both sexes were equally represented. Many youth participants that were presented to the researcher were not educated beyond secondary school level; therefore, those who have attended from secondary school above were selected, so they can meaningfully contribute to the subject of discussion. The group was conducted with a total number of eight youth whose ages range from ages 25-40.

Table showing distribution of Participants

Table Two: Youth group

S/N	Academic Qualifications	Gender	Ages
1	1st Degree	Female	25-40
2	1st Degree	Male	25-40
3	Certificate Course	Female	30-38
4	Certificate Course	Male	30-38
5	Certificate Course	Male	25-30
6	Secondary School	Female	25-30
7	Secondary School	Male	25-30

Focus Group with self-disclosed HIV infected Persons

Another group to be interacted with are adult members of the Church who are HIV positive. The researcher's intention is to find out how stigma and discrimination is fuelling the spread of HIV in Todi Diocese. Another reason for interaction with PLWHIV is to ascertain the kind

of assistance the church renders to them. Based on the information given by their pastors some of them were willing to make themselves available and openly disclose their HIV status without minding the stigma and discrimination attach to one's status by the society. Some of them were cautioned by their spouses especially their male counterparts for fear of being exposed to members of their various congregations of their assumption that their partners would have been definitely infected.

The researcher must acknowledged that it was not easy selecting participants in this group, the reason was that some of them who used to be assisted by the researcher, thought that those that would be selected will be given a special assistance. After much explanation, few of them understood, and from there those who can express themselves very well were selected; other infected persons later assisted the researcher in selecting those they thought can give useful information. As mentioned earlier, out of fourteen participants living with HIV, six requested to opt out for fear of being stigmatized and discriminated against. Their ages range from 40-60.

Table Three: Persons living with HIV

S/N	Academic Qualification	Gender	Ages
1	NCE	Female	40-55
2	NCE	Male	40-55
3	Secondary School	Female	40-50
4	Secondary School	Male	40-50
5	Secondary School	Female	55-60
6	Secondary School	Male	55-60
7	Diploma	Female	40-55
8	Diploma	Male	40-55

Focus Group with DEC Members

This group consists of leaders or council members of different positions: Council members from the Diocesan level, Divisional level, District and local congregational levels. The decision to interact with this group of members is to distinguish the roles they had played as policy makers who are shouldered with the responsibility of promulgating policies in the church. The seven council members that participated in the focus group discussion were men and women from different educational background. Two of them did not receive formal education to secondary school level but were very instrumental to the research discussion

because of their level of experiences for a number of years in the church. Two had their first degree in different theological colleges and one of the council members had his Master's degree in theology. Their age bracket was between 40-65 years. Three of the council members hold Diplomas in theology from Bronnum Lutheran Seminary. This group was selected by their pastors. According to the pastors, those who were selected have been in leadership position from twenty to thirty years of experience in the ministry.

Table Four: Diocese Executive Council Members

S/N	Academic Qualifications	Gender	Ages
1	Masters	Male	40-65
2	MDiv	Male	40-65
3	B.Th	Male	45-40
4	B.Th	Male	50-55
5	NCE	Female	55-60

3.4 Data analysis: Procedure and Methods of data analysis

3.4.1 Procedure of data analysis

Having described how research data was collected, the following is a discussion on the ways in which the data was analysed. According to Dane, data analysis is not only tools the researcher uses to make sense of the data gathered in a research project; proper data analysis is more than contributing to knowledge; it also involves treating other researchers ethically (1990:52). Dane further posits that doing a research is not just a formality, other scientists use our research as a basis for their contributions to knowledge; therefore, if our analyses are not correct, effort and money may be wasted by scientists when relying on them (1990:52). The scientists proffer solutions to life's challenges when proper research has been made and analysis is properly done.

The primary objective of analysis is to look for meaning of what is being researched. What is actually said is data, but the analysis goes beyond this at face value. In practical terms, analysis and interpretation require time and effort and there is no best method. Essentially they involve the researcher immersing himself or herself in the text corpus. The analysis is not a purely mechanical process; it hinges on creative insights (Martin, et al, 2000:53). The data generated from the field was reflected upon through the incorporating of other relevant materials such as literature and personal experiences in the ministry.

This research will adopt narrative analysis. In the narrative analysis, the researcher does not occupy the main discussion, but carefully paying attention with keen interest to stories and experiences of the individual participants in an effort to understand the connection between the experiences shared and their social background.⁴⁴

The qualitative study involved four focus groups discussion conducted separately. The selection of the participants was done with the assistance of the Diocesan bishop, Deans of various Divisions, Pastors and Elders of different congregations. PLWHIV who voluntarily made their HIV positive status known not only to the researcher but to the community were asked to participate in the group discussion. Transcribed data were analysed to identify the most frequently occurring themes and grouping them in the context of other information given by the respondents.

3.4.2 Methods of data analysis

The procedure of data analysis began with the coding of the field information. It was coded purposely to identify the central themes and connection between the themes that developed from the data as articulated by Westbrook who states that the coding process identifies main categories and associate sub-categories from a body of data (1994:247).

The researcher uses the descriptive method of analysis to transform data as to investigate the rationale behind stigmatization and discrimination of PLWHIV among Christians in Todi Diocese. In a descriptive study the output end of analysis can be decisive in the case that the project is seeking knowledge about a firmly defined question. In order to investigate people's lived experiences this study employs the qualitative research methodology. The descriptive method of interpreting research data was used to understand the ways people make sense of the world and human experiences and to understand the meanings people ascribe to phenomena and experiences. The descriptive method of data analysis is therefore suitable for this study over other methods.

3.5 Methodological limitations

The researcher's insider position as a member and a clergy in the LCCN connected him to the participants through a dependable and sincere social network that simplified his access and

⁴⁴ Definitions of Narrative Analysis <http://medical-dictionary.thefreedictionary.com/narrative+analysis> (Accessed on the 22nd June, 2015).

relationship with the participants. However, this insider's position has both advantages and disadvantages. Some of the disadvantages include being embarrassed that a pastor is becoming aware of their HIV positive status which was initially hidden., that is, the tendency to draw oneself closer to the participants as members of his community rather than viewing issues at hand from the perspective of an objective researcher (Reynolds 2012:106) In order to overcome this limitation, in-depth explanation of the role of a researcher was given in order to facilitate critical distance and respect for my role, not as someone "working on behalf of the church" but as a scholar seeking critical information that will contribute to knowledge as Reynolds explains (2012:106

3.6 Confidentiality and Ethical considerations

Knowing that the topic the researcher is dealing with is a sensitive one and having understood the ethical issues involved in this research, a consent letter was given to the participants to enable them make informed decision before contemplating to participate in the focus group discussions. Participants who agreed to participate were assured beyond any reasonable doubt that neither their names nor pictures would be reflected in the final document. For this reason pseudo names were chosen to ensure that the participants' identities remain anonymous. The participants' protection is outlined in a consent form, which categorically states the possibility of their voluntary withdrawal at any point in time in case they later decide to do so. The participants were also assured that their HIV status will never be disclosed even to their spouses who are unaware that their partners are HIV positive, let alone divulging the information to the public which will further aggravate their situation of being stigmatized and discriminated. The participants were given the informed consent form for them to study and sign if they agreed to participate and they were also told to feel at ease when they want to withdraw from the discussion any moment.

3.7 Conclusion

In this chapter effort was made by the researcher to highlight how the research was conducted. Chapter three discussed how the research is designed; the methodology used in conducting the research and the tools for data collection. This discussion concerns the methodology and focus group discussion. How the data analysed was presented; confidentiality and ethical consideration and then conclusion. Having discussed the methods that were used in conducting the research, the researcher now moves to chapter four where he

focuses on the cultural, socio-economic and political developments that impact on sex in relation to HIV and AIDS in Todi Diocese and consequently the presentation of data.

CHAPTER FOUR

HOW CULTURAL, SOCIO-ECONOMIC AND POLITICAL DEVELOPMENTS IMPACT ON HIV AND AIDS IN TODI DIOCESE- ADAMAWA STATE-NIGERIA

Data Presentation and Analysis

The data presented in this chapter was obtained from the focus group discussions. The focus group discussions were conducted by the researcher (Cletus Haniel Dading). The focus group discussions were conducted with the following people: the LCCN pastors in Todi Diocese, Executive Council members in Todi Diocese. Discussions were also held with those who were living with HIV and lastly the youth group in the church.

4.1 Introduction

The second objective of this study as stated above is to examine how cultural, socio-economic and political development impact on sex and sexualities in connection to HIV and AIDS in Todi Diocese.

Efforts will therefore be made to explore relevant literature on the topic to unravel how cultural, socio-economic and political development impact on sex and sexualities relating to HIV and AIDS in Nigeria and of particular interest, in Todi Diocese. Bad leadership which has climaxed on impacting negatively on the people of Todi Diocese. There is less evidence of political transformational leadership as being canvassed for during campaign propaganda. In this chapter, the researcher will discuss how Nigeria as a nation is indeed endowed with both human and natural resources and the political leadership has all it takes within its financial capability to curtail the spread of HIV through transformative programs aimed at alleviating the impoverish condition of its citizens, but due to poor governance the huge resources which are supposed to be distributed to the masses are but only in the hands of few corrupt political leaders. Effort will also be geared to ascertain the resultant effects of corruption which has plunged the citizens to untold hardship (abject poverty) and exposed them to undertakings which promote the spread of HIV. In the era of HIV and AIDS the choices that people make can sometimes have a direct bearing on the spread of HIV. Some women who are not economically stable may resort to transactional sex in order to earn a living (Parry, 2008:27).

4.2 How cultural, socio-economic and political developments impact on Sex and sexualities in the context of HIV and AIDS in Todi Diocese

4.2.1 The Impact of Cultural antecedents on sex and sexualities in the Context of HIV and AIDS

Culture is the lifestyle and the way of understanding of a particular people in a particular geographical location. This cultural lifestyle could be as a result of people who practice the same religion, speak the language, social habits or music and arts (Zimmermann, 2015). Some cultural lifestyles of some tribes in Todi Diocese through discussions were discovered to be weakening the battle against the spread of HIV.

There are negative cultural practices which need to be dealt with. Some of these cultural practices are not given considerable attention they deserved. Women due to their feminine gender where not accorded any respect when it comes to culture. Their men counterparts were seen as superior and are therefore expected to decide what ought to be done. These negative cultural practices increase exposure to HIV infection by women. Such practices include among other things: forcing young girls to undergo female genital mutilation, unhygienic male circumcision; wife inheritance and widow cleansing practices (Parry, 2008:26).

There are other cultural practices that involved skin piercing through which HIV can also be transmitted. In some tribes in the research area piercing of ears, nose and facial mark are mandatory so as to give that particular tribe a special recognition. Most at times the instruments used are not sterilized or cleaned properly as noted by Ramaiah (2008:41). Not all cultural practices have direct bearing on HIV; however, some cultural practices definitely contribute to the spread of HIV. In Todi Diocese, many tribes do not encourage circumcision in hospitals. Many children including the researcher were circumcised in a traditional way using locally made instruments which are not sterilized before using it on another person, and this practice has a high propensity of transmitting HIV infection to another person.

Similarly, Wende argues that “factors that stand against successful execution of the fight against HIV in Nigeria are cultural and religious practices. Across the country there is strong cultural and religious bias against the use of condoms for the control of HIV. Culturally, in the research area, condom is seen as a modern method of denying man not a woman the

ability to enjoy sex to the fullest. However, in the era of HIV as argued by Bongmba: Any prevention campaigns that does not include the use of condom or demonize condoms are callous, deceitful and immoral in light of the dangers that many face today in Africa (2007:28).

Question: How do cultural antecedents impact on sex and sexualitiesin the context of HIV and AIDS?

The focus group discussion in response to the above question has revealed that wife's inheritance is one of the cultural practices in some tribes in Todi Diocese that people find difficult to do away with it. A group of women stated that, *men exercise authority over us as soon as we lose our husbands. They force us to take a family member of the deceased as a husband, without raising any objection as to whether the man is promiscuous or not or else face the consequences of our action. Even if you have ten children, and you are not willing to be inherited, you will be forcibly mandated to pay the dowry your late husband had paid on you many years ago. Most of us agree to be inherited because we don't have such huge money to pay* (FGD with mothers living with HIV, 2016).

Demanding that a woman should pay for the dowry paid on her 30 or 40 years ago is a way of saying that the woman must against her wish allow herself to be inherited or suffer humiliation. The above group further contended that, *our culture demands that a woman does not object to her husband's sexual advancements. When it comes to sex men do not ask our opinion; regardless of whether we are in the mood or not, and this is why we cannot even advise them to use protective methods. Besides their forceful attitudes during sexual demands, we are warned before wedding never for any reason deny our husbands their conjugal rights* (FGD with mothers living with HIV 2016). In the discussion, the group acknowledged the role tradition plays in most communities in Todi Diocese. *It is a tradition in our tribe to caution a woman on the day of her wedding before she exchanges her marital vows with her husband either in the church or any designated place by the most elderly person in front of the house to the hearing of all family members, warning her never to voice out when her husband approaches her for sex, no matter what, she is expected to be submissive completely without grumbling. If you have any complain, you allow him to have sex first and after that you can now say what was in your mind. That is why most times we don't appreciate sex with our partners because we are dormant; they do it alone* (FGD with mothers living with HIV, 2016).

The domination of male sexuality and the objectification of women is one of the key factors justifiably responsible for male to female infection with HIV in Todi Diocese. Out of twenty seven (27) women in three focus group discussions, 21 among them were found to be exclusively house wives. Some of them who have their relatives in strategic positions in the state or local government can assist them to gain employment, but they were denied such opportunities. Unanimously, these women attest to the fact that in their culture, men believe that if women were working and earning salary, the tendency is that they will not respect their husbands any longer; they will see themselves as equal with men. *So we are forced to remain at home and be in the farm. We are relatively valuable only when our husbands were alive. When we lose our husbands to AIDS-related diseases or any life threatening illnesses no one recognizes our contributions in the family. Some of us were thrown out as a used and dumped property, not giving us any recognition in terms of property sharing* (FGD with mothers living with HIV 2016). *Our culture demands that anything women acquired in their husbands' houses belong to the family. Once the man died, no penny will be given to the women even if they agreed to be inherited. That made us miserable in the community and we become a laughing stock. We are subjected to ridicule and humiliation with some of these cultural practices targeted at diminishing the worth of a woman* (FGD with mothers living with HIV, 2016).

Women in the southern part of Nigeria are relatively accorded more dignity than women in the northern part, the reason being that women in the south are more civilized and advanced in education than their colleagues in the North (Olatunde, 2010). Another area where culture plays a leading role in exposing teenage girls to HIV infection is the early marriage which is culturally promoted by some tribes in the north, particularly in Todi Diocese. Participants assert that it is culturally disgracing to allow a girl at the age of twenty to continue to stay in the family house. The family members through their inflammatory utterances and actions will do everything possible at any slightest provocation to remind her that age is catching up with her. *The painful language our mothers use against us is, "Old woman." This will start as soon as we reached the age of 14, and worse of it all, when you are 22 years and above, you will be threatened with such provoking statement* (FGD with youth, 2016). For fear of being embarrassed publicly on daily basis, young girls struggle to get someone who will marry them to avoid those kinds of comments both from parents and neighbours. This can potentially expose young girls to HIV most especially those who do not understand anything about it.

This finds resonance in what Adeyemi said: the practice of child marriage in Nigeria (especially in the North) is so rampant which is highly supported by culture. Obviously, there are various risks associated with the practice of early marriage among female teenagers which include domestic assault, forced sexual act which intensify the susceptibility to STDs including HIV (2013). Some families do not see the necessity of girls' education in the Northern part of Nigeria. It is apparent that when girls lack education, in their illiteracy can become exposed to transactional sex without any knowledge of protection. I concur with Pete Odochie⁴⁵ when he says that, "When a girl has beauty without brains, the private parts suffer most". This is also accountable for reason many young girls in Todi Diocese who have not acquired basic knowledge of their reproductive system are more vulnerable to HIV infection than their fellow girls who are educated in the Southern part of the country (Nigeria).

The DEC members admitted that *the only way a woman can remain subjective to her husband is to be a full time house wife. Many women in this community are living in peace with their husbands because they are under the control of their husbands in all aspects. As DEC members, we will not like a situation where women would start rubbing shoulders with their husbands simply because they are either more educated or have more money than their husbands. The few of them who are civil servants in this church are really giving their husbands headaches* (DEC members, 2015). Education and financial equality among married couples are considered as culturally unacceptable. The researcher used to assume that it was lack of financial strength that has been denying women especially those who are married from going to schools, but in the course of this research the researcher has discovered that many men see their wives' education and employment as a threat to their financial control and superiority in the house.

4.2.2 How socio-economic developments impact on Sex and sexualities in the context of HIV and AIDS in Todi Diocese

Question: How does socio-economic development impacts on sex and sexualities in the context of HIV and AIDS?

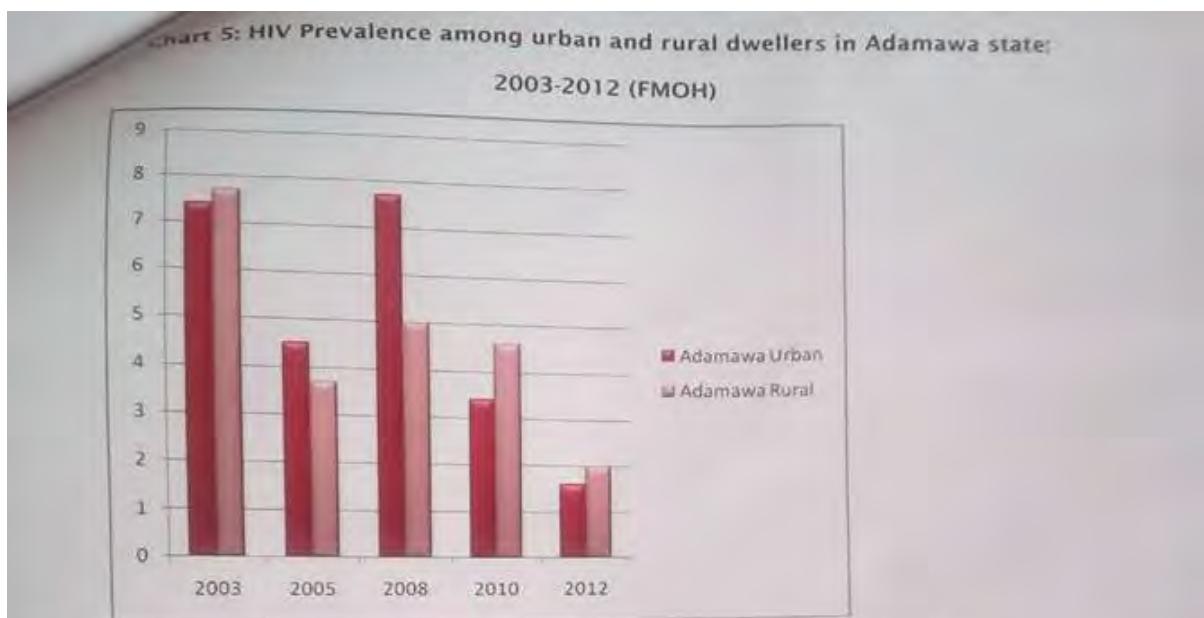
The fact that most discussions are directed towards women does not entail that women are the only ones living with HIV in Nigeria, and particularly in Todi Diocese, however, women bear the larger percentage of the epidemic. Economic hardships are sometimes orchestrated by

⁴⁵ Pete Odochie is an actor in the Nigeria's movies who said the above statement in one of his acting in Nigerian films.

political leaders which inevitably enhance the spread of HIV in Nigeria. Violence and insurgencies continue to undermine the economic stability in Adamawa state. Ochelle notes that, in some parts of Nigeria, paucity of food and other necessities of life are most prevalent due to reasons such as economic instability, insurgency and ethnicity. Adamawa state takes the third position among the 10 poorest states in Nigeria. The state has severally suffered attacks from Boko Haram terrorists and other conflicts between farmers and cattle breeders. These have in many ways hindered economic development and contributed to the state's 74.2 percent poverty rate (2015). When security of life and property is improved people will find something meaningful to do which can reduce women over dependency on men. Participants in response to the question, lamented that, the whole of 2013 and 2014, they could not go to their farms: *the Boko Haram insurgents threatened to kill anyone who flouts their instructions. And you know they do what they say, and some Boko haram members are from this village, so if you sneak out and go to the farm, the following day they come to your house and kill you. Most of us here are farmers and for two years, no one goes to his farm, this is the kind of hardship the insecurity has plunged us into* (FGD with fathers living with HIV; youth group and DEC members, 2016).

Parents who are economically vulnerable resort to sending their children to where they can find something to do which sometimes culminate into having their children infected with HIV in the course of their struggle to earn a living (Garland, 2005:143). Participants assert that *the economic instability here in Bille (One of the Divisions in Todi Diocese) has made some of our young girls to go to the cities and because they are not educated they become house helps (home managers) and are sexually assaulted most times. Out of the 21 girls who went to the city, we lost 13 of them to AIDS, and the remaining 7 we don't know if they are HIV positive or not* (FGD with Executive council members, 2016). Most rural dwellers in Todi Diocese are extremely poor and they are more vulnerable to the HIV epidemic.

Fwa in his article contends that the severity of poverty in rural areas of Adamawa state where provisions of social amenities are not given desired attention has been responsible for reasons why HIV and AIDS has taken its toll among the rural dwellers (2009). Report presented by Adamawa State agency for the Control of HIV and AIDS from the Federal Ministry of Health indicates that HIV is more prevalent in the rural areas of the state than in the urban settings (**see table 1**).



The HIV prevalence was lower in rural Adamawa in 2005 & 2008 but a prevalence reversal began in 2010 and continued.

Challenges

- Non availability of internet facilities at most levels
- Paucity of implementing partners/donors
- Insurgency has restricted all health services in Northern senatorial zone of the state.
- Health workers on strike for over 16 weeks.
- Validated HTC sites are too minimal

Recommendations

Make provision for internet facility at health facility and LACA levels
Advocacy to state executive council for more/alternative funding sources

For more information, please contact The Project Manager, HIV Program Development Project-2 Adamawa State Agency for the Control of AIDS.
Address: ADSACA, adjacent psychiatrist ward, Specialist Hospital Yola)
Tel: 07066503305
Website www.adsaca.org.ng
Email: chubadokaigama@yahoo.com
Data Sources: DHIS, HMIS, NARHS plus, FHI-360 & AHNI FT

Figure 1: HIV prevalence among rural and urban areas

The researcher has observed that some members of Todi Diocese are living in hunger and children within school ages were left roaming the street. Hunger causes young girls to engage in early sexual misconduct, and consequently get infected with HIV; those who got infected can scarcely have access to drugs.

Most of the places the researcher visited in Todi Diocese (which is typically located among the rural people), people were living in rooms without doors. The houses were not fenced even with ordinary weaved thatch. Some members of the church were found lying down sick who do not even know what the causes of their sicknesses are, let alone having access to drugs. HIV does not kill, but when people cannot have access to clean waters, and cannot afford to go for HIV testing, they can be living with HIV unknowingly and they can easily become exposed to opportunistic infections which can complicate their health conditions. The researcher concurs with Usdin when he postulates that the HIV is not found in poverty, however, there is no doubt that, as with many other diseases, poverty increases the spread of the virus. While wealthier people are not immune, the epidemic clearly follows the fault lines of poverty and social upheaval; poverty renders people more susceptible to HIV infection, unlike in the developed World (2003:34).

In most cases, it is poverty that causes one to fold his or her arms while his or her child, husband, wife and relative is dying without doing anything to salvage the situation as rightly explained by Usdin: poverty can limit people's access to HIV treatment and other necessities. In many countries, the cost of providing overpriced antiretroviral treatment would exceed the entire national health budget. Where countries have been able to bring treatment to poor people, poverty can affect the efficacy of such treatment. Many of the drugs used to combat AIDS and opportunistic infections need to be taken with food to be effective is impossible in many parts of food-scarce or famine stricken in Africa (2003:42). Some people who have access to drugs do not have food to eat before taking them. Participants asserted that *some of us always managed to collect our drugs every month, but the challenge we have is that most times we take our drugs without eating anything. In the rainy season, there are vegetables around that we can cook and eat before taking our drugs, but in the dry season, most times we take our drugs with empty stomach, most especially in March and April when there is acute shortage of food and sometimes we feel dizzy and shaky which discouraged us from taking the drugs* (FGD with mothers and fathers living with HIV, 2016).

ARVs cannot work effectively when they are always taken without food as argued by Masten: HIV drugs can quickly stop working if they are not taken properly; that is if you do not follow the food requirements, you may not have enough medication in your system to suppress HIV (2011:131). Masten was even talking about required foods, the group above

was not even talking about a particular food, but generally, cannot lay their hands on anything they can just eat to enable them take their drugs. This is one of the reasons why Oladipo argues that poverty in Nigeria accounts for 70 per cent of the reasons why PLWHIV do not adhere to their drugs; even in places where the drugs are given out free (2006). Conditions of poverty lead to poor nutrition and make people weak which hasten the rapid erosion of the immune system and consequently expose them to other illnesses, which often become chronic.

Nigeria with over 180 million is classified among countries whose citizens are living in abject poverty; the World Bank declared that over 70% population of Nigerians live under \$ 1.25 per day. The World Bank report among other things has shown that 7% of 1.2 billion people living below poverty line in the world are Nigerians (World Bank, 2014). Some of the contributing factors are the decades of military rule, mismanagement and corruption in the country, religious and political crises and structural adjustment policies (World Bank 2014).

The Adamawa state is making effort to ensure that PLWHIV have access to antiretroviral drugs, but due to the economic hardship many cannot afford to transport themselves to hospitals where drugs are given. Those who could not afford transport money to hospitals resort to borrowing drugs from their colleagues and those who did not share their drugs were characterized as uncompassionate and unchristian. It is amazing that the country which is extremely rich, yet its citizens are living from hand to mouth; struggling to have daily bread. Nigeria is a country of paradox as rightly affirmed by Obadan: “Nigeria is a country of extremes – extreme wealth on the one hand and extreme poverty on the other” (2014). Beggars are all over, in every street and high ways soliciting for food. Poverty is glaringly seen on the faces of people as they move around unchallenged by the political leaders. Campaign slogans are not translated into stringent measures in combating poverty by dealing with corruption. Ugwu was right in his assessment that poverty walks in the street of Nigeria with impunity, giving people plate number on their foreheads (2014).

As the researcher has earlier pointed out, economic hardship has brought the emergence of the Boko Haram which is today one of the groups spreading HIV in the northern part of Nigeria, especially in Adamawa state. Anadozie postulates that the rates of Boko Haram in the Northern part of Nigeria are directly attributed to poverty (2005). Young girls who were abducted and never had sex before were infected with HIV. There were several reports where the Boko Haram insurgents were tested HIV positive. This indicates that those girls and

women who were forced to have indiscriminate sex with the insurgents were possibly exposed to HIV. With various crises in Adamawa state ranging from ethnic, religious, cattle owners and farmers and scores of others, people are continued to be rendered homeless, winning the battle against the spread of HIV would be a hallucination. Some faults may be attributed to the masses; however, the negligent on the part of government is disgusting.

Women who were abducted and sexually assaulted by Boko Haram insurgents have reported how they were raped and roughly handled by their assailants. They were threatened with knife and guns to have sex with them, which they had no option but succumb to their illicit demands. They were said to have been reduced to nothing more than “sex machine” for their daily abuse.⁴⁶ Many of the girls abducted had traumatic experiences in the hands of their abductors and were consequently infected with HIV. For those who were fortunate to escape from the insurgents found themselves in different camps and were infected with HIV. The insurgencies have contributed in making the battle against HIV difficult in Northern part of the country as rightly argued by Dongel who describes the insurgency in the Northern region as unfortunate and calls for urgent attention from the government to ensure that such menace does not rear its ugly face in the future when finally tackled, but if nothing is done quickly, in the next ten years the Boko Haram menace will be a child play and the HIV infection will be worse in Adamawa state (2015).

4.2.3 The impact of political development on sex and sexualities in the context of HIV and AIDS

Question: How does political development impacts on sex and sexualities in the context of HIV and AIDS?

When there is political disorder in any nation, there is likelihood that the masses would be negatively affected, both socially and economically. In Nigeria, the incessant political upheavals portray the economy of the country in a bad shape. As a result of crisis, people migrate to different places in search of peace and tranquillity. The political unrest in Nigeria has caused a lot of backwardness to the economy of the nation which has directly impacted negatively on sex and sexualities in the context of HIV and AIDS.

⁴⁶ Boko Haram in Nigeria: Women describe being 'sex machines' for Islamist captors
<http://www.ibtimes.co.uk/boko-haram-nigeria-women-describe-being-sex-machines-by-islamist-captors-1500247> (Accessed on the 14th November, 2015).

Beyond the tragic loss of lives, terrorism took a staggering economic toll on Nigeria. In 2013 it was estimated that terrorism cost the Nigerian economy US\$28.48 billion—a number that has likely increased in light of the escalation of the ferocity of attacks in 2014.⁴⁷ If this 28.48 billion US \$ was translated into Nigerian currency, it amounts to huge amount of money that could have improved the impoverish life conditions of the citizens.

The fight against HIV demands political transformation and courageous leadership in Nigeria. African states including Nigeria need leadership at the presidential, Senatorial, Ministerial levels to harness their synergy to wage war against the spread of the HIV epidemic. HIV is a health crisis and a threat to human development. According to Bongmba, political leaders especially in Africa should act decisively to reverse cultural norms that continue to place the lives of so many people especially women at risk. The Battle against the spread of the epidemic is more than World AIDS Day Speeches (2007:33). Political transformation in Nigeria holds one of the keys to the successful battle against the spread of HIV. There is an estimated 2.200 million children orphaned by AIDS in Nigeria (UNAIDS 2012). Development will be adversely challenged when the citizens of any nation lose their parents to such an alarming rate, who are supposed to educate them. The country's young, talented and intelligent citizens are enormously dying of AIDS and the government seems not to be doing enough to reverse the trend. Political leaders in Nigeria are more of making propaganda than doing what they promised the citizens simply because they are canvassing for votes. The researcher will like to discuss below how corruption impact on HIV in Nigeria.

4.2.4 The Impact of Corruption on the spread of HIV epidemic in Nigeria, particularly in Todi Diocese

Corruption is defined by Oxford Advanced Learners' Dictionary as dishonest or fraudulent conducts by those in power, typically involving bribery and misappropriation of public resources.⁴⁸ If there is one thing that Nigeria needs to fight with all enthusiasm to pave ways for development is the monster of corruption. Any political leadership class of a country that embraces corruption, and its politicians accept corruption as a way of life, it becomes difficult for it to act positively to the benefit of the state and its citizens (Ogbeidi 2012:2). Several

⁴⁷ See: <http://www.vanguardngr.com/2015/05/buhari-youth-frustration-escalating-threat-of-boko-haram/#sthash.sA8btetg.dpuf> (Accessed on the 16th June, 2015).

⁴⁸ Oxford Advanced Learners' Dictionary. <http://www.oxforddictionaries.com/definition/english/corruption> (Accessed on the 3rd June, 2015).

administrations at different times came with a slogan of bringing corruption to its knees; nevertheless, the monster of corruption continues to infiltrate the country unrestrained (Daily News Paper 2014). The researcher observes that there will be drastic reduction of poverty in Nigeria; if political leaders succeed in dealing with corruption, Nigeria would be a good place to live in. The jobs are there, money to pay workers is there, Nigeria with the highest population in the continent is not lacking in manpower, and more importantly, Nigeria has intellectual people who have the intelligence to make this country like western countries, but corruption is killing its citizens.

Corruption and mismanagement by a number of government functionaries and individuals has contributed to the problem of economic challenges in Nigeria. Most Nigerian presidents often blame their predecessor and successors, seeing nothing bad with the way they had governed the country. Eight years of Olusegun's administration, if concrete effort was made to tackle corruption in the country, his successor (Jonathan) whom he blamed for corruption in the country would have built on the legacy he had left on ground.

Corruption at the national level has spread its tentacles to almost all parts of the country. Health workers are not left out when it comes to corrupt practices. Participants who are also health workers revealed that *our senior officers are so corrupt that even anti-retroviral drugs that were meant for ordinary people were diverted to their private clinics, leaving the patients in perpetual hardship. They also made us to become pilfers, when they instructed us to take these drugs to their clinics; we also divert some of the products to help our immediate family members living with HIV* (FGD with youth, 2016). Badeson attests to the fact that some health workers in Adamawa state are using government drugs and hospital equipment for private purposes: it is not an exaggeration to say that most of the workers in hospitals and dispensaries who have access to drugs help themselves regularly to liberal quantities which they take home for their private use and for sale to their family members at cheaper rates, and this made HIV treatment in Adamawa state inaccessible to many people (2013:123). When the government fails to tackle corrupt practices in the country, it should therefore braze itself for more spread of HIV in the country and also restive Nigerians due to poverty, malnutrition, and starvation.

Corruption in Nigeria is not limited to money alone, even the drugs meant for patients are diverted for self-aggrandizement. Participants describe doctors in Adamawa state as people

that lack compassion. They contended that, many health workers show indifference to the plight of PLWHIV; they have their private clinics where they spend most of their time, leaving patients who could not afford their exorbitant and skyrocketing bills for treatment to wait under the scorching sun and rains for hours without being attended to, while they spend 80 percent of their time to their business enterprises. The most painful aspect of it is that medications that were meant for people who are less privilege are stolen and transferred to their private clinics. They refer patients to their private clinics for treatment from the same drugs allocated from the public hospitals to their own (FGD with fathers living with HIV, 2016).

Corruption has a way of discouraging health workers to seek for the common good of the common people on the street. Paying extra charges to have medications which were originally meant for the people becomes the tradition in Adamawa state and the resultant effect is social inequality and widened gap between the less privilege and the wealthy. The drugs were diverted to private clinics and attention (time) is not given to patients. According to Badeson, some workers from health sectors in Adamawa state are using government time for private use. It is common knowledge that in many departments, especially technical departments, officials report in the morning and a few minutes later, they disappear to pursue their private businesses; they sometimes leave messages behind that they have gone on inspection. Leaving the hospitals with government's drugs and equipment meant for the public to their private clinics with their charges beyond the reach of the poor masses (2013:124). Nigeria lacks leaders with strong political will to be able to fight the monster of corruption in the country. It is evident that the six years of President Jonathan's administration, little effort was made to tackle the issue of corruption. It is a heart-breaking situation that the president who ruled the country for six years could not do anything about corruption, but was still promising that when he was re-elected for another four years; he will ensure that corruption would become the thing of the past in the country.

Maduka argues that Nigerian government cannot devote its resources to assist its citizens who are living with HIV. This shows the extent of poverty the people are subjected to in the rural areas. The debt issue has made it impossible for the nation to address issues such as HIV and AIDS and other related problems. This has contributed to the high mortality rate in the rural areas" (2002:22). Rural people as opined by Maduka, feel the brunt of corruption in the country which has reduced many people in Todi Diocese to untold hardship. Participants vent

their anger over the financial misconduct and misappropriation of funds that were meant to cushion the effects of the plight of PLWHIV. *We wished that the children of those who take advantage of our plight to enrich themselves with money designated to assuage the conditions of PLWHIV will have their children infected with HIV so that their fathers would know the kind of pains we are going through* (FGD with fathers living with HIV, 2016).

The participants' mentioned above were referring to the incidence of corruption and mismanagement of funds that occurred in Kogi state where 78 million naira that was donated by the World Bank to stem the HIV epidemic was misappropriated by people who claimed to be working for the health improvement of those living with HIV.⁴⁹ This corrupt incidence was not peculiar to Kogi state, but in other parts of Nigeria as well. This report tallies with McCain's assertion that the devastating spread of HIV is generating a lot of compassion in the international community toward Africa and a great desire to help. Foreign government, the United Nations, NGOs, Foundations, Churches and Christian mission groups and even private individuals are investing huge amounts of money, into the battle against HIV. Unfortunately, wherever there is money, there are greedy people who are more interested in the money than they are in the purpose for which the money has been given. This is certainly the case with AIDS battle. Many NGOs have been created because people see opportunities to make money; unfortunately, we have AIDS mercenaries-those in the AIDS battle for the money (2008:174).

Perhaps one of the most serious responsibilities of the media is to be the watch dog over the funds that are being used to fight HIV as McCain further suggested that the Media Organisations should commit full time reporters to investigate NGOs and government agencies and even religious organisations involved in AIDS work. They should expose those organizations and individuals who are just skimming the money off the top without really making the difference in the battle; if the media fails to expose these people, who is going to do it (2008:174)? Participants revealed that, even among the HIV positive persons who were opportune to work with World Bank in

⁴⁹ See: <http://www.vanguardngr.com/2014/07/kogi-aids-agency-crisis-n78m-world-bank-grant> (Accessed on 6th September, 2014).

Adamawa state were also corrupt. The kinds of expensive cars they drive signify that they are not clean from corrupt practices (FGD with fathers living with HIV, 2016).

Those living with HIV and were employed by the World Bank in the state are not also helping matters; they give people the impression that having HIV is an invitation to riches. The monster of corruption will hardly be dealt with because corruption is celebrated in Nigeria in public even after the culprits were convicted. The fundamental reason is that most Nigerians worship material success whichever way it was acquired. Badeson reports a scenario where a Nigerian was once jailed in Britain on charges of corruption, on returning home after his jail term, he called an all-night party at his residence and the venue was congested and jam parked with friends and well-wishers who throng his residence to felicitate with him for his release (Badeson 2013:128).

In a civilized society where the sense of values is not misplaced, such an ex-convict would hardly dare show his face in the public arena, let alone call a party, and if he did, no decent person will turn up as a guest, but in Nigeria, you become a celebrity instead. If the battle against HIV is to be initiated and sustained by political leaders, they must do everything possible to ensure that corruption and corrupt leaders are decisively dealt with, otherwise, the less privilege who are struggling to earn a living will resort to any means available which may plunge some of them into sexual activity culminating into HIV infection.

4.2.5 Unemployment: The machinery that perpetuates poverty and facilitates the spread of HIV in Nigeria

Unemployment in Nigeria is occasioned by corruption. Corruption in the country has led many citizens who are qualified to be employed roaming about the street with their certificate without any meaningful job to do, simply because the resources are not available, because they are in the hands of the few rich Nigerians. Unemployment is, therefore, (as stated above) is a branch of corruption. Unemployment has become a serious challenge in the country. The unemployed citizens who are struggling to make ends meet have chosen to engage in commercial sex which in itself fuels the spread of HIV. All political propaganda by political officials to transform the course of the nation by creating employment has not yielded any fruitful result. Njidda points out that, Adamawa state has recorded over 75 per cent of unemployment (2009). This means that only 25% of the citizens are employed.

With 75% of unemployed citizens which of course mostly are youth, there is indication that such people may possibly settle down for any means of livelihood, legitimate or illegitimate including prostitution. See below how Nigerian youth are losing their lives in a struggle to gain employment when there is announcement on recruitment in the country:



Figure 1: Seven people were reported to have lost their lives during the stampede.⁵⁰

This mammoth crowd will continue to increase daily and every administration that comes pays lip service to the challenge and does not give it the attention it deserves. Both Presidential and Gubernatorial candidates take advantage of the unemployment in the country to campaign for votes, as soon as the elections are over; no thoughtfulness is given to the vows they have taken with the Holy Bible and Quran; manifestoes are not translated to manifestations. Egbulem says unemployment and poverty affects PLWHIV, the ability to undertake routine tests, eat good food and transporting themselves to care centres become unbearable (2006). Most students today in Nigeria do not know their fate after completing their studies, unlike in the past when employment awaited students who were about to graduate. Men unlike their female counterparts struggle to make a living through menial jobs available, but the females who can hardly engage in hard labour, resort to commercialization of sex or sexual transactions to earn a living, which eventually land them into being infected with HIV.

⁵⁰ Immigrations Recruitment: 7 feared dead in stampede in Abuja <https://www.naij.com/61885.html> (Accessed on the 18th January, 2016).

It has been established that half of Nigerian women are unemployed and in their effort to provide for their children could drive women living with HIV into sexual undertakings to source for money and this could enhance the spread of HIV to other people (Attah, 2014). The Nigerian government is not sensitive to the yearning of its masses; Instead of the government making massive employments for its graduates, alternatively it resorts to purchasing sophisticated weapons to fight these youths who have no other means of livelihood and were ensnared to engage into sexual activities. Udoh rightly asserts that women who go to the city to find employment after sometimes return to their rural communities and become agents of HIV transmission to their sex partners (2009). This could be one of the reasons rural areas are most infected and affected with the HIV epidemic.

Investigations have revealed that, due to endemic corruption, employments are not available to those who deserve them. Participants in response to the above question: how does socio-economic development impact on sexualities asserted that *for those of us (graduates) who are looking for employment, different demands are made from our employers: severally, we would be asked to give a huge sum of money (which we cannot afford) to facilitate our instant employment, and the amount is dependent upon what kind of job one is looking for. More than three times, some of us were sent away, simply because we don't have the amount we were asked to give* (FGD with youth, 2016). Corruption is so conspicuous that even those who are not working, money is still demanded from their hands to secure jobs for them, and it is not a guarantee that paying for job will be automatically translated into getting the job which was paid for.

Demanding sex from female applicants before employment has become a recurrent decimal and is particularly prevalent among the middle ranks of the public service, this always occur among young girls who are willing to have sex with their employers purposely to gain employment. Most times these young girls are used and dumped. In this regard other participants argue that women, who are fortunate to be beautiful, become sexual tools in the hands of big officers, most especially in the police force and other law enforcement agencies. The females are requested to submit to the sexual advancements from those who are saddle with the duty to give them employment. Those considered to be ‘repulsive’ are on their part demanded to pay a sum of money like their male counterparts (FGD with mothers living with HIV 2016). This is the kind of suffering that young graduates are subjected to in the state and the country at large which led so many of them to seek the easier way (commercialization of

sex) to push life forward. There are quite a number of ladies, who passed through vigorous study but became immaterial to the government and end up becoming HIV infected by seeking the alternative means of earning a living.

The researcher is not in any way justifying the nefarious activities of the insurgents and the commercial sex workers, but arguing that the resultant effect of unemployment which is the off-shoot of corruption breeds poverty and made criminality and sex selling inevitable. Nguvughar concedes that “The actions of some people cannot be justified, because they had other alternatives which they refused to explore. They are not the only poor people. Many people are poorer than them but have not taken to criminal or promiscuous behaviour or vices because they are contented” (2004). How can one become content? Can one be content with nothing? I see contentment to mean managing the little you have. But in the case where one has nothing to live on, it is a difficult situation one will not expect his daughter or son to experience.

The government owes these youths a duty to ensure that employments are provided to them so as to engage them. The resources that are supposed to be used to employ the citizens and purchase drugs for those infected with HIV are used to procure weapons to fight the unemployed youth. Asante corroborates this and opines that, a high percentage, i.e., about 40 per cent of the total budgets of African States including Nigeria are spent on Arms manufactured in the developed world. These arms are hardly used against outside enemies, primarily; these arms are used to fight within the boundaries of our own countries (2000:20). Similarly, Frank explains that “the seizure of a combined sum of \$15million (about N2.43billion) by the South African to purchase weapons to fight the youth in Nigeria, mostly who are not on the pay roll by the government shows the type of political administration that we are unfortunately saddled with as a nation (2014). In a nutshell, unemployment breeds poverty and consequently insurgency and other criminal activities, and HIV thrive more where poverty hit most. The National Council for International Health examines that “poverty does not just affect the controlling of HIV in Nigeria; poverty is the second cousin of HIV infection” (2006). The spread of HIV cannot decline when unemployment continues to ascend disproportionately.

In all this, where is the prophetic voice of the church? If the church which ought to be the conscience of the society particularly, the political leaders cannot rebuke some of these social

ills then it has failed in its God-given responsibility in the society as stated by Gennrich: another area in which the church needs to become more vocal and more active is in the area of poverty and unemployment, by being vocal about government policies and misspending. But of course, we as Christians need to examine our own spending habits and priorities (2004:59). An adage says, “He who goes to equity must go with clean hands.” The church will find it difficult to challenge the excesses of government on non-people oriented projects if it is guilty of the same offence.

4.3 The link between poverty and the spread of HIV in Nigeria

The spread of HIV is inextricably linked to poverty as stated earlier. Certainly, the virus is not transmitted by poverty, but poverty plays a major role in spreading it. Rightly observed by Magezi, poverty is likely to top the list of factors that cause HIV in sub-Saharan Africa. But if one is asked “How?” “Why?” then one may be less certain. It is undoubtedly true that poverty and HIV and AIDS are closely linked, but the challenge lies in delineating the link/relationship (2007:49).

As explicitly explained in chapter six, due to poverty, couple with ignorance, sharing drugs in Nigeria, particularly in the area of my research is so common to the extent that any drugs can serve any medical purpose. Participants asserted that, *here in this community we cannot go to hospital every month because we are not salary earners and we don't differentiate drugs, we have one person here (name withheld), who is our saviour. He buys plenty of drugs (not antiretroviral drugs) and keeps for us, when we have health challenge, he helps us. We use a particular drug for all diseases. When we are in pains we go to him and he gives us drugs on credit which we pay with interest after harvesting our crops, we do not have the knowledge to verify whether the drugs are expired and harmful* (FGD with mothers living with HIV, 2016). This is hazardous when people don't even know the name of particular drugs they are given and this is the reason why some of them have various health complications for taking drugs not related to their illnesses.

The researcher observes that, when people are financially self-determining, in most cases, they have alternative to sexual life. However, those who are economically defenceless are sometimes lured into unprotected sex for pecuniary reasons. A group of mothers living with HIV argued that, it takes the grace of God for a married woman, who cannot raise 100 naira a

week, and here comes a man who gives her 5.000 naira⁵¹; it will be hard to counterattack the same man when he demands for sex. What usually comes to mind is ‘after all, no one is perfect’. Before you know it you find yourself doing what you never intended doing; *some of us, as soon as we get married, it will be difficult for our husbands to give us 2000 naira unlike prior to our marriage. We are aware that no one is above temptation, however, a woman who has money for her upkeep, will hardly be lured by any man especially for financial reason* (FGD with mothers living with HIV, 2016). When people are poor and have no means of livelihood, they can be vulnerable to temptation. It is not only the poor that are lured to temptation; the rich in the society are also tempted. However, those who are financially independent, even when they are tempted can choose to negotiate for safer sex, unless they have chosen to do otherwise, but this choice would be very difficult to a poor woman out there in the village.

It is not within the scope of this research to provide a full examination of the causes of poverty. Rather the researcher would like to undertake an overview of how human designed poverty plunges many Nigerians into illicit and unprotected sex, exposing them to HIV infection. In many communities in Nigeria, poverty has eaten away the defences of many families, leaving them open to HIV and all its suffering (Garland 2003:130).

As noted earlier, one of the challenges faced by PLWHIV in Todi Diocese is their inability to adhere strictly to the rules of taking their drugs consistently. In most cases, poverty is responsible for this attitude, for many do not know the implication of skipping their daily drugs. For those who know the implications but are financially handicapped, there is nothing they can do about it. McCain warns of the danger to skip taking the drugs as scheduled and prescribed by medical personnel: Because of the tendency toward developing resistance, the experts insist that the anti-retroviral drugs be taken according to a very rigid schedule. If this schedule is not followed carefully, the disease will develop resistance more quickly. If a person takes the medicine only every other day rather than every day, the medicine will be only partially effective and this will allow the disease to adapt and develop resistance. If this person, who has developed a drug- resistant form of HIV, infects another person, the new person is infected with the latest resistant form of the virus. This is one of the reasons that

⁵¹ 1 US dollar is equal to 380 naira. Therefore, 5.000 Naira is equal to 13 US dollars.

medical scientists are not optimistic that they will create either a cure or a vaccine for the disease in the near future (2008:238).

Most participants living with HIV in various groups admitted that there are times they can stay for more than four months without drugs. They assert that, *most of us take our ARVs from December to April. During December period our sons and daughters who come for Christmas celebration from cities give us money to buy the drugs in December and January. February is the period we harvest our crops, we therefore buy drugs in February and March, sometimes to May, depending on how good the harvest is; from June to November we live on the generosity of people around* (FGD with mothers living with HIV, 2016). These are some of the reasons, ARVs cannot work effectively among some church members in Todi Diocese because they are taken occasionally and the health of the patients will continue to deteriorate.

Upson rightly said that, at best ARVs prolong the life of PLWHIV. At worst, if started and stopped, the client may develop resistance that will make it difficult for an HIV patient to find a regimen of drugs that suit him or her in the future (2004:23). But this is what poverty is doing to people in Todi Diocese who for financial reasons cannot adhere strictly to their drugs. Where they managed to get drugs, getting the required food is a challenge faced by PLWHIV. The reality of poverty, misery, and exploitation in the life of the vast majority of Nigerian people doubtlessly constitutes the most radical challenge to the HIV epidemic. It cannot be denied that poverty is a growing problem that is posing serious challenges to the members of Todi Diocese living with HIV. The Nigerian situation resonates with Dube's argument that "poverty is the chief cause of HIV epidemic (2008:52). In the same manner, Sunter corroborates Dube and asserts that one cannot say emphatically that HIV is a disease of poverty, although poverty undoubtedly helps drive the epidemic (2000:91).

Despite the fact that HIV has begun to stabilize in the western world and other parts of the developing world, the epidemic has continued to ravage people who live from hand to mouth in Todi Diocese. Poverty is a factor that promotes the spread of HIV, because it pushes one to engage in risk behaviours leading to the contraction of HIV (Magezi, 2007:59). Sometimes the researcher doubts if people go into prostitution simply for the fun of it. The researcher observes that poverty is chiefly responsible for sex work in Todi Diocese. When I was doing my Masters of theology in TCNN- Jos in 2007, I was made the leader of Hotel Evangelism.

A lady who was staying in the hotel for commercial sex told our group that “I hate to be here, but I have no alternative means of livelihood. Only today, 12 men had sex with me, given me 200 naira each, all in all I got today 1200 naira (see the dollar equivalent to naira above) and all of them refused to use condom” (Josphine, 2007). Josphine (not real name) later gave her life to Christ and was going from one church to another, without being ashamed to warn girls of the danger involved in sex work, because according to her, those who live wayward lives will hardly live long which she later realized (Josphine, 2007). Having sex with 12 men in one day, this opened the researcher’s eyes when McCain points out that “in the Jos⁵² area 11.3% of the adults in cities are HIV positive and 5.7% of the adults in rural areas in some parts of Nigeria, particularly in Jos are HIV positive. That means that one out of every ten adults you see on the street of Jos is HIV positive and will die within a few years without a medical breakthrough or supernatural miracle” (2008:163).

Gomwalk concurs that “Plateau state has been classified among states in the ‘hot zone’ of HIV infections” (2012). My concern about Plateau is that, the state serves as the Headquarters of all the Middle belt states with conducive whether, where people mostly from Adamawa state go to for one thing or the other. Many indigenes of Adamawa state seek admission in various schools in Plateau state as I did and many others and quite a number of Adamawa people do work in the state. The possibility of people getting infected with HIV and taking it back home is high.

Another phenomenon that causes poverty is the prolong illness caused by AIDS in Todi Diocese where the little money that the family has is spent on the patient to secure drugs. Participants affirmed that, their families are now in debt, because they had spent all their resources and at the end they lost their loved ones. And worst of it all, when the health conditions of their family members become severe, they could not go to farm throughout the season, some of them now live at the mercy of their relatives (FGD with mothers living with HIV, 2016). Most at times after the family had expended all its resources to save their family members the patients will eventually die and the cost of burial arrangement in Todi Diocese is expensive most especially if the patient dies in the hospital far away from home. The cost

⁵² Jos is the Capital of Plateau State, one of the 36 states in Nigeria, situated in Northern part of the country. Jos is the only state in the northern part of Nigeria that has a favourable whether without the use of Air-conditioner, where people mostly from Adamawa go for retreat, vacation and other programs. From Jos to Adamawa state is 522 kilometres. If 1 out of 10 adults in Jos is infected with HIV as opined by McCain, then, there is every likelihood that the neighbouring states will not be spared from contracting this virus from those who troop in from other parts of the country.

of transportation alone is expensive and after the committal, family members are prohibited to go about their normal occupation, sometimes for three weeks depending on how closed the deceased was to the family. When this occurred in the rainy season during the planting period, then the family is left with no option than to stay at home and mourn their loved ones. This can impoverish the family for the whole year.

Because of poverty, parents may not have the resources to take care of their children. They sometimes push their young girls into marriage. When the marriage proposals come, the parent may not seriously consider whether the man is suitable to marry their daughter or not. They may not investigate his background but are just glad to have him take responsibility for their daughter because it means one less mouth to feed in an already poor family; the girl may go into marriage where the man is already infected by HIV (Garland, 2005:145). As poverty continues to soar high in Adamawa state, many parents give their daughters away to a man who does not have money to pay the bride price immediately. Poverty in Adamawa state has caused what I describe as exploitation and selling of young girls as Dube points out: “many young girls in many parts of the world are exploited because of their gender and abject poverty they are sold into sexual slavery (2008:23).

Participants in focus group discussion with mothers asserted that the birth of a baby girl in the family is more welcomed than the baby boy. When a baby girl is born, we joyfully say that Bisapdikwane di petarem buwai⁵³, but for a male child, sometimes we don’t know what he will become. When he graduates and he is unfortunately not employed, he may resort to becoming armed robber and get killed; but young girls are more disciplined and they are more sympathetic to their parents than boys even when they grow up and become responsible, once they get married, they care about their immediate family members. We don’t even want to know anything about the HIV status of these young men who want to marry our daughters (FGD with both mothers and fathers living with HIV, 2016).

⁵³ Bisapdikwane is money paid by a young man in Mayah land, when a girl is engaged to the young man. This is the only money given to the Mother-in-law which is 5000 to 10,000 naira. This money is given in preparation for the wedding. While for the father-in-law, the husband to be has to organize about 30-50 young men and women, who will go to the father-in-law’s farm for about two three times in a year, as long as they remain in courtship. This farming by the son-in-law to-be gives the family a bumper harvest. For this reason parents in some communities prefer girl children than boys.

4.4 The Socio-economic Impact of Poverty on Women and Children in Todi Diocese

The socio-economic powerlessness of women in Todi Diocese renders them helpless in terms of self-defence to HIV vulnerability and other infectious diseases from their sexual partners. According to Atere, Women subservience can contribute negatively to women's health and this also has the possibility of affecting the unborn baby if the woman is pregnant (2000:22). Furthermore, Atere observes that Nigerian children have poor health much worse than in most other African countries due to malnutrition and these results to wasting and stunting. The widespread subordination and powerlessness of women is another channel that spreads HIV (2000:57).

The effects of poverty on women include low self-esteem, inequality, ignorance, illiteracy, poor health, and poor nutrition among other things. It has been observed that poverty in women usually result in higher birth rates and the physical and social under-development of their children. Thus malnutrition, infectious diseases, and lack of education, rob hundreds of millions of opportunity to develop their human potential. The world is therefore, denied the vast social and economic contributions of the women (Atere 2000:57). Empirically, Research has revealed that so many women in Todi Diocese do not deliver their children in the hospital, because they cannot afford the medical bills. According to participants, ***90% of our women here in Bali give birth at home. There is an old woman called Nyonnigilimang⁵⁴ who specializes in midwifery. We don't know what will happen to our women, when she dies. Presently, she has advanced in age, so we hope God will provide another woman who will continue to help our daughters during delivery*** (FGD with mothers living with HIV, 2016). The researcher argues that this is one of the reasons accountable for many children in Todi Diocese who are continually born HIV positive during primitive way of delivering them, and poverty is seen to be the driving force. Nyonnigilimang has gained popularity due to poverty in the area; because people cannot afford to go to public hospitals. The traditional midwifery (Nyonigilimang) has no knowledge of HIV, let alone ascertaining the number of women who might have given birth to HIV infected children in her home.

⁵⁴ Nyonnigilimmang, means, 'Hand it over to me'. When a woman is in labour, they will send a bike man to go and take her to Nyonnigilimmang. As soon as she comes, even those who have evil intention in causing any harm to the mother or the unborn child will no longer have access to them. The few who are educated and also have money are the ones who go to hospital to deliver.

In Todi Diocese, poverty bites more on women than men. Women are not allowed to be financially independent to run business outfits or have personal farm besides their husbands', as that would be viewed by the community as not being subjective to her husband. Where few women were privileged to be civil servants, mere allegation of being into extra- marital affairs can easily lead to their withdrawal from their jobs without following due procedures. This made women to be over dependent on men for almost everything and that potentially diminishes their financial strength and makes them beggars on the streets. Many of the HIV infected persons who could not participate in the group discussions were visiting the researcher to justify the reason why they cannot afford to go to hospitals and could not continue with their treatment because of financial reason. Some of them are widows and live in rooms that do not even have doors. If one cannot afford \$2 in a month it is noticeable that the level of poverty on the people is agonising. Poverty often induces many women within the Diocese to resort to health care in the African way. It is not because they do not want to go to the hospital but insufficient funds make them to consider the traditional African health care as a viable alternative, because it is what they can afford.

Some traditional healers are taking excessive benefit of the impoverish condition of LCCN members in the Diocese to convince them of their power to cure HIV. A man is believed in one of the villages (Gada) in Todi Diocese to be curing those with HIV, but no one has ever been confirmed to be treated and cured as many are still on drugs for years. Because of the intense poverty in the village many women living with HIV and children are still patronizing him in large number. According to participants, *this man has finished all our chickens, anytime we are going for drugs, he demands that we go with one chicken and without a chicken; he does not give you any herb. We have been receiving treatment from the native doctor in the village because we don't have money to be travelling to Numan for drugs and the man who treat us only collect little amount of money from us every month with a chicken* (FGD with Mothers living with HIV, 2016). A lot of women who as a result of poverty and cannot afford to go to hospitals resort to getting alternative medications from people around who claim to have solutions to HIV, but at the end make them more traumatized and miserable. The role of traditional healers cannot be unappreciated. In their own little way, they are making positive impact in treating people living with HIV, but should not be placed over and above the medical experts who were trained to treat various diseases. The researcher cannot dispute the fact that some of their medicines heal the HIV patients either physically (by reducing their pains) or psychologically (emotional stability),

but to claim of total cure from the virus is where the researcher has a point of departure with the traditional healers.

It has been pointed out that four out of every five PLWHIV patronize traditional healers and use traditional treatments. It will not be ideal to create unnecessary animosity between both the modern and the traditional way of treating PLWHIV, but should be encouraged to harness their synergy in combating the spread of HIV, while continuing to advocate for improved access to western medicines and treatment (Sniddle and Welsh, 2001:49). If traditional and medical experts are working towards the same goal of finding a lasting solution to the HIV epidemic, there shouldn't be any reason of denying those treated by the traditional health practitioners to go for scientific verification after claiming that the person infected is completely cured from the HIV infection.

Boys and girls at school age got struck by the menace of HIV in Todi Diocese and were withdrawn to hawk on the highways and streets for the sustenance of the family. Those who managed to go to schools were forced to stay at home on market days to peddle goods, even if the market days fall on the days the schools have examinations. Poverty makes children hawk on the streets to support their parents in the quest for survival with some negative effects on these children. Most streets in Nigeria are littered with children who are supposed to be in schools, but their parents who cannot afford to pay their fees engage them in street hawking.

In Nigeria, even though there are no documented records of street children, but casual observations in most major streets suggest that an increasing population of these youngsters are living on the streets. They are involved in bus-conducting, car washing and human trafficking. And these street children are involved in various hazardous practices like engagement in unprotected sexual activities which eventually leads to high rate of unwanted pregnancies, death, infectious diseases like HIV, gonorrhoea, which can lead to infertility later in life (Atere, 2000:59). Some mothers living with HIV admit that their children sometimes sleep on the streets buying and selling. *Our means of livelihood is hugely dependent on the little profit they make from street hawking. We are aware that some of them are HIV positive, but we cannot buy drugs for them even when they have fever, we only buy aspirin and other drugs we can afford from nearby medical stores. Three years ago some of us lost two of our children who were buying and selling on the highways and*

streets to accident. A trailer crushed them to pieces; we did not even see their lifeless bodies (FGD with mothers living with HIV, 2016). The above arguments indicated in Todi Diocese, men and children bear the larger percent of HIV infection than men.

4.5 Conclusion

Chapter four seeks to explain how cultural, socio-economic and political development impact on sex and sexualities in the context of HIV and AIDS in Nigeria, and particularly in Todi Diocese. Effort was made to discuss some of the factors that promote the spread of HIV in Nigeria such as endemic corruption and unemployment which were so rampant in the country which have also left the citizens with no option than to engage in hazardous or unprotected sex and/or commercialization of sex and other unaccepted behaviour in the society which consequently exposed them to HIV infection. In a situation where young graduates with expectations were abandoned to fend for themselves and without employment became economically miserable and their impoverished conditions straightforwardly make both young and older women easily fall prey to HIV infection by yielding to sexual demands from those who promised to better their condition.

CHAPTER FIVE

FACTORS MILITATING AGAINST THE CONTROL OF THE SPREAD OF HIV IN TODI DIOCESE

5.1 Introduction

Chapter four discussed how cultural, socio-economic and political development impact on sex and sexualities in relation to HIV AIDS in Todi Diocese. Drawing from the focus group discussions, various themes that occurred from the field research will be discussed in this chapter (five). The various factors which are suffocating the preventive effort and militating against the control of HIV in Todi Diocese are discovered through focus group discussions. In responding to the few questions asked below, different behaviours that help in facilitating the transmission of HIV in the area of research were revealed through discussions. Some of these behaviours fuelling the transmission of HIV would be discussed as follows: Multiple concomitant of sexual partners, Gender inequality, the denial of being HIV positive, no one desires to be identified with a stigmatized disease; claims of possible cure by Nigerian pastors and medical experts which give false hope to the HIV infected persons, the incompetency of health workers in Adamawa state. Other factors are: the role of the law enforcement agents, especially the role the Nigerian police and the Nigerian army play in the spread of HIV in Todi Diocese; Lack of knowledge on the HIV epidemic in the Diocese would be discussed.

5.2 Factors contributing to the spread of HIV in Todi Diocese

HIV is not spread simply in a drink or eating any specific food. One can only get infected with HIV through blood transfusion or sexual fluids. It is not a virus one can contract through mosquito bites, sharing of domestic substances. Before someone is infected, the virus has to pass through the body's self-protective mechanisms. And these transmissions can occur primarily either through blood or sexual intercourse.⁵⁵ Below are some of the features through which HIV can be transmitted or spread as revealed through focus group discussion in response to the following question: what are the causes of the spread of HIV in Todi Diocese?

⁵⁵ HIV can be transmitted through blood... <https://aids.gov/hiv-aids-basics/hiv-aids-101/how-you-get-hiv-aids/> (Accessed on the 3rd June, 2015).

5.2.1 Multiple Concomitant of Sexual partners

Multiple sexual partners were acknowledged to be one of the major channels of HIV transmission in Todi Diocese. Both men and women engage in sexual immorality without any form of protection. A group of fathers living with HIV accused the LCCN leadership of denying them the liberty of marrying more than one wife. They acknowledged that the greatest sin that is seen as the most abominable in the LCCN is marrying more than one wife in this Diocese. Most times the pastors do not even greet such a person who marries more than one wife, or visits him or her even if he or she is bereaved, simply because he has two wives. *Therefore, if the church will allow us to marry more than one wife, promiscuity which is so rampant would be surely minimized* (FGD with fathers living with HIV, 2016).

There is evidence that most young women in Todi Diocese have multiple sexual partners who have sex with them for various reasons: some for pecuniary reason while others for attractiveness and prominence. A group of DEC members lamented that some young men and young women who come from the city during festivities (Christmas, Easter, Sallah etc), are the ones mostly spreading HIV in the Diocese. One person may have sex with more than five different partners in the village within two weeks before going back to the city and continue with other sexual partners. With this multiple sexual partners, those who were infected from the city can possibly be the channels of transmission to those in villages. That is why during Christmas period, we don't allow the celebrations to go beyond 7 pm (FGD with DEC members, 2016).

There was little disagreement over the policy formulated by DEC members in some of the Districts to cut short Christmas and other celebrations as stipulated above. Others still presume that promiscuity is more rampant because of the above decision, because from 7 pm, people are allowed to do whatever they want. Another group of the DEC members revealed that, they are always afraid when it is Christmas or any occasion in the village. As many young boys who come from the city will be infecting our daughters with various kinds of diseases. If you want to believe what we are saying, after Christmas, come back in January and see how many young girls were impregnated by both young boys and old men as well. Some of them leave their wives in cities, only to come and deceive our daughters with little money and infect them with HIV. Therefore, allowing the LCCN members to marry more than one wife as they are clamouring will never bring solution to the challenge of HIV in Todi Diocese (FGD with DEC members 2016). I agree with Moyo when he observes that, the

church speaks as if the elderly people are exempted from HIV infection and are therefore talking to the infected young generation. Even though HIV is prevalent among the youth, this epidemic knows no boundaries, the old, the young, the newly born, the rich and the poor and non-Christians can be infected with HIV (2015:149). Policy restricting celebration beyond 7pm would not eradicate sexual activities among members of the church; instead, the LCCN members should be taught to desist from illegitimate sex and for those who cannot resist the temptation should protect themselves both from those who come from cities and those at home during festive period. Multiple sexual partnerships, high rates of partner exchange, promiscuity, extra-marital and cross-generational sexual relationships, and casual sex without protection are factors leading to increased HIV transmission rates in the Diocese and Nigeria at large; sex trade as a result of living in town, travelling abroad or villages, as argued by Adamu, leads to promiscuity and increased prevalence of sexual transmitted diseases (2001:36).

There are indications that the spread of HIV in Todi Diocese will not be checked until unprotected heterosexual promiscuity is checked. The spread of the virus can only be prevented by behaviour change. As long as persons who are infected with the virus infect even one other person in their lifetime, AIDS will not be checked (Nicolson 1996:35). In a group discussion the youth confirmed that one of the reasons they engage in premarital sex without the use of condom: according to them, many ladies in this church have committed abortion on several occasions, and we don't know if they can still give birth to children. Therefore, it is better for us to commit the sin of premarital sex than divorcing our wives after exchanging marital vows at the altar (Till death do us part) and later discover that she is barren, and by then, it will be too late. You know, having children is something that is non-negotiable and divorcing a wife is the most abominable thing to do in the LCCN (FGD with youth group, 2016). In the same group, girls argued that they were also tempted to engage in premarital sex without any form of barrier, because there are men who only have water in their body, but they lack the real sperm which can impregnate a woman; it is therefore imperative to test their ability to produce children (FGD with youth, 2016). With this mentality among the youth, the research revealed that one of the reasons the youth in LCCN Todi Diocese do not practice safer sex methods was primarily to ascertain the ability of their counterparts if really they can have children after marriage. When things did not go well between them, they switch off to another one. If unprotected sex is successfully checked in Todi Diocese, the spread of HIV would be weakened and brought to its knee.

McCain was right when he observes that over 90 percent of people who were infected with the virus in Nigeria, were infected through unprotected sex in most cases. The unprotected sex that spread the virus was either before marriage or after marriage (2008:14). In the course of discussions from various groups, it has been revealed that men are at the forefront of spreading HIV in Adamawa state, especially in Todi Diocese. A group of fathers testified that if men are sexually disciplined like women, HIV would not have spread to this level in the Diocese and the whole of LCCN (FGD with fathers 2016). Similarly, women acknowledged that they cannot deny the fact that some of them at some point in time were also tempted to have extra-marital affairs, however, for our husbands, having sexual partners is a fashion; it is no longer a temptation but a lifestyle or habit (FGD with mothers living with HIV, 2016). This confirmation is emanating from men themselves, who were aware of their weaknesses.

This was also confirmed by Osotimehin who asserts that, men should take full responsibility for the escalation of HIV in Nigeria, because they have continued to patronize sex workers without adequate protection simply because they feel that sex with condom doesn't satisfy their sexual urge (2007). That is not to exonerate women totally from being agents of HIV transmission. However, suffice to say is that men are bearing the higher percentage of fuelling the spread of HIV in the Diocese; the reasons being that some men have economic benefit over their women counterparts. With the above revelation, the group acknowledged that women are not completely exempted from spreading HIV in the Diocese, but admitted that men push them to do what they have no intention of doing. The fathers' group further acknowledged that poverty is the chief reason for the spread of HIV in this community. There are situations where the men are aware of their wives' extra-marital affairs, but due to poverty in the land we allow them, because their sexual partners are taking responsibility of our domestic needs. Sometimes we know those who constantly sleep with our wives, even if you don't apprehend them red handed, people will tell you that they saw your wife entering a lodge with someone but when the same person is the one who pays your children's school fees and always assisting them financially, we find it difficult to confront them. Sometimes we find it difficult to ascertain between a husband and a wife who infected the other (FGD with fathers living with HIV, 2016).

Nqiwa corroborates the above statement that, men are the key to the prevention of HIV; if you can inform and educate men; you can eradicate the spread of HIV and that if men will avoid sexual promiscuity and properly shoulder their responsibility as breadwinners, the spread of HIV will radically diminish (2002:39). Nqiwa's argument may not be absolutely

realistic, because research has found that women also play significant roles in spreading HIV. There are women who do not lack anything for a living, but still have extra-marital sex without protection. Therefore, the education should not be limited to men but to women as well. The education should emphasize the use of safer methods, instead of avoiding sex, because in Todi Diocese, the knowledge about the use of condoms is very low. Even when some men who were confirmed to be HIV positive, they still want to have sex with their sexual partners without concern to their partners as doing so would raise suspicion.

There are some men who are consciously aware about the danger of their HIV status but still refuse to give up the practice of numerous sexual partners, furthermore, they refuse to use condom, simply because they do not want to betray their manhood which encourages them to be brave and take risk; at the end no one wins-only HIV and AIDS (Dube, 2008:51). Most women in the research area who were found to be HIV positive suffer humiliation more than their men counterparts. Most men do not want to admit that they were the ones who infected their partners as expressed by the participants that, a mere rumour that cannot even be substantiated can make a man to divorce his wife, let alone when found to be HIV positive, even if he is the one that infected you, a woman will not be allowed to remain in the house. *That is why sometimes, when we are tested HIV positive, we come back home and say it is malaria. One good thing is that, our husbands do not follow us to the hospital, to be able to ascertain what the problem really is. Men should do unto us what they want us to do unto them; when they are found to be HIV positive, we commiserate with them, we even allow them to have sex with us without a barrier of any form, just to comfort them, we should therefore not be treated differently* (FGD with mothers, 2016).

Looking at the attitudes of most men and women in Todi Diocese towards sexual misconduct, there is need for behavioural change as McCain declares that: AIDS is primarily a behavioural disease. Most diseases come upon a person through no fault of their own. For instance, a person gets malaria by being bitten by a mosquito, one gets air-borne viruses by coming in contact with someone or having someone sneeze on them. However, behavioural diseases arise because of certain behaviours that people choose. This is truer with sexually transmitted diseases. Syphilis, gonorrhoea and other sexually transmitted diseases almost exclusively are spread from one person to the other by sexual activity. Although there are other ways that HIV can be spread, about 90 percent of the time, the infection is spread as a result of sexual activity.

The more one reduces promiscuous sexual activity, most especially without a barrier the less likelihood there is of HIV infection. The more the society reduces illicit sex, the less likelihood of the disease spreading. Therefore, it makes sense that the society should do all that it can to reduce promiscuous and unprotected sex (2008:121). As mentioned by McCain, even though there are so many channels through which an individual can get infected with HIV, but the empirical studies (see chapter six) have corroborated that most women living with HIV in Todi Diocese got infected by their husbands as a result of their promiscuous sexual behaviour.

5.2.2 Gender and economic Inequality worsen the spread of HIV in Todi Diocese

Gender inequality is defined as an unequal treatment or perceptions of individuals based on their gender. It arises from differences in socially constructed gender roles as well as biologically through, brain structure, and hormonal differences.⁵⁶ Another factor discovered to be aiding the spread of HIV in Todi Diocese is gender inequality. Men in the Diocese often claim superiority over their wives. Women seemingly have nothing to say or contribute to their husbands in regards to sex. In chapter four, a group of participants had acknowledged how culture which goes hand in hand with gender inequality plays a significant role in most marriages in Todi Diocese. In the same manner, gender also plays an important role among couples. A group of mothers asserted that, *because God has placed men over women, and because they are in possession of money, men decide when and how sex is performed. Most times, when men are tired, we hardly talk to them about sex, but for us, except if we are on hospital beds, but if the sickness can be managed at home, sex can also be managed when men are in need* (FGD with mothers living with HIV, 2016). The group further asserted that, men's financial superiority makes them take decision in the family, including sexual matters. Women are not allowed to negotiate harmless sex with their husbands, even when women are fully aware that their husbands are HIV positive. During sexual intercourse, we are only helping our husbands to fully satisfy themselves (FGD with mothers living with HIV, 2016). God placing women under the dominion of men does not guarantee that a woman has nothing to contribute during sex. When sex is done in a mutual agreement, it is more gratifying than when it is self-interestedly done by one person.

Another area where inequality is visible is the way women were treated when found to be HIV positive. Some women in Todi Diocese suffer humiliation and stigmatization when

⁵⁶Gender Inequality. <http://wwwENCYCLO.co.uk/meaning-of-Gender%20inequality> (Accessed on 8th June, 2015).

found to be HIV positive. Some men find it more disgusting to tolerate an HIV positive woman, even when the woman acquired the virus through blood transfusion or other means which are not related to sexual promiscuity. A group of DEC members declared that, married women who are living with HIV are facing serious problems from their husbands within Todi Diocese. *The challenge is that even if a man wants to live with a HIV infected wife, people in the community will find it difficult to associate with you and they may not feel free to eat and drink even water in your house because of the stigma involved in HIV issues in the Diocese. Men are therefore left with the option of taking their wives to their parents and give whatever they need for their upkeep* (FGD with DEC members, 2016). The DEC members have not done enough to cripple the rising of stigma and discrimination but rather allowing stigma and discrimination to grow wings in the Diocese and placing men's decision more valuable than women. This is purely a display of gender discrimination; if women whose husbands are HIV positive can still remain with their husbands till death do them part, worse of it all, they still allow them to have unprotected sex with them just to commiserate with them, why is it that men cannot do the same?

This attitude find resonance in the words of Hoare that, more often than not there is likelihood than women living with HIV suffer from stigma and discrimination more than men who are equally living with HIV, a situation closely connected to their unequal status in the society (2008:184). Unequal gender relations foster disproportionate power relations especially where sexual activity is concerned. In the geographical location where the researcher hails from, there is this mind-set that sex is mainly for the pleasure of men, and women are required to play a passive role. For this reason, men determine which style they want to go for at any given period. Any attempt by the woman to suggest to the husband how sex should be performed at any given time is to risk being labelled as a prostitute, either prior to her marriage, or having secret extra marital affairs. According to Gray, women disparity in gender contributes to their susceptibility to HIV infection (2009). Prevention of HIV transmission from men to women would become an illusion as long as women continue to remain under the financial grip of their partners.

The economic inequality among men and women in Todi Diocese is so widespread that most women solely depend on their husbands for almost everything in terms of money and other basic necessities of life; the over dependency of women on their husbands for financial needs exposes them more to HIV infection. A group of participants confirmed that before some of them got infected with HIV, they knew that their husbands were HIV positive, but they could

not insist that condom must be used, because that will always irritate their husbands, and the resultant effect of their annoyance is that there will be no food in the house, and in the situation where you don't have anything to feed the family with, you have to submit to their demands. *Even when some of us were infected by them, instead of pacifying us by meeting our needs, we are still humiliated by their utterances on daily basis by the same men. We have to remain silent without telling anyone, until after their deaths that we can freely talk about it* (FGD with mothers living with HIV, 2016).

According to a group (DEC), due to the widespread of the economic inequality in the Diocese, the church was trying to map out strategies to financially assist women with loans to do small businesses that can earn them money which can equally ameliorate their plights of relying completely on their husbands for all their domestic expenses, but some LCCN members opposed that decision, saying that the DEC members want to bite more than they can chew. Meaning, they are trying to create crisis among couples in the Diocese which they cannot find solution to, because women will start rubbing shoulders with their husbands. When our women are financially elevated, the end result will be crisis in our homes; because they cannot be controlled any longer. That was how that policy suffered setback (FGD with DEC members, 2016). Men in Todi Diocese are enjoying their financial superiority over women and they see the effort of the church as bringing out policy that would bring unhealthy competition among partners.

When it comes to employment in the country, men are mostly given priority over women, limiting women to only domestic responsibility, which does not usually grant them economic power, freedom and/ or equality with men. Ekweremadu states that if the issue of gender discrimination is seriously checked, the spread of HIV in Nigeria would have been halted. If Nigeria will work against gender inequality, in no distant time, HIV would be eradicated to a large extent (2006). The mothers who were infected and affected by the epidemic declared in a group that, *halting the spread of HIV is nearly impossible except women are granted economic equality with men, because even here in the church we are subjected to inferiority to the extent that even in church positions we are not considered qualified to occupy it. At home, a man you call your husband will give you only 20 naira in the day time when he knows that he wants to have sex with you that night. However, if the man knows that you are having your menstrual period, he will never give you anything, because he will ask you, what will he get in return? So, we only see their money if they want to have sex with us. They will not give us money and they will not allow us to look for employment*

even if you have the required qualifications (FCD with mothers living with HIV, 2015). Some women in Todi Diocese acknowledged that they only receive material compensation for sexual favours; this appears like the life sayings: "Some people will only "love you" as much as they can use you. Their loyalty ends where the benefits stop."⁵⁷ This is the situation with most women in Todi Diocese who depend on their husbands for almost everything. The inability of most women in Todi Diocese to secure gainful employment render them financially handicapped and make them vulnerable to HIV infections by their male counterparts.

The above argument is in line with what Wood, et al, identify as one of the chief reasons why high rate of HIV infections is prevalent among African women. Their highest HIV incidence is due to their economic vulnerability. They are not only more often infected, but also affected more, since they are the ones who care for the sick members of the family (2008:51). In Todi Diocese, most women are traditionally accorded a low social status, denying them the ability to negotiate safer sex practices or to insist on marital fidelity. Traditional societal norms in Todi Diocese tend to keep the status of women low and empower men to take control of resources and decision making. I concur with Wood, et al, when they contend that, Gender fairness needs to become a reality, in order to beat HIV. Considerably, the emphasis is on equality, not on granting women more power at the expense of men; a gender perspective of HIV does not place on men-it questions the beliefs of both men and women towards their sexual practices, gender roles and attitudes (2008:51).

What women in Todi Diocese need most is financial elevation; they are not in any way competing with their male counterparts but to be financially self-reliant which will go a long way in reducing their dependency upon men, which makes them subjective to their sexual supremacy regardless of their HIV positive status. A Nigerian adage says, "A beggar has no choice" As long as women in Todi Diocese remain under the clutch of poverty, they have no choice when they are offered money in exchange for sex, even when they are fully aware that their sexual partners are living with HIV. Some women in Todi Diocese who attempt to suggest to their husbands on how they need to be treated in sexual matters mostly end up being humiliated and divorced. Participants assert that *when we newly got married, within the period of four years, we used to talk about sex with our partners, even before it is done, but now some of us cannot remember the last time we ever talked to our husbands that we*

⁵⁷ See: <https://twitter.com/itslifeact/status/505248544526438401> (Accessed on the 1st October, 2015).

are not ready for sex today, or we wanted sex. We submit ourselves to them as soon as they ask for it, sometimes we don't tell them even if we are on our menstrual period, as that will be interpreted as being reluctant and the end can be predicted from the beginning (FGD with mothers living with HIV, 2016). When a woman knows that denying her husband his conjugal right can cause a serious misunderstanding, she reluctantly submits against her wish. This means that the fear of his reaction is more than the fear of becoming infected with HIV.

In supporting the above discussion, Kauffman postulates that while a woman is certainly aware she could get infected with HIV from a man who demands that they have sex without any form of protection, she equally knows that there is a consequence for not agreeing to his wishes which may include abuse and loss of financial support. In most cases, when the woman weighs the advantages and disadvantages of her actions, she will rather prefer to take the risk and have her peace of mind than doing otherwise and setting her matrimonial home ablaze (2004:23). The economic gap between men and women in Todi Diocese made some of them who are living in abject poverty to rely on sex from their partners as a means of earning a livelihood. Sex can pervasively be used to secure basic needs such as food and clothing.

Another area where inequality is demonstrated is in education. The researcher considers educational inequality as a factor that has the propensity of fuelling the spread of HIV in Todi Diocese. According to a group of mothers, *our husbands are more educated than us. Sometimes we know that they are infected, but they will tell us that they know how they are doing it and they will assure us that we will never be infected, only to later discover that we are victims of HIV infection* (FGD with mothers living with HIV, 2016). Educational inequality among women in Todi Diocese is a threat to the fight against the spread of HIV, which required to be tackled. Adopting a culture of gender equality will enable women in Todi Diocese to get education which will in turn enable them to think and analyse issues in a critical manner.

5.2.3 Lack of knowledge on Sex and sexualities and HIV and AIDS in Todi Diocese

Question: Do your Pastors freely talk or preach about Sex and sexualities and HIV and AIDS and what is your understanding of sex and sexualities in the context of HIV and AIDS?

Lack of information often breeds ignorance. Martin Luther King Jr. suitably states that, “Nothing in the world is more dangerous than sincere ignorance.”⁵⁸ The leadership of the LCCN have neglected their duty to be watchmen, directing people on how the gift of sex and sexualities should be appreciated and expressed in such a manner that it will not pose health challenge to its members; instead, the members are left in total ignorance about sex and sexualities. DEC members indicated that *pastors instead of teaching us issues concerning sex always embarrass us* (DEC members, 2016) *when we come to sort out issues with our wives; when we face challenges with our wives who always presume that after 50 years we should not be talking about sex any longer. When we come to our pastors for counselling, the pastors always throw their weights in support of our wives by saying that, they are surprised that some of us are still quarrelling about sex at this stage which is very unfortunate. They will always say to us, don't we have other meaningful things to engage in other than sex? They will continue, as matured as we are, we are still talking about sexual matters, what will our children who recently got married talk about* (FGD with DEC members, 2016)?

The scripture has not provided us with specific ages which sex can be performed between couples. Limiting sex to particular ages poses a serious danger in the era of HIV in Todi Diocese. As noted above, men who are still active and have been denied sexual satisfaction from their wives may resort to seeking for it elsewhere and consequently, that may lead to getting a partner becoming infected with HIV. It is possible that some women who are living with HIV in Todi Diocese are victims of sexual denial to their husbands which prompted their husbands to seek for alternative means of satisfying themselves which subsequently led to their infection with HIV. Wheat contends that, sex after 60 yeas can be better than ever! This is not propaganda, but a frank statement of fact. Let me assure you who are approaching sixties or seventies that you will not have to settle for memories if you and your partner

⁵⁸ Martin Luther King Jr Quotes about Ignorance <http://www.goodreads.com/quotes/tag/ignorance> (Accessed on the 2nd May, 2015).

remain in reasonable good health and have a loving communication with each other. Sex is a natural lifetime function; attitude is the key factor (1977:214).

Lack of information on sex and HIV is another challenge that keeps contributing to the spread of HIV in most communities in Todi Diocese. Many schools were restricted to furnish students with information about sex and HIV, and pastors who are leaders in various communities distant themselves from it, this result to discriminating of those infected to stay away from them so as to avoid being infected (Garland, 2003:115). Similarly, participants in the youth group asserted that, *Some of our pastors are retired soldiers, and any time they speak about HIV and AIDS, they use military language, and the way they sound seem as if they are only scaring us, that made us developed an attitude of not taking them serious on the HIV matters, even when they speak about those who are living with HIV, they refer to them as those who refused to listen, and that they will suffer here and suffer in hell (FGD with youth, 2016)*.

The pastors sound too judgemental, which made some of us to stay away from the church. For them, anyone who is infected with HIV got the virus from prostitutes and should therefore not be sympathetized with (FGD with youth group, 2016). Even pastors in the Diocese who were supposed to be well informed about HIV and AIDS epidemic are also unfamiliar of how HIV is transmitted; holding on to one channel of transmission, which is through sex. Another group of youth responding to the above question asserted that, *in this church many people assume that when a HIV infected person gives you food, the virus can be found in the food. This is responsible for the reason most of us don't eat anything in the house or from the hands of a HIV infected person* (FGD with youth, 2016). The youth group described HIV even AIDS as one of the communicable diseases through casual contacts, and for that reason, people should distant themselves from it by avoiding those who were infected. This is nothing but an outright display of ignorance.

There are some people in some rural areas of Todi Diocese who have no information on the epidemic. Lack of education and social amenities hinder rural dwellers to have access to information on HIV and AIDS as rightly observed by Wood, et al that “Illiteracy and low education levels make prevention work more difficult and often lead to people not been aware of the true facts of the disease and how it is spread. Myths and misconceptions also flourish where education levels are low” (2008). People in Todi Diocese who are mostly from the rural areas find it difficult to have access to information which contributes significantly to

ignorance of the epidemic and resulted to its wild spread. Poor access to information on sex and HIV as argued by Usdin must be dealt with, so that men and women can adequately familiarize themselves with the prevention strategies (2003:39). Not only men and women are at risk, the unborn children who may be infected especially in the course of delivery are also at risk.

Obisesan contends that ignorance is deadlier than AIDS; as citizens of this country, and our first assignment is to fight ignorance with knowledge and understanding. If we can defeat ignorance, then we have defeated AIDS and the spread of its virus in Nigeria. However, if ignorance continues to strive, the spread of HIV will be in the increase (2010:25). One of the biggest challenges in Todi Diocese is lack of awareness. Pastors who are close to people in the community display ignorance on the epidemic. The government agencies that supposed to play a significant role in disseminating information cannot reach a huge population in most villages in Adamawa state. Sometimes efforts are made through the state radio broadcast to enlighten people on how HIV is spread, but the information is limited as majority of people in the rural areas do not have electricity and consequently have no access to those gadgets which has ravaged the people in the Diocese.

Research indicates that, in Adamawa state, only 32.5% of the households have access to electricity. 69.6% of women in Adamawa state are unemployed while 74.8% of the men are unemployed.⁵⁹ Some people managed to purchased radio and television but cannot use them due to the high cost of fuel, most especially now that the Buhari's Administration has removed the fuel subsidy, which caused hike of petroleum products. The cost of maintaining electronic appliances when they develop technical problem is beyond the control of people living in poverty especially those in rural areas of Todi Diocese. Participants in the fathers group contended that most communities in Todi Diocese are without rural electrification, *the same thing applies to this village, we don't have electricity, and only three people have Televisions and generators, and if they put it on, we only gather in the house to watch films, because they cannot hook up to ATV⁶⁰ due to poor network. So we have never received any information on television or radio patterning to HIV and AIDS. Those who have radio exaggerate too much, they will tell you news from their minds more than what had been said. For this reason we lose confidence in them* (FGD with fathers living with HIV, 2016). Many people who are impoverished by lower standard of living in Todi Diocese

⁵⁹See: <http://nigeria.unfpa.org/adamawa.html> (Accessed on the 10th June 2015).

⁶⁰ATV stands for Adamawa Television Authority.

cannot afford to buy television and radios which has a way of denying them access to information.

There are various rationales why people do what they do; some reasons are justifiable while some are out of ignorance. When people are ignorant about the HIV epidemic, the fundamental rights of PLWHIV can easily be infringed upon. Participants in the women group discussion lamented that because of their lack of understanding of what HIV truly is, the health workers who were perceived to be more knowledgeable on the issue of HIV and its modes of transmission have warned them on the consequences of becoming pregnant when they know that they are HIV positive. *The nurses advised us to allow our wombs to be blocked so that we will not bother about becoming pregnant let along giving birth to HIV infected children in the community. Right from the time they warned us, anytime some of us are pregnant, we always commit abortion because of the fear of given birth to HIV infected children and live continually in perpetual stigma and discrimination by church and the community at large* (FGD with mothers living with HIV 2016). Here one can see the display of ignorance not only by the HIV infected persons but also by the nurses who do not have much knowledge that the HIV-infected persons can give birth to a HIV-negative child if necessary steps are taken. Lack of correct information in Todi Diocese is causing more harm to the pregnant women than good. Where women receive update information on HIV, and were taught the use of ARVs during pregnancy, will have their babies delivered especially through caesarean services without becoming infected with HIV.

Ebulu narrated publicly on the pages of Nigerian newspapers how she delivered her children without being infected by HIV even though she is HIV positive. Being adequately informed about HIV, when she discovered she was pregnant, she decided to be taking her drugs as prescribed, she acknowledged to have given birth to three children free from HIV infection and counselled women who are HIV positive to take their drugs and to use standard hospitals during antenatal services in order to have HIV negative babies.⁶¹

This is one of the cases of people who live in the cities and are furnished with information about HIV, they were able to manage their HIV condition and have healthy children without being infected with HIV. Such enlightenment and educative programs should be extended to women in the rural areas of Adamawa state, particularly in Todi Diocese. Women who are

⁶¹ HIV-positive? Your baby can be negative 2014. <http://www.punchng.com/health/healthwise/hiv-positive-your-baby-can-be-negative/> (Accessed on the 1st May, 2015).

opportune to attend antenatal care in the early stages of their pregnancy have the greater privilege to save their yet to be born children.

Another area where ignorance thrives most is in the manner in which the HIV patients borrow drugs from their colleagues. Because of the paucity of drugs and the inequality in the area of treatment, PLWHIV assumed that with paucity of drugs, one can borrow drugs from friends which according to them will serve the same purpose. To them HIV is HIV, and AIDS is AIDS, by the way we are all humans, therefore, in their lack of understanding, a particular drugs can serve the need of everyone; as far as they are concerned, there is no medical implication in taking drugs that belong to a colleague.

A group expressed their displeasure over the attitude of their colleagues who refused to assist those who have no drugs or those who could not for monetary reason go for their drugs. According to them, *as Christians, being in the same church, we always profess in the church that, ‘we are our brother’s keeper’, and if we mean what we profess we can share our sorrow, joy, feelings and drugs as well, but some people are so wicked that they cannot even assist with their drugs. They don’t even mind if their neighbours die* (FGD with mothers living with HIV, 2016). The participants said, there are times when they do not have money to go to hospital, when they run to their brothers and sisters to help them with their drugs; some people will help but others will start behaving to them as if they are not Christians. *In fact, we are sometimes disappointed in the attitude of our fellow Christians; how can we love one another, when we become stingy with our drugs* (FGD with mothers living with HIV, 2016)? Some of the HIV infected persons acknowledged that, from time to time they share their drugs; because there are times when one has no money to go to the hospital.

The participants were of the opinion that leadership of the church should encourage PLWHIV to extend their hands of fellowship by sharing their ARVs. *There are times after we have collected our drugs, along the line something may happen, like our children flinging our drugs in the water; throughout the month we live on the open-handedness of our colleagues. Therefore, we need to assist one another* (FGD with mothers living with HIV, 2016). A lot of people in Todi Diocese and Nigeria at large are unaware that every HIV infected person has peculiarity in his or her own case; therefore, treatment need not be generalized. Wood, et al, confirmed that, there are no general rules for treatment of PLWHIV and there is never a single management protocol; the focus of HIV infections should always

be on the specific needs of each patient. The treatment of each case is based on a thorough clinical assessment of the person's health (2008:18). Different combinations of ARVs work for different people so the medicine you take will be for your specific medical needs. A drowning man or woman does not have a choice most especially when he or she lacks the basic information on HIV and how it is treated. When PLWHIV have access to information and ARVs, they would not see the need to borrow drugs from colleagues. In a bid to fix the challenge of HIV in Todi Diocese, ignorance which encompasses the HIV and AIDS must be decisively dealt with.

5.2.4 Nigerians and denial of being HIV-positive

The magnitude of denial of being HIV positive is truncating the longevity of people who are supposed to live long after being detected of being positive. For various reasons, many Nigerians who were confirmed to be HIV positive deny the existence of such virus in their body, by mere conviction that you possess what your mouth admits; and this attitude continually frustrate the battle against the spread of HIV in Todi Diocese and Nigeria at large. A group of pastors in response to the above question on the spread of HIV acknowledged that: Here, LCCN members barely open up and divulge their HIV positive status to family members, except if the condition starts deteriorating that is when some family members will start spreading the news of the root cause of the person's illness, and also when it becomes imperative for the patient to do so, for the purpose of getting assistance. In the situation where the family members are not sure of what the problem is, they will investigate to know the cause of the disease, most especially when the family members become worried over the incessant symptoms prevalent in their son or daughter which suggest that it is similar to that of HIV and tried to find out on their own what the problem really is; the suspected infected person even when he or she knows that he or she is HIV positive will keep mute about it (FGD with pastors, 2016). This is one of the prices the pastors and members of the LCCN Todi Diocese are paying for directly and indirectly stigmatizing and discriminating PLWHIV. The fear is that when one's HIV positive status is known, the immediate family members are the ones who will first of all stigmatize and discriminate against such person before outsiders.

The group of pastors further attests to the fact that, because of this denial attitude, we have lost many of our relatives and LCCN members to AIDS related diseases, because even when the symptoms seemed to be signifying that they have not only HIV but AIDS, they will still deny vehemently, until few days to their deaths, some of them will confess to the family to

forgive them for not telling them the truth all this while which has caused them all they had (FGD with pastors, 2016). Because of stigma and discrimination, dying from AIDS-related diseases is viewed as a family embarrassment in Todi Diocese. People, therefore, prefer to conceal the root cause of their illness even at the point of death. Paterson rightly declared that due to stigma people who are infected are likely to deny the existence of HIV in their bodies, and ignoring the necessity to seek help or change behaviour and this attitude can be fatal to prevention method (2011:350).

A group of DEC members in their anger demanded that all LCCN members who died to AIDS- related diseases should be published to serve as deterrent to other members. The DEC members admited that, when you hear family members saying that their son or daughter or any family member died of typhoid here in this village, then it is indisputable in most cases the same person died of AIDS-related diseases; because here nobody wants his family member to be reportedly said to have died of AIDS, as this will cause stigma to the whole family for years. People will believe that there are still some family members who are HIV positive, most especially if the person infected has children, all the children will be labelled as HIV positive. So, the reason for denial is to protect the family of the deceased (FGD with DEC members, 2016).

The DEC members among whom are pastors contributed to this attitude of denial because children of the deceased members who died from AIDS-related-diseases have been plunged into untold hardship as would be seen in chapter six. There is a misconception in Todi Diocese for those who deny that HIV exists, that even if there is HIV, it can only infect those who believe in its existence. As a result of this denial, many still get infected and consequently die from AIDS-related diseases. There are churches in Nigeria, where people are prayed for and are cautioned, never to imagine again that they are living with HIV. According to the pastors, they say, the manner in which you condition your mind determines how you live your life. If you think you are free from the clutch of HIV, then you remain negative all your lifetime, but if you also assume that you are positive, then all the symptoms of HIV will surface.

During prayers for healing in some churches, pastors and some church leaders invite PLWHIV to come forward for prayer, after which they literally burn the person's anti-retroviral medications and declare the person cured.⁶² The so-called⁶³ cure is not without

⁶²Pentecostal pastors in Africa trick victims of HIV into thinking prayer are a cure.

payment and some PLWHIV complain of being dispossessed of their belongings which they live on. Unfortunately, some who paid for the prayer died soon after few days or months. PLWHIV are desperate; they fear the stigma of the disease and family rejection which makes the HIV infected person to run from one church to another looking for miraculous healing. Victims were declared “cured” but more often, they are not. As their condition worsen, they go back to continue with their medications; but they soon discover that it is too late. A group of youth declared that, many of them including elderly people in this church deny the fact that HIV exists, or that AIDS is real and even if there is AIDS, ‘their bodies are the temple of the living God’, therefore, HIV and all AIDS-related diseases have no dwelling place where God lives. Some youth and elders as well, also dispute the results of their HIV testing if they are tested HIV positive after going to hospitals. They often say things like “I reject that result in Jesus’ name” Once they make the pronouncement, “I reject that result”, automatically they believed their HIV status has been short-changed from positive to negative (FGD with youth, 2016).

These statements are very common in Nigeria, where church members from different denominations often say that, the Bible says, “Your confession is your possession.” Church members believe that speaking negatively hinders God’s desire to bring healing in their lives. They believe that when you say I have HIV, that means you have it, but if you say, I don’t have HIV, then, truly you will never have HIV. This is a common phenomenon in some churches in Nigeria, where the pastors tell their members that it is your mouth that gives you what you want and at the same time, your utterances will distant you from what you detest. And the worst part of it is that, some pastors discourage their members for going to doctors for medical check-up to ascertain their HIV positive status, as this will amount to disbelief. Those who insist to go for medical check-up are labelled as the biblical “Thomas” who will only believe when their eyes see.

The researcher is of the opinion that, if people are convinced that they are cured, there should be no exhibition of fear as noted above, the same person should medically verify his or her healing so he or she can testify publicly that surely, they have been cured. An argument broke up among the youth group as to whether it is right to go for medical verification. Others are

<http://doubtfulnews.com/2013/12/pentecostal-pastors-in-africa-trick-victims-of-hiv-into-thinking-prayer-is-a-cure/> (Accessed on the 10th January, 2015).

⁶³ The purported healing connotes the acclamation by both pastors and members that their patients are healed, but after few weeks the same people are admitted in the hospital for the same disease. Even on the hospital bed, they still deny that they are HIV positive.

of the opinion that *As believers we should take God's words with all seriousness" without doubt. The Bible says "whose report will you believe, God or doctors?" (Quoting Isaiah 53:1), and continued, If God says you are cured from HIV and you want to go for scientific verification, this shows that one is doubtful and underestimating the power of God. Therefore, going for medical confirmation is putting God to test* (FGD with youth, 2016). Others responded by asserting that people should not only stick to a portion of scripture which favours their argument. They continued: *we are recommended by Jesus to pray for the sick; if we are really following the footsteps of Jesus, Pastors who deny their members from medically verifying their HIV status, must do what Jesus did; Jesus told those he had cured of leprosy to go to the priests (their medical experts at that time) to confirm their cure in Luke 17:14* (FGD with youth, 2016).

Dixon in corroboration to the first argument asserts that, God can heal people with different medical problems whenever he wants. Amazing things can happen that astound the doctors. However, believers and pastors can easily make fatal mistakes. They are not doctors, so how can they be 100 per cent sure the person is really cured from HIV (2010:117)? No disease is strong enough to challenge the curative power of God, however, if the battle to subdue HIV is to be won, religious leaders should stop unnecessary interference on what they have limited knowledge about. Dixon further argues that “such mistakes can easily make HIV spread faster. Really, serious errors are made in ignorance everyday about whether people have been completely healed or not, by respected senior church leaders who have great faith and integrity. While we can certainly pray for healing, anyone who believes they may have received healing, they should now test negative. Let the doctors confirm what has happened” (2010:117).

Those are some of the reasons why if someone is told he or she is cured he or she may stop using condoms with her husband or his wife or sexual partner. This may end up causing the infection of their partners and their children too. A pregnant woman may throw away her anti-retroviral medicines that are protecting her unborn baby. Adults may stop treatment and die fast, leaving their young ones orphans. A group of mothers living with HIV have registered their displeasure over the attitudes of some pastors who collect money from PLWHIV with the promise to conduct a week dry fasting for them until they are cured from their HIV infections. When these people suddenly get better for a while they often think that what happened to them is a miracle of God, or some traditional herbal remedy that they took. This is how many false cure stories begin. For those who have been prayed for after a month

or two without being cured were blamed for lack of faith (FGD with mothers living with HIV, 2016).

It is possible that some PLWHIV do fake their healing so as to please their pastors as argued by Dixon “Some people with HIV do not want to disappoint those who are praying for them, who are still convinced (against all evidence) that they have been healed; sometimes the sick people put on brave faces for pastors, hiding the truth from all except close friends and family” (2010:119). Dixon further expresses that he often gets upset if people in the church suggest that the reason someone is not healed is because of the person’s lack of faith, or lack of holiness. What a terrible burden to load onto the back of someone who needs comfort and support! The people start blaming themselves for their own lack of faith as the reason they have not experienced a miracle. Faith in God should be a comfort, not to cause a crisis (2010:119). One cannot under estimate the power of God to cure HIV, but caution should be intensified to ascertain the veracity of the so called cure by pastors whose interest is possibly for financial gain. Another phenomenon that aggravates the spread of HIV in Nigeria is the propaganda by some medical experts and religious leaders who lay claims to possible cure.

5.2.5 The Contribution of various Claims of possible cure of HIV and AIDS by some Nigerians to the spread of HIV

Another area which contributes in boosting the spread of HIV in Todi Diocese is the various claims by those who publicly circulate information of their ability to cure HIV. Upon hearing such information, people no longer take precaution during casual sex by adhering to the advice of using protective methods. People who have no adequate information on the spread of the epidemic become apprehensive and eventually become victims of circumstances from their fellow community members with speculation that AIDS has been defeated and that there is therefore no reason to be afraid of HIV infection any longer.

A renowned Professor in Nigeria (Ibeh) publicly declared that he had found drugs that will permanently take care of HIV epidemic, indicating that the present ARVs are for the management of HIV, however, he assured the public that his new discovery is a complete cure from HIV.⁶⁴ The same professor after misleading people had apologized to Nigerians for his inability to substantiate his discovery with convincing evidence. Even though, he has publicly tendered his apology for confusing people, the implication is that the damage has

⁶⁴See:<http://www.premiumtimesng.com/news/114260-nigerias-university-of-benin-unveils-cure-for-hiv-aids.html> (Accessed on 25th January, 2015).

already been done. The University of Benin is situated close to my residence and also to the Lutheran Church where I was a Pastor when this information was aired out. Many were trooping into the University to see the Professor including members of my church and some LCCN members from Todi Diocese who came from Adamawa state to look for a cure, only for them to be informed later that the Professor said he was lying. People spent the little resources they had to come to Benin for cure, but all their effort proved abortive. For those who were able to go to Benin realized that it was nothing but a blatant deception, however, thousands in various communities were in jubilation that a cure for HIV has been found. This deceit has caused many citizens to engage in unprotected sex out of ignorance, thinking that HIV and AIDS epidemic has been overpowered. There are various claims from different quarters of possible cure by some medical personnel and religious leaders such as: Abalaka claims of complete cure form HIV infection⁶⁵; Okwori, whose claims was full of contradiction. Who declared that HIV epidemic is a punishment by God; at the same time said that he has the power to completely cure PLWHIV.⁶⁶

With all these claims, Nigeria government has issued a warning to its citizens not to patronize those self-acclaimed doctors and pastors who believed to have found a solution to HIV challenge (Folabi 2000). The fact still remains that damage has already been done even when some of them came out to say, they were deceitful. The news of possible cure spreads quickly than the later apology which only few people have access to the latest information. Government's warning may not circulate to the people living in the rural areas, like in most villages in Todi Diocese. Many people in the midst of shortage of financial ability have spent the little resources they had and end up in more frustration. A group of fathers and mothers living with HIV lamented that, *those who claimed to be educated are inflicting more injuries in addition to our plights with rumours of possible cure by some doctors and pastors; our ears are always open to hear that HIV is finally defeated so that this additional disease of stigma and discrimination can be rolled away. So we spent the little we have to go to where this news are coming from, only to end up in disappointment; and our youth upon hearing such news without making effort to verify the veracity of such rumour continue to engage in unprotected sex leading to infection with STDs (FGD with fathers and mothers living with HIV, 2016)..*

⁶⁵See:<http://pointblanknews.com/pbn/exclusive/nigerian-prof-who-claimed-hiv-aids-cure-says-i-lied/> (Accessed on 25th January, 2015).

⁶⁶<http://www.nigeria-aids.org/reports.cfm?read=1> (Accessed on the 18th February, 2015).

This is a serious distraction in a struggle to scuttle the spread of HIV in the country. McCain notes that, a serious distraction to the AIDS battle in Nigeria is the claims by some to have discovered a cure for HIV. This is another area that needs the attention of the media to inform the general public about all kinds of news, including news about possible cure for HIV. Devoting too much attention to these stories is a distraction from the real battle. These claims, regardless of how strange or unbelievable, often give young people false security and impression that they can live their promiscuous lifestyles and then go to one of the non-orthodox AIDS healers and be cured of their disease (McCain 2008:176).

HIV is a health challenge that is affecting all and sundry in the society, therefore, medical professionals, and all concerned individuals should harness their resources, intellects in bringing it to a standstill; it should not be viewed as an avenue where people do all kinds of experiments for self-glorification. In Todi Diocese, the widespread of promiscuity by the peace keepers is found to be another channel of the spread of HIV.

5.2.6 Peace keepers as a trajectory of HIV in Todi Diocese of Adamawa State

The Nigerian security agents are often deployed to many troubled areas to restore peace to the distressed communities. Some of these restive communities within Nigeria and other countries have high prevalence of HIV and the security agents who were deployed to such areas and have no restraints over their sexual escapades, often get infected and consequently infect their sexual partners when they return to their home states or countries. Taiwo stresses that “during the ECOMOG operation in Sierra Leone, AIDS became the second largest killer of deployed Nigerian troops next to gunshot wounds” (2011).

Almost all the participants in all group discussions attested to the fact that law enforcement agents contribute considerably to the spread of HIV within the geographical location of the LCCN Todi Diocese. The participants discussed that the law enforcement agents (particularly, police and Soldiers) who were deployed to various countries for peace keeping only come back to infect their daughters, sisters and brothers with HIV. Participants in the pastors, youth and DEC members’ focus groups discussions described the Nigerian Police force and the Nigerian Army as major purveyors of the HIV in the area. According to the participants, *the reason is that, these people come back from Liberia, Sudan or Somalia with money, and will start sleeping with our daughters simply because they have money, and as a result infect our daughters with HIV. In this community, we do not want our*

daughters to get married to law enforcement agents; neither do we allow our male children to join those agencies any longer. We warned our daughters not to associate with them, but poverty forces them against their wish to intermingle with these people (FGD with pastors, 2015; FGD with Youth, 2015; FGD with DEC members, 2016).

Even within the country some police officers are usually deployed to various states to restore peace and order to either communal clashes or insurgency, which warrant them to be at their duty post for one or two years without their spouses and the resultant effect is that some of them end up becoming infected and consequently infect their partners upon return. Participants further lamented that *the police officers, who were sent to villages in Todi Diocese to restore peace and order, during clashes between farmers and cattle breeders, and also to protect people from Boko Haram's attacks are impregnating our daughters and getting them infected with HIV* (FGD with youth, 2016). *When girls become infected by these officers as discussed by the youth, the infected girls will continue to transmit the virus to us, because most of us(youth group members)are not married and may end up marrying those infected by the law enforcement officers* (FGD with youth, 2016).

The Nigerian police authority acknowledged that HIV is prevalent in the force, attributing it to the long time spent on the duty posts by the officers without their spouses, which led some of them to engage in sexual activities.⁶⁷ The police officers first of all, upon their return transmit HIV to their wives, while their wives out of ignorance consequently transmit the virus to their unborn children when giving birth; they proceed to their home towns infecting young girls. This happens most times when they return from the peace keeping mission, the authority often gives them one or two months as leave, they mostly divide this leave into two; if it is two months, they spend a month with their immediate family and move to spend the other month in their villages. These are periods the officers mostly engage in transmitting the virus to their sexual partners.

Nigeria's soldiers and other para-military agencies lobby their way to peace keeping so as to enable them improve their financial well-being which in some cases result in getting the money needed but coming back home infected with various infections, including HIV. Taiwo bemoans that STDs including HIV have been recognized as the second major cause of death of Nigerian soldiers during peace keeping operations within and outside Nigeria (2011).

⁶⁷See <http://www.nigeria-aids.org/news/content.cfm?371>(Accessed on the 17th April, 2007).

5.3 Conclusion

Chapter five presented six major themes which emerged from the participants responses in focus group discussions. Responses relating to the causes of the spread of HIV were discussed and the researcher presented findings on some of the various ways through which HIV is spread in Todi Diocese. Having multiple sexual partners among the LCCN members in Todi Diocese has been thoroughly discussed to be one of the causes of the spread of HIV. Secondly, Gender and economic Inequality as women who were not privileged to be economically stable relied exclusively on their husbands for their financial needs, find it challenging to counter attack or negotiate safer sex methods, even when they are conscious that their partners are sexually immoral. The stigmatization of women and girls is an indication that they are in some way lesser human beings, especially with fewer rights than men and boys in terms of property ownership, income generation and control and the right to co-determine the terms of sexual encounters. The research has revealed that some women who knew that their husbands were HIV positive, and did not want to use safer methods were allowed to have sex without persisting on the use of condom, so they cannot be denied their basic needs.

Another area that facilitates the spread of HIV in Todi Diocese that was discussed was the inability of those who were infected to disclose their status, and consequently, denied the existence of the virus in their bodies so as to stay away from being stigmatized and discriminated. Related to this, are the various claims made by some medical experts who had publicly broadcasted to have found the cure for HIV, leaving many people with false hope which has also contributed to the spread of the virus as people were misinformed, by assuming that there was no need for the use of any safer methods. Another area of pertinent concern is the role of religious leaders, especially pastors who encourage their members to have only faith which is the pre-requisite for their cure which in itself has also contributed to the spread of HIV, as members believed that their HIV status has been converted from positive to negative by mere declaration of rejecting its (HIV) existence in the body , and the infected person continues to have unprotected sex, and as a result continue to infect other innocent people. Lack of knowledge on Sex and sexualities and HIV and AIDS in Todi Diocese which has also opened the ground for numerous infections of many LCCN members were discussed and lastly, how peace keepers have also played significant roles in the spread of HIV in Todi Diocese were discussed, and conclusion was drawn. The following chapter

(6) the researcher would be presenting further findings or information gathered during field work.

CHAPTER SIX

LINK BETWEEN STIGMATIZATION, DISCRIMINATION AND THE SPREAD OF HIV IN LCCN TODI DIOCESE

6.1 Introduction

As previously explained from the beginning of this study, stigma and discrimination remain the predominant factors spearheading the spread of HIV in Todi Diocese. If PLWHIV were loved and sympathized with, definitely, they will have the desired courage to openly disclose their HIV positive status and seek for treatment which will go a long way in depressing their viral load which will consequently reduce onward transmission to other people. The objective of this chapter is to demonstrate how stigma and discrimination promote the spread of HIV in Todi Diocese. Chapter six primarily discusses the connection between stigma, discrimination and the spread of HIV in the research area.

The negative and detrimental language which is used towards PLWHIV will be discussed. Underlying causes of stigmatization and discrimination and the resultant effects of stigmatization and discrimination in Todi Diocese will be unpacked through various focus group discussions and that will help us to understand why Christians who are supposed to love and carry the burden of each other stigmatize and discriminate against PLWHIV. The focus group will discuss how treatment of HIV patients is selective in the state, and how religion, tribalism play significant role in the distribution of ARVs to PLWHIV. The chapter will assess the level of knowledge of LCCN members in Todi Diocese on HIV and AIDS, interact with those living with HIV to also explore why discussions on sex become detested that members of the church shun from discussing openly, including pastors who are positioned in the church and the community to teach members on what they need to know about it. The responses from various group discussions will be thoroughly analysed to ascertain the likely causes that influence the stigma and discrimination in Todi Diocese.

6.2 The relationship between stigmatization and discrimination and the spread of HIV in Todi Diocese Adamawa state

Question: What is the relationship between stigmatization and discrimination and the continuing spread of HIV in Todi Diocese?

A focus group with pastors declared that, the discrimination against PLWHIV in Todi Diocese remains a strong factor in making the battle against HIV difficult to combat in the area of this research. For one to disclose his or her HIV status, one must be ready for the consequences that go with stigma and discrimination. For this reason PLWHIV continue to conceal their status for fear of being treated inhumanly. We need people who will enlighten us on the disease, because, misconceptions about the disease is promoting the stigma and discrimination (FGD with Pastors, 2016). This attitude can give rise to numerous HIV infections in the Diocese. For a group of pastors to demand that they needed ‘people’ who will enlighten them, shows the level of ignorance pastors have on the epidemic. As noted by the above group, the inhuman treatment meted against PLWHIV has necessitated their resolve to keep their HIV status to themselves.

Moving in the same vein, a group of PLWHIV declared: *That, the most neglected people in Todi Diocese and by extension, Adamawa state, are PLWHIV; for kidnappers, armed robbers, corrupt government officials, even members of the Boko Haram have lawyers who defend them in the court of law. But for those of us LWHIV are never seen as human beings, possibly that could be the reason, the government is doing nothing to protect our fundamental human rights. Some people will humiliate us and if you demand justice from the law enforcement agencies, you will certainly be adding salt to injury; because you will become a laughing stock. We are still humans and therefore, HIV has not taken away our rights and dignity. People want us to be wicked and some of us are doing what we don't want by consciously and unconsciously infecting other people. Perhaps if all of us are infected, the government and the church will fight stigma and discrimination head long* (FGD with fathers living HIV, 2016). When people who are HIV positive felt neglected, scornfully treated and out of anger determined to consciously infect others and out of annoyance openly pronounce that they will not die alone, it is a clear warning that the battle against the spread of HIV will continue to suffer setback and those who were infected will continue to infect innocent ones and the same church which stigmatizes and discriminates against PLWHIV will suffer the backlash of their silence to protect PLWHIV in the Diocese.

.Another area where stigma and discrimination is visibly demonstrated is among the Law enforcement agencies like the Nigerian Army and other para-military organizations in Nigeria in the process of recruitment. These agencies often look for reasons to reduce the number of people looking for employment to go for compulsory HIV testing, which if they were found positive were asked to go back home. This attitude is jeopardising the lives of so

many HIV positive persons. Participants confirmed that: *Some of us went for recruitment in the Nigerian Army after graduation from the University. We had all that were required and we started the recruitment process, after six month we were assured by officers to get ready to go to the Academy and start proper training. We called our parents and informed them that we have succeeded. The following day, quite a number of us were told that one thing was required from us; our HIV test result. Which the Army Hospital carried out on all of us, a day later, some of us were told that, we made all requirements needed, except that our HIV results were positive, therefore, they wish us the best of luck in our future endeavours. Some of us felt like wearing explosives and destroying the whole of Nigerian Army* (FGD with youth, 2016). When these young and agile youth who were often disheartened and humiliated return back to their respective locations with nothing at their disposals, to treat themselves continue to be vehicles of HIV transmission to other people out of frustration.

The researcher observes that PLWHIV and other diseases should be accorded special attention in terms of employment, to enable them become self-supporting; as this will enable them to have access to ARVs which will in turn suppress their viral load and reduce their rate of infecting other people. In relation to mandatory HIV testing as a pre-employment screening which continues to demoralize Nigerian youth who are living with HIV, Oladipo gives us a scenario where people were discriminated because they were tested HIV positive. The mandatory tests as a pre-employment screening mechanism has further impoverished PLWHIV in Nigeria who could have made use of their salaries to enhance their health status. Even in a situation where the people living with HIV are qualified for the post, this test gives reasons for the private sector to discriminate against HIV positive people by denying their right to employment (2006). Oladipo reports the case of Owolade, who applied as an accountant with an oil company, he was successfully employed but was later tested HIV positive and immediately he was denied the employment. In his words: "I applied just like any other person and was successful until the point they asked us to do some medical test which they said was in line with the company's employment policy. I tested HIV positive and was not given the job" (2006). Oluwale bemoans that another way out of the woods is for every government and non-governmental organization to adopt the inclusion of PLWHIV, this, he stresses, will help provide stable jobs for PLWHIV, when there is a steady employment, that will reduce poverty and diminish the impact of HIV on the Nigerian population (2006).

A group discussion with PLWHIV in responding to the above question: Admit that the most stigmatized and discriminated people in the state are PLWHIV. The same group suggests that, Adamawa state government needs to enact laws that will defend the rights of PLWHIV. *When we go to hospital, after waiting for several hours, the doctors come back to call us with so many derogatory names such as “Ina masu ciwon duri? Meaning; “where are those suffering from the disease of vagina”? Even though, sometimes they later admit that they are joking, but that kind of jokes are slaps on our faces. Out of frustration, we once beat a doctor who thought that HIV patients are less human. If there are laws protecting us, people will mind their careless and provocative utterances which in a way upset PLWHIV* (FGD with fathers living with HIV, 2016). The researcher observes that there is no law enacted to defend PLWHIV by the Adamawa state government as it is in the case of Bayelsa State government which has shown concern to PLWHIV (see page 21).

It was in respect of the high level of stigmatization in Adamawa state that the Chairperson of the Adamawa Agency for the Control of HIV, Nyako has urged the state government to accelerate the passage of the Anti-stigma and discrimination Bill to redeem the image of PLWHIV in the state. Nyako said the call became compulsory to defend PLWHIV against stigma. The Chairperson requested Adamawa State House assembly to consider the passage of the bill so that persons living with HIV could have respite and a sense of belonging in the larger community.⁶⁸ The above call was made since 2006 by the wife of the then governor, who ruled for over eight years, but nothing was done to secure the weak (PLWHIV).

PLWHIV continue to be stigmatized and discriminated against. Some of them were publicly disgraced in public gatherings simply because they are living with a ‘stigmatized disease’. Governments at various levels in Nigeria are responding with variations to the problem of stigmatization and discrimination in their various locations. For instance, in Ondo State, a jail term of five years is handed down to anyone found discriminating against people living with HIV.⁶⁹ Oleyelogun, who presented the bill before his colleagues, said there will be an option of N500, 000 fines. He said that people, whose offences are considered grievous, will pay the fine and spend five years behind the bars. This followed the passage of the anti-HIV bill by

⁶⁸ See: <http://www.nigerianbulletin.com/threads/nyako-urges-adamawa-assembly-to-pass-hiv-anti-stigma-bill.24306/>(Accessed on the 14th January, 2015).

⁶⁹ Discriminate against people living with HIV/AIDS, face five year jail term <http://www.premiumtimesng.com/regional/ssouth-west/165218-discriminate-against-people-living-with-hivaids-face-five-year-jail-term.html>(Accessed on 4th December 2014)

the state legislators.⁷⁰ This effort made by other states such as Bayelsa and Ondo should be extended to Adamawa state so as stop people from using derogatory names to describe PLWHIV so that their rights will be protected.

6.3 Stigmatization and Discrimination of PLWHIV in the LCCN

The secular authorities as mentioned above is a gathering of people from different faiths and have different motives for doing things, but for the church which is described as the body of Christ is supposed to be a place where God's love is experienced. The secular authority may not have the compassionate feelings of carrying the burden of those who are suffering of any kind; however, the church in demonstrating the love of Christ must enter into solidarity with PLWHIV. It is through this solidarity that makes our hope in Christ comes alive and becomes visible to the World (World Council of Churches, 1997:102).

If the church which is supposed to be a relief zone to the demoralized and those afflicted turns out to be a place of hostility against PLWHIV, then something is definitely wrong with the body of Christ. Participants in focus group discussion with mothers living with HIV still in response to the question: if they had ever been stigmatized and discriminated against by the Church or in their places of work asserted that, A Lutheran pastor within Todi Diocese was requested by a doctor to be one of the pastors along other Pentecostal pastors who will from time to time visit those on admission at HIV and AIDS wards in the General hospital to pray and encourage them by giving them hope; because the Pentecostal pastors do not understand Hausa, which is the common language of communication in the Northern part of Nigeria, but the pastor declined and said "He is not a pastor of the dead people" and that he has other numerous obligations that God has given him, not to look after those who have wasted their lives and are suffering the consequences of their sins (FGD with mothers living with HIV, 2016). The group admitted that *the Pentecostal pastors will come to HIV and AIDS wards to visit them and pray with them, but there has never been a time you will see the LCCN pastors coming to our wards*. When the LCCN pastors continue to play the ostrich by assuming that they have nothing in common with HIV and AIDS and continue to view PLWHIV as people who have wasted their lives or equating the epidemic with a divine punishment rather than adopting a compassionate attitude, they will continue to foster hatred

⁷⁰ See: <http://www.premiumtimesng.com/regional/ssouth-west/165218-discriminate-against-people-living-with-hiv/aids-face-five-year-jail-term.html> (Accessed on 4th December 2014).

towards PLWHIV and this prejudices will jeopardise the collective effort needed to fight the epidemic.

Some pastors are afraid that by associating with PLWHIV in counselling and encouragement, their reputation will be marred. Oluduro in his article was right when he contends that, in a conscious move to combat the spread of HIV in Nigeria, the religious leaders are not helping matters, and their actions have increased the stigma and discrimination against PLWHIV (Oluduro, 2010: 4). Church members often learn from their pastors. If the LCCN pastors cannot visit HIV and AIDS wards how possible will it be for those under their leadership comfortably visit those areas? During my field work, a friend of mine refused to accompany me to the HIV and AIDS wards in the hospital. When I inquired from him the rationale behind his refusal, he explained: *As the Secretary in the LCCN Todi Diocese Cathedral, going to where HIV and AIDS patients were admitted will tarnish my image and integrity as a leader in the church, because someone may sight me and conclude that I am a HIV positive person and consequently, that would be the end of my leadership. Because whatever I tell them, they will never believe that I am not HIV positive*⁷¹ AIDS ward in (Numan) Todi Diocese is one area that people are reluctant to go. Those who go there are family members who have no choice, because some of them cannot abandon their loved ones. There are also few people who are compassionate towards PLWHIV, but not so common among Lutheran Pastors and members.

As Christians it is right to say that faith requires us to always live by the golden rule to do unto others what we would expect them to do unto us (Muyika, 2010:137). Do we expect that people should stigmatize us when we are to be in their position of being HIV positive? We are interconnected bodies, communally, nationally, continentally and globally. Therefore, whatever affects one, affects all. When Christians imbibe the characteristics of Christ, they will not only go to where they feel comfortable, but where people are hurt in order to bring succour to the afflicted and by doing so fulfils the law of Christ.

⁷¹ Martin Dauda, We went to Numan together on the 28th November, 2014, but when I requested him to go with me to the HIV and AIDS wards, he declined, because of the fear of being marked as a HIV infected and be stigmatized by church members.

LCCN has a hospital, one Referral Center and eleven (11) Clinics and Dispensaries spread across the nine Dioceses.⁷² The health care professionals who work in these hospital and clinics are also in the right position to help eradicate stigma and discrimination of PLWHIV, unfortunately, some health care personnels in the church are seen as the forerunners and vanguard of disseminating information on the members' HIV status most especially when tested positive. A group in response to the above question reported that, **the LCCN has health care professionals who were trained to keep people's results confidential but regrettably, some of them are the ones who make phone calls and inform members of your family as soon as you are tested HIV positive, before you get home your HIV result is talked about by neighbours. Therefore, I don't advise people to go to where they are recognised, except if they are ready to cope with the challenge of having the news of their result blown-out all over** (FGD with fathers living with HIV, 2016). When the church health workers cannot be trusted, they can equally promote stigma by their unguided and inflammatory comments, the infected will hardly find it comfortable to disclose their HIV status.

It is imperative for the medical personnels to recognize their own stereotype and attitudes before they can educate people on HIV prevention. They should be conscious of the language they use when they speak, especially to PLWHIV (Dyk, 2005:95). When the LCCN fails to discourage stigma and the use of language which is aimed at demoralizing those living with HIV, it will continue to lose its members to the epidemic, and sooner or later the church will regret its actions and inactions. The church is the last hope of all those who are assaulted with different challenges and should therefore do everything possible to comfort those in pains. PLWHIV run to the Church to find consolation, but when churches which are perceived to be the community of believers who are supposed to live in the footsteps of Christ are the ones stigmatizing and discriminating, where would the depressed and despaired find courage to live positive lives? Lending a helping hand to PLWHIV is not to be seen as encouraging people to continue in their sinfulness as contends by Oluduro that the rationale behind stigmatizing PLWHIV by some religious leaders is that, sympathizing with them and giving them any financial support could be misinterpreted as tolerating the promiscuous activities of PLWHIV and other people around (2010).

⁷² LCCN Pocket Diary, 2015.

Lack of compassion towards those living with HIV can even be a serious hazard to people who are not yet infected. Participants in the HIV infected group still in response to how stigma is linked to the spread of HIV in the Diocese asserted that: *We know ourselves, but we don't want those who presume to be holier than God to know us. They should leave us alone, no one dies twice, and whether you have HIV or not, no one lives forever in this mortal flesh. We are not bordered by the stigmatization out there in the community, but for church, it always beat our imagination that the same church that preaches about loving one another, goes contrary to what it professes. Some of us stopped going to church because of their attitude of discrimination. The love of Christ which they preached does no longer exist in and outside the church. We admit that we are sinners, let us continue in our sins, they should leave us alone; one thing is certain, some of them are unaware that their wives, husbands, children, are living with the same HIV, which they got from us* (FGD with Fathers living with HIV, 2016).

The painful feeling of having HIV is not as excruciating compared to the stigma and discrimination attached to the epidemic. When people know they are living with HIV and instead of seeking for treatment decided to remain mute on their status and only continue to infect other people, the rate of infections will continue to be on the increase and the battle against HIV will hardly be overcome. Stigma and discrimination must be eradicated to pave way for treatment, or else even when there are ARVs, people will not avail themselves for fear of being detected and discriminated. The two evils (stigma and discrimination) are fundamentally accountable for the high rate of HIV infections among Nigerians, especially in Todi Diocese (Kenechi 2010). This is corroborated by Paterson 2011:350; Nord 1997:61; Meteru 2011:96 in their setting.

The dignity of those infected or living with HIV is being relegated to the background in Adamawa state, which has affected their consciousness. Kapor and Nanda rightly assert that PLWHIV are constantly facing stigma and discrimination which harmfully upsets their sense of dignity and rob them of the joy of living (2010:34). In the same disposition McCain strongly advocates for the need to treat our fellow human beings with dignity that they deserve. He asserts that: We are all made in the image of God. Since God took personal interest to make human beings and since God chose to make human beings with at least some of his personal qualities, this suggests to us that all human beings, whether educated or illiterate, sick or healthy, Christian or non-Christian has value in the eyes of God and

therefore should have value in the eyes of fellow human beings. Every human being who is handicapped in any way, whether blind or deaf or cripple or having some other disability has worth. Everybody who has been diagnosed with HIV has worth. Everyone who is dying from AIDS has worth. Therefore, for us to separate ourselves from those suffering from AIDS is contrary to a Christian philosophy of life (2008:229).

Some people who are infected with HIV do not condemn themselves the way we do. They are aware that something in their bodies is really missing, but not everything. A story that was told by a HIV positive person is a pointer to the fact that the infected persons need to be given due respect and dignity. Mapanao said Being HIV positive means that she has merely lost her immunity, not her humanity (2010). Immunity and humanity are two different things. This goes in consonant with the saying that If wealth is lost, nothing is lost, if health is lost, something is lost, but if character is lost, everything is lost".⁷³ A character lost is more damaging to humanity than losing part of one's health. If a person who loses his legs or eyes and is not stigmatized and discriminated against, those who lost only their immunity should neither be stigmatized nor discriminated against.

The doctors and nurses are not well equipped to compassionately treat PLWHIV. A group of mothers further asserted that, *If God who is without imperfections is mercifully enough to forgive us, why do humans with similar deficiencies like us find it so difficult to forgive? A church Elder preached in the church and said, those who say they are born again after they got infected with HIV have a question mark on whether they are forgiven by God or not. When God was calling them they refused to hear, and now that they are calling God after becoming infected with HIV, God is saying, "Remember, when I was calling, you refused; now it is over* (FGD with Mothers living with HIV, 2016). God does not reason the way human beings do and his thoughts are not human (Isaiah 55:8).

In response to the above question, a group of mothers living with HIV lamented that: *The manner in which the church discriminates against us makes us feel humiliated. Some of us were cautioned by Women Fellowship not to participate in cooking during Women Conventions; because church members will not find it comfortable to eat our food, simply because they believe that HIV is a communicable disease which is transmitted by mere*

⁷³ Character Quotes: Character Quotations - About.com <http://quotations.about.com/od/characterquote1/> (Accessed on 3rd September 2014).

contact. Because of this we personally withdrew ourselves from any church gathering, because we don't find it comforting the way the church is treating us. Non-Christians are better off than those who call themselves Christians. The Christians will not assist you neither will they keep your discussion with them confidential. Stigma and discrimination in Todi Diocese seems to be more widespread and detrimental to us than other Dioceses in the LCCN (FGD with mothers living with HIV, 2016).

What does cooked food has to do with the HIV transmission, that PLWHIV are prohibited from participating in a communal cooking? Even in the church, PLWHIV are disallowed from leading in songs, and if he or she courageously decides to lead, many will not respond, because it is considered an abomination to respond to a song raised by a HIV positive person. Participants in the above group lamented that, *we women are the ones who stigmatize our fellow women in the church more than the men. Some of us were elected in the women fellowship to various positions, most of the times, when we raise songs during rehearsals and Sunday services, some women will not respond, simply because we are HIV positive. Some of us were relieved from our elected positions on the pretext that our fellow women were bitterly complaining about our HIV status, and our 'Uwar Zumunta' (Women Leader) will condescend to their grumbling and ask us to willingly relinquish our elected positions, which we did. Because of these attitudes to those of us who are living with HIV, some of us decided to leave the fellowship and stay on our own. The women are always glad when we do not attend rehearsals or even Sunday services* (FGD with mothers living with HIV, 2016).

Furthermore, during Holy Communion, women were instructed to boil water to thoroughly wash the cups members are using, so that the particles of the HIV left in the cup can be destroyed. There is no particular disease that people are more afraid of in the Diocese than HIV. The group said that, *it is because of us (PLWHIV) that the LCCN started introducing the use of hot water during Holy Communion purposely to destroy HIV. Pastors do not allow us to assist during communion services, on the pretext that members are grumbling. Non of our pastors who were posted here ever preached against stigmatization and discrimination of PLWHIV; that means they are in support of the way we are often humiliated by church members* (FGD with mothers living with HIV, 2016).

According to the DEC members, it is true that in this congregation members stigmatize and discriminate PLWHIV perhaps more than the other religious organisations, such as Islam, African Traditional religion, etc. There was a time members protested the employment of a woman who was asked to be sweeping and cleaning the church. People still have a misconception that she could spread HIV on the pews and people can easily get infected. Some people stopped coming to church, on the ground that those who contracted HIV should be withdrawn from public view and wait for their pre-meditated death. After all pleas to see reason to the decision of the elders, members were adamant, until we had to terminate her appointment for peace to reign (FGD with DEC members, 2016). When members do not understand what HIV is, they can assume that the virus can be spread haphazardly.

The DEC members should ensure that pastors stoop down to enlighten its members on how the virus is spread or else misconception on the virus will continue to linger on people's minds. Because of these kinds of attitudes by LCCN members Sunderland and Shelp observe that people, who realized that they are HIV positive, often retreat into a fear-filled and threatened world, withdrawing from people to whom they have been closed (1990:88). In responding to the above question, Pastors acknowledged that sub-groups in the church should not be blamed alone for stigmatizing and discriminating those people who are HIV positive. By the way, in my assessment the researcher wish to observe that PLWHIV are the ones who are supposed to avoid the so-acclaimed HIV-negative persons, because the virus is not contracted through casual contact, but the infected person can easily be infected with opportunistic infections. This is reaffirmed by Usdin when he contends that, while many people wrongly believe they are at risk from a person with HIV through casual contact, the truth is that it is the person living with HIV who is more vulnerable to getting infections from others (2003:81). In Todi Diocese, it is difficult for PLWHIV to do any business related to buying and selling of food items, most especially palm oil. For those who in their ignorance assumed that HIV can be contracted through blood conclude that the infected can drop his or her infected blood in the oil so as to get her enemies infected.

A youth group asserted that, *to eat food cooked by a HIV infected person in the LCCN is a battle one has to grapple with. Even our relatives who are living with HIV, we scarcely eat their food, because we were told that those who have HIV do go to toilet every minute, and*

'our culture'⁷⁴ demands that a woman does not go to toilet and still cook for the family and even people outside the family, it is an abomination. Sometimes, to summon courage and eat food provided by them, you may end up vomiting (FGD with youth, 2016). Similarly, PLWHIV in their discussion confirmed that, *some of us used to be business women, but when people knew that we are living with HIV, no one patronizes our business any longer, even our fellow Christians buy food from other people under our watch. Those who managed to buy things from us were our immediate family members* (FGD with mothers living with HIV, 2016). Meteru's assertion in her own context fits here when she corroborates that, "people lose their means of livelihood. Food vendors lose their customers after their HIV status has become known. Some of them are selling food, fruits and vegetables, products that customers would not under any circumstances dare to buy if they suspect the person is HIV positive" (2011:96). HIV does not kill, being infected with the virus is not the same as having AIDS. Therefore, the fear of HIV is grounded on the misconceptions surrounding the HIV, HIV cannot not be transmitted by eating food cooked by an infected person; it is either transmitted through sex or other channels such as the exchange of vaginal fluids.

Language also can neither be separated from our thoughts and feelings. Stigmatization is not without language that contributes in weakening the morals of those living with HIV. Below is the assessment of the harmful and detrimental language used against PLWHIV in Todi Diocese.

6.4 The Detrimental language of stigma and discrimination towards PLWHIV in Todi Diocese

Question: How do members of the church stigmatize and discriminate against you?

Mothers and fathers living with HIV asserted that, the most painful and hurting stigma and discrimination is the manner in which church members described PLWHIV. Church members who are supposed to protect those of us who are living with HIV are fond of describing us as walking corpses. When one person is infected in the family, the whole household is referred

⁷⁴ Culturally, Mayah people expect that a woman should not go to toilet before preparing food for the family. Hence people are not opportuned to eat breakfast because of poverty, lunch is prepared from 11-12 o'clock during the dry season period. After 11-12 and when she is done with her lunch, she is allowed to go to toilet. But in the rainy season women cook from 6-7 in the morning, after which they can be allowed to go to toilet. My father told us that "if a woman wants to be respected, she should not be seen going to toilet in the morning, even in the night before sex with her husband, as she will be contaminated. A man who sleeps with a woman immediately after she went to toilet is seen as irresponsible person". People know when you go to toilet, because people around will see you going. It is not something one does secretly. A common place is designated in most communities for toilet.

to as “Gidan gawaki”⁷⁵ People believe that no one lives long after being infected with HIV. If a member in the family is HIV positive, then it is presumed that all the family members are equally living with HIV and the assumption is that the family will soon be wiped out in a short while. There is no treatment for HIV it is a waste of money to go to hospital when one is diagnosed to be HIV positive. That is why in this community if someone goes to hospital and is tested HIV positive, then; he or she should put his or her house in order (FGD with Mothers and fathers living with HIV, 2016). HIV was once a death sentence; of course, there is now a reason to celebrate the achievement of modern medicine (Masten 2011).

One can deduce from the above argument that HIV is not a killer disease; it is the mind set attached to the virus that kills. The misconceptions on the virus often lead to hatred towards PLWHR. HIV is treatable unlike AIDS which have more complications than the HIV. Many PLWHR are aware they have antibodies, but never see themselves as walking corpses with the availability of anti-retroviral drugs. With the current improvements in anti-retroviral treatment, as noted by Chitando, HIV should no longer be allowed to progress to AIDS leading to premature death (2007:66), but that is not the case in Todi Dioceses. In Todi Diocese, people hardly pronounce the name or understand the meaning of HIV or AIDS. Some pastors are struggling to know what HIV and AIDS stands for. Some of them cannot differentiate between HIV and AIDS. A group illustrated how pastors struggle with the name HIV: *Our Pastor went for HIV workshop, he came back to share with the Church the knowledge he had acquired from the workshop but could not remember the name of the disease. Fortunately enough, he remembered that counting from 1-10, he will be reminded by one of the numbers. He then asked the congregation to start counting from 1-10 in English, when we got to number 8; there he remembered with exclamation, “Yea” this is the name of the disease* (FGD with youth, 2016).

Hence many people in the Diocese do not have adequate information on HIV and AIDS, once contracted with the virus; the closest thing around the person is nothing but death. All future plans terminate with the arrival of “8 or takwas.”⁷⁶ That is why from that moment most

⁷⁵ Gida is house, while gawaki stands for corpses (The household of late people). Because, one person known to be HIV positive in the house is believed to transmit the virus to all family members in no distant time.

⁷⁶ 8 is referred to both HIV and AIDS. Takwas is from Hausa term which is also translated as 8 in English. Few people know the acronyms of HIV and AIDS. Out of ignorance, some people say, any person infected with HIV or have AIDS has only 8 months to live, that is why a white man calls it 8. Those who live beyond 8 months are said to be living by the ancestors’ power.

people in Todi Diocese called it 8 or takwas. In Hausa⁷⁷ language some people called HIV and AIDS “kabari, sallama alaikum, ina zuwa”, literally translated as, “Excuse me, grave, I am coming soon” (This is referring to people who have HIV), reminding them that they have only few days to live. A youth group asserted that, *what is the essence of going to school when one knows that he or she has but a limited time to live? Nobody wants to labour for another person. Because we will only be wasting our time and the little money we have, it will not be proper to spend it in school instead of saving the money for our children. Because we know that with HIV our days were numbered. And even if we want to summon courage and do something for the future, we become disheartened when people start calling us ‘Kabari’ (Grave). Language of this nature does not give hope to those of us who are living with HIV* (FGD with youth, 2016). This made PLWHIV to live in bondage of fear, believing they will not be alive the following year, for that reason those who are farmers become apprehensive of doing anything, thinking that they will only suffer for no cause while another person will eat the fruit of their labour.

Fathers living with HIV in a group declared that, *we are called different names: one of the names is ‘Siriri or Kashi.’⁷⁸ Anyone who falls sick and begins to lose weight can be called with such names. Our children, even those who were not infected, were called, “quarter to go, meaning, they will not live long* (FGD with fathers living with HIV, 2016). There are many diseases that can cause people to lose weight, not necessarily HIV or AIDS. Someone should not therefore be branded as HIV positive because he or she as a result of illness suddenly becomes lean.

The group of youth reported that, *it is a tradition to ring a church bell in a peculiar manner when a church member dies, to alert the rest of the members. So, when this bell is ringed, people often draw conclusion that it is that man or woman who has HIV. Anytime you hear people crying that someone is dead, it is mostly assumed that it is one of us who are living with HIV. When there is a wailing in town, what comes to people’s mind is, one of these ‘Siriri men or women is gone. For those of us who have our relatives living with HIV, they will be calling our numbers to find out if it is one of them* (FGD with youth, 2016). Masten in his interview with Mario who was living with HIV, at the age of 53, Mario says, Tell those

⁷⁷ Hausa is one of the three major languages spoken in Nigeria, most especially in the Northern part of the Country.

⁷⁸ Siriri or kasha is literally translated as slim person or skeleton.

who always asked if I am death; I'm still Here (2011:7). By implication, Mario is sending a message to those who mock them and after hearing a cry of someone's death, which they quickly assumed she was the one, she is saying; tell them that I am still here; many in Todi Diocese who labelled those living with HIV as quarter to go, die and leave them long before their death. A group of fathers living with HIV testified that, many of their friends and neighbours who called them different names, and said to them that they are sorry for them because they will soon die, today; many of them are dead, either through accident or other sicknesses (FGD with fathers living with HIV, 2016). The fact that someone is HIV positive does not mean that he or she will die before those who presumed to be healthier and HIV negative.

The manner in which those living with HIV were stigmatized and discriminated in Todi Diocese has created an atmosphere of hostility among the infected and those who claimed to be negative. The researcher continues to use the word, 'claimed' deliberately; the reason being that someone who has never been tested to ascertain his or her HIV status cannot emphatically say he or she is not HIV positive. The mothers living with HIV acknowledged that *because of the way people stigmatize and discriminate against us, someone in this community has been dehumanizing us by calling us with names like Late Magdalene or Memuna while we were still living. Fortunately enough, he had a short-lived illness, after two days his obituary posters were flying everywhere, and instead of sympathizing with the family, some of us were celebrating his death* (FGD with mothers living with HIV, 2016).

When the LCCN members are adequately informed that when PLWHIV have access to ARVS, can live longer than some of us who claimed to be living without HIV, the level of stigma and discrimination will be reduced if not eradicated. When people are not positive in their use of language towards those living with HIV, the impact of such language is disastrous. McCain cautions that HIV and AIDS have its own language and vocabulary: In the HIV and AIDS industry, there are certain terms that we do not use. In our attempts to promote positive living among people living with HIV, we discourage and condemn those who use negative language such as dead people, about to go, sick people; one should always use positive language to talk to PLWHIV (2008:169).

When PLWHIV are called all sort of names, they may tend to condition their minds on the proximity of their deaths and consequently become disheartened about life. When people are

misinformed that HIV kills, and those living with it are on their way to their early graves, this can have negative impact on their psyche, which may in turn demoralize their effort in doing anything meaningful for their up keep. As a result of stigmatization and isolation, coupled with negative languages, not only is prevention and quality care hindered, people die a social, spiritual, and psychological death long before the virus can degenerate to AIDS and physically kill them. Therefore, the majority are not only HIV positive but they are likely to be stigma positive (Dube 2003:3).

A group of mothers asserted that *anytime our pastor wants to talk about HIV and AIDS, he is always negative about it. We have never heard him using positive language in relation to HIV and AIDS. He mostly uses skeleton pictures and will often say, If you are stubborn, this is how you will soon become, ask them, they will tell you; without him even recognizing the fact that some of us were infected by our spouses. People will be looking at us in and outside the church as those who are sexually undisciplined. Our pastor always thinks that by using such pictures, he is scaring the members of the church from engaging in immorality; he doesn't know that those descriptions are hurting us* (FGD with mothers living with HIV, 2016). The group further asserted that both LCCN pastors and church members during the farming season are fond of saying that, some people are planting seed on their farms; unfortunately, others will harvest it on their behalf, because they are HIV positive (FGD with HIV infected persons, 2016). Such messages can really send a wrong signal to those living with HIV. Even those whose health conditions culminated to AIDS deserved to be encouraged through the use of positive language on the pulpit and for those who can do one or two things either farming or any business of their choice should be encouraged instead of dampening their morals.

As mentioned above by a group, many at times, Church leaders are not polite in their use of language to those infected. The Church leaders use military language such as, “In ka ki jin bari, zaka ji oho.”⁷⁹ A group discussed that, they do not have confidence in their pastor any longer, because anytime the pastor climbs the pulpit, most especially if he sees any of us in the church, he does not talk or preach around the prescribed text for the day, except comments like: ‘If you don’t stop this sexual promiscuity, you will soon find your anus bleeding and finally find yourself in your early grave’; you will be given a “dog burial” (FGD

⁷⁹ Literally meaning, if you don’t hear stop, you will hear, suffer it.

with fathers living with HIV, 2016). When pastors equates PLWHIV as dogs and could be treated as such even when they die, the situation does not portray the life of Jesus.

HIV and AIDS should be seen as the enemy not PLWHIV as stated by McCain, The person carrying the virus is not the enemy, but a co-fighter or a fellow soldier in the fight against the HIV epidemic (McCain 2008:54). In the situation where the person living with HIV is being regarded as an enemy instead of the virus, it portrays the little knowledge and affection of the church members towards HIV infected persons. The researcher observes that the military language is good but misdirected. When those languages are used on the virus, different ways would be explored in tackling the virus; I presume the spread of it will surely be controlled.

6.5 The causes of stigmatization and discrimination in Todi Diocese

Question: What do you understand to be responsible for the reason(s) why people are stigmatized and discriminated against in Todi Diocese?

6.5.1 Sex alone was perceived as the only practice accountable for the contraction of HIV in Todi Diocese

A group discussion with pastors revealed that *the relationship between the church and PLWHIV can be likening to a relationship between snakes and human beings. We as Pastors, to be honest, we are not happy with those living with HIV, because after several warnings to be cautious of HIV, they developed an I don't care attitude, by sleeping around either before marriage, extra-marital or with prostitutes, and now, they have got what they deserve. In the same vein, the HIV infected persons run away from us when we tell them to come out and tell us their HIV status so we can assist them, because they know that we are not pleased with the way they lived their lives which led to their infections with HIV* (FGD with pastors, 2016).

There is a danger, when pastors limit HIV infections to sexual intercourse, without minding the fact that many of their members got infected through other conduits such as blood infusion, getting infected through exposure to accident victims etc. Of course, PLWHIV cannot approach their pastors, because, the conducive environment has not been created, most especially when those infected are viewed as sexually defiant people. Moyo rightly observes that, the question of sin linked to HIV infection and sexualities is a serious challenge to the church. The church seems not to have a response to questions about sin and

God in relations to HIV and AIDS and this is not helpful in the ongoing fight against stigmatization. This is complicated by linking sexual intercourse to sin. In fact, HIV is still being linked to illicit sexual intercourse. If you say, ‘I am HIV positive’, the next question will be “What have you done?” So the theology of retribution is still alive (2015:155).

Participants expressed dismay over the half-hearted attitudes of some health workers towards HIV infected persons in Todi Diocese. The group asserted that they were discouraged from going to collect their medications monthly as scheduled, because doctors are not sympathetic to their plight, after leaving them in the scorching sun, they only come back and start shouting and humiliating them as if they were small children; sometimes if they complain because of the way they are treating them, the doctors become angry and instantly they will say there is no drugs available, come back next week (FGD with fathers living with HIV, 2016). The group members further explained the way they were continually tormented in the hands of health workers: ***we were called all sort of names, when some of us were trying to tell them to sympathise with our condition, a doctor humiliated us by telling us that “he was not the one who sent us to go and fuck prostitutes. From that time, some of us decided not to go for the drugs again and started taking native medications*** (FGD with fathers living with HIV, 2016). If ordinary (untrained) people presume that all those who are living with HIV are immoral or got it from sex workers, those who are educated (doctors) are in a better position to enlighten the populace that many who are living with HIV did not deliberately do anything unwanted to warrant their infection. Unfortunately, some doctors are the ones promoting stigma and discrimination by their inflammatory comments.

Fathers and mothers living with HIV lamented that ***in Todi Diocese, if there is a particular sin that people abhor above others is the sexual immorality, and it is the same sin that is so prevalent even among the LCCN pastors. Some of our pastors even sleep with our wives, but when they hear that we are HIV positive, they are the first people to stigmatize against us before church members. A man who cannot be content with one wife and marries a second wife is regarded as irresponsible man, who does not deserve to be respected in the community, when it comes to church matters, he is not expected to sit on any of the first pews or the middle ones, but their seats are arranged at the back, closed to the door. They are referred to as “Fadadu”⁸⁰*** (FGD with fathers and mothers living with HIV, 2016). If

⁸⁰ Fadadu is a Hausa language, literally meaning “The fallen ones or backsliders” those who have erred and cannot control their sexual urge. They are also called “Back Seaters”. These are people who are not supposed to say a word in the church as doing so will portray the church as the gathering of immoral worshippers. Even

those living with HIV perhaps got infected through sexual misconduct, it is possible that other members of the church are also guilty of it and some are probably infected but eschew to be tested due to stigma attached to it.

A group of youth insisted that *the church should not assist PLWHIV because of their waywardness, as that will encourage those who are living in sin. The youth group declared that it is wrong for church to assist someone who went and wasted his or her productive life with prostitutes and after getting infected, the same person will run to the church for help, and the church will not tell him or her to go and face the consequences of his or her misconduct, but will give him financial support. If the church starts assisting those infected with HIV, the implication is that most of us will go into immorality so as to attract their sympathy when we are also infected* (FGD with youth, 2016). It is possible that some members got infected by means of sexual recklessness or unprotected sex; one should not therefore, deliberately engage in sexual misconduct so as to get infected and attract sympathy from the church.

Oluduro in his article disputes that; people need to understand that HIV is not only transmitted through sex alone. Therefore, the mentality by the church leaders that getting infected is the result of moral fault is misleading and that should be discouraged (2010). Oluduro further contends that, Viewing PLWHIV as the most sexually immoral or equating HIV with a curse by our religious leaders, instead of adopting a sympathetic and loving approach greatly contribute towards the stigma and discrimination of PLWHIV (2010). Supposing the only mode of HIV transmission is through sex, developing the habit of sympathizing with those members who have fallen into sin will create a good relationship that foster unity among PLWHIV (who are labelled as sinners) and ‘other’ members (considered to be holy) who are not infected so that the battle against HIV can be won (Galatians 6.1-5). Bongmba concurs that: HIV is a catastrophe that brings about severe suffering. It is a condition, which should evoke compassion and care from Christians.

The Christian community in Africa and around the world has an obligation to share the pain and suffering of PLWHIV. Compassion and responsibility are what we owe people whom we

though many within the week had committed fornication and adultery, as long as you do not take a woman as a second wife, and no one knows that you are involved in any sexual sins, you still remain a leader or a member of good standing. This perception contributes to the reason those who got infected with HIV are seen as the worse sinners in the Diocese.

encounter in face-to-face relations; in such encounters, where there is suffering, the proper response is compassion (2007:66). Suffice it to say that the church within its limited financial ability should create a level playing ground for all in terms of assisting its members. The church should be generous enough to incorporate other members of the church by also empowering them with money for business; members should be treated equally. Financial help should not only be limited to those who are living with HIV as that may send a wrong signal to other members. Other members may be tempted to presume that they will only be assisted when they are also infected with HIV.

A group of DEC members had divergent views on the advent of HIV: the first part asserted that they are totally convinced beyond any reasonable doubt that HIV is a tool that God has created to punish people who have decided to go contrary or in contravention to his divine idea of sex. They concluded that God brought the epidemic as a result of our disobedience to His directives particularly on sex. Therefore, if we don't want God to readdress his anger against us, we should leave the HIV infected persons to carry their crosses alone; because the Bible says, "He who sins shall die" (FGD with E.C members, 2016). The second faction immediately debunked the claim of the first group that HIV was from God. Citing the case of innocent babies who were infected through their parents, probing God that if AIDS is sent by God, then, he is not fair to have allowed the guiltless ones to be infected for sins they did not commit. If HIV was from God for those who commit sexual sins then, again God is not being fair to this generation, because sexual sin did not start from our generation, why then is God so partial (FGD with E.C. members, 2016)? The prevalent discrepancies among DEC members in Todi Diocese indicate that it is difficult for them to come out with policies that will protect PLWHIV. When HIV is exclusively viewed as a tool in God's hands to punish sinners, stigma and discrimination will continue to be on the increase, because no one will like to identify with someone who is under God's chastisement.

In showing compassion to our fellow human beings, Christians are admonished to demonstrate their affections to accident victims and robbery attack victims like in the case of a Jewish man traveling from Jerusalem to Jericho (Luke 10:30), such people cannot be avoided even when there are no hand gloves to use. Therefore, if HIV is a punishment, then when people find themselves in such an accident which led to excessive bleeding, should they be neglected? And if in the course of rendering support and one gets infected; what sin has he or she committed? The second part of this group's argument finds significance in the

words of Dixon who corroborates the above opinion that, AIDS is not the judgment of God and it never was. HIV was not an invention of God as a tool to punish the world. If it was, God's judgment must be remarkably selective. What about babies infected in the womb or through medical treatment (2010:121)? Sin is sin; no sin is greater than the other in God's sight. Sexual immorality should not be placed above other sins. The researcher is not in any way denying the fact that sexual sin has contributed in the widespread of HIV in Todi Diocese and the LCCN at large, but I uphold with Nicolson that Jesus acknowledged sin and did not pass it over, but he did not see sin as a reason for not loving indeed, he is reported to have said that sinners were closer to the kingdom of heaven, and that those who had been forgiven most also loved the most (Matthew 21:31; Luke 7:47).

The general perception of many in the church is that sinners should receive the punishment they deserve, and should distant themselves from "the holy people." The opposite should be the case. Like Jesus, the church should be the friend of sinners. Unlike Jesus, members of the church are themselves all sinners. Yet we claim Jesus is our friend, we must wish to bring others to the same realization (1996:38). Sexual sin is not different from other sins. I agree with Moyo when he says that, Why is God not punishing other sins such as murder, abortion, robbery and corruption? What is so particular about sexual intercourse that God has to punish it now with HIV rather than wait for the biblical judgement day? There is also the danger of promoting stigma against those living with HIV if it is taken as a punishment for sin and irresponsibility (2015:155).

6.5.2 Lack of confidentiality among health workers and pastors fuels stigma and discrimination in Todi Diocese

Question: How free and confident Do PLWHIV have to approach the church and health workers for help or disclose their HIV status?

The incompetency of health workers in Todi Diocese who do not exhibit confidentiality in their dealings with their patients had led many mothers living with HIV to shun antenatal care services which has resulted in giving birth to HIV infected children. Participants in the youth group point out that: *Some pastors serve as information ministers, because they are the ones who disseminate or peddle the information of one HIV positive status to the church members, by extension to the community members. They continued: the youth of this village almost humiliated a pastor at a funeral service of our colleague. Yes, we know that he died of 'HIV', but when the pastor was conducting the funeral service; his sermon was*

centred on HIV. Knowing that it was confirmed that the man died of ‘HIV’ disease’ and that was only revealed to the pastor, but he could not keep it to himself. He keeps saying, ‘HIV knows how to deal with you. That is how you (youth) will all die one by one like this one’. It’s like he is not wishing us well or not sympathizing with the temptation youth are facing. Some Pastors and health workers are predominantly responsible for the prevalence of stigma and discrimination in Todi Diocese (FGD with youth, 2016). Both pastors and members alike, see HIV as a disease that kills. People do not die from HIV but AIDS-related diseases, and HIV is not a disease but a virus. Death by AIDS should not be celebrated where there is compassion. The person who died of AIDS might have been sexually promiscuous or having unprotected sex, but LCCN pastors and church members should demonstrate their compassionate attitudes as being reprimanded by the Bible. Participants vent out their bitterness to those pastors and church leaders who lack leadership qualities of keeping the HIV status of their members confidential only to the infected person.

Unanimously, the youth group admitted that *if their pastors will learn how to maintain confidentiality towards PLWHIV, many of us will approach them for counselling and other instructions related to HIV. In a situation where pastors will disgrace you and make you regret going to their offices for counselling is seriously disheartening* (FGD with youth, 2016). The same counselling giving to those who have diabetes, high blood pressure and other illnesses should be extended to those living or infected with HIV; when HIV is viewed otherwise than other sicknesses counselling to the patients would be difficult. When the LCCN becomes an HIV competent church as would be fully discussed in chapter seven, their pastors would be compassionate enough to console those who are bereaved rather than adding to their sorrow.

Another group of pastors totally supported the forceful disclosure of the members’ HIV positive status. They argued that when people continue to hide under confidentiality and do not want to disclose their HIV results, other church members will not learn their lesson and they will continue in their promiscuous lifestyles and the battle against HIV will never be won. The analogy given by the pastors in this group is the case of armed robbery, kidnapping and other criminal offences. Arguing that armed robbery is almost nipped in the bud in Todi Diocese because when someone in this community is a criminal, the same person is reported to the law enforcement agencies and such a person is apprehended and punished accordingly; this has brought armed robbery to zero level in this community. HIV should also be treated as

such, and those who are infected and continue to infect other people should also be brought to justice (FGD with pastors, 2016). When pastors continue to criminalize HIV and continue to see those infected as ‘sexual criminals,’ to be compassionate towards those who were infected with the virus would be very difficult. The Nigerian constitution has criminalized those offenses, but HIV is an illness that has nothing to do with criminality.

Most LCCN pastors are seen as local champions in their parishes and some of the health workers working in various clinics in the LCCN are its members; when pastors are confidential about the HIV positive status of its members, and treat them with compassion, they can command same to these members who work in clinics. When stigma and discrimination is finally eradicated, members will not be intimidated from disclosing their HIV status. But because some pastors do not treat PLWHIV with utmost confidentiality and compassion, they cannot call to order those health workers who take pleasure in disseminating information of someone’s HIV status.

A focus group discussion with fathers and mothers living with HIV admitted that, going to hospital in this village is like committing suicide, because most of the health workers are so wicked and unskilled to keep one’s result confidential. They can even tell people without a test that this person looks HIV positive, before you even come to the hospital. The health workers can report you to the pastors; and our pastors are the most terrible people to disclose your HIV status to. You will start hearing some elders indirectly telling you things that will suggest that your HIV positive status is no longer a secret but a public knowledge. In no distant time people will start using your name to sing in the church (FGD with fathers and mothers living with HIV, 2016). Where there is no confidentiality among church leaders and health workers, people tend to lose self-reliance, because any hidden information could easily be divulged. Many marriages did not stand the test of time in the research area, due to lack of confidentiality among church leaders; likewise, some HIV test results which were supposed to be kept secret were publicized to people who have nothing positive in terms of treatment to contribute.

The above group contended that, Pastors and health workers who were supposedly trained to exhibit maturity in terms of confidentiality are the ones promoting the spread of HIV through stigmatization and discrimination of PLWHIV in Todi Diocese (FGD with Fathers and mothers living with HIV, 2016). Lack of confidentiality especially among health workers and pastors has become a thing of concern in the LCCN and the country at large. The youth group

confirmed that all the health workers in this clinic in the whole Division (Deanery) are LCCN members. If the government who post them here wants us to have confidence in the health workers, they should transfer them and bring those who are not LCCN members, preferably non-Christians; because Muslims and those who do not even adhere to the two religions are very confidential, unlike those whom we presumed to be in the same faith with us. When you have HIV testing today, especially if it is on Saturday, the following day the news of your HIV status will form the topic of the sermon on Sunday and everywhere in the community. Health workers will break the news to pastors, and the pastors will tell their council members and before you know it, it is all over the place. But if the health workers are from other faith, they have no business of going to the church, let alone, divulging the information to church members (FGD with youth, 2016). Other faith organisations who were supposed to learn from Christians, who are the salt of the world (Matthew 5:13), are becoming more trustworthy and confidential than the followers of Christ.

6.6 The impact of Stigma and Discrimination of PLWHIV in Nigeria, particularly in Todi Diocese

6.6.1 The loss of employment and other benefits

Question: Have you ever been stigmatized and discriminated against by the Church or in your place of work

Some employees who were found to be HIV positive were dismissed by their employers and sent home to die. Even those who were employed to work in the church were later dismissed on the ground of their HIV status. A group discussion with pastors lamented that, their congregations are becoming empty, simply because rumour (by health workers in our clinic) abounds that some of us (Pastors) are suspected to be having AIDS. Their argument is that by mere looking at some of us, our slim bodies suggest that we have AIDS. People are no longer comfortable in receiving Holy Communion from some of us because of the nature of the disease. The youth always protest that the Holy Communion should not be administered by someone who is suffering from this kind of disease. We suggest that such pastors should voluntarily retire so that the Holy Sacrament will not be continually defamed (FGD with Pastors, 2016). To be HIV positive is not a condition that one can easily ascertain by a mere look. Once there is a suspicion labelled on a pastor of having HIV, his congregation will ensure that he or she is transferred or be requested to compulsorily retire. Calling on a pastor to voluntarily resign with dignity or openly face embarrassment through discrimination by church members is against one's violation of human dignity and right. Holy Communion has

nothing to do with one's status; in as much as the pastor knows that he or she is living with HIV and religiously⁸¹ taking his or her ARVs will live relatively healthy like any other person. Some pastors in Nigeria were dismissed from service because they are HIV positive.

McCain gives a scenario of a pastor who was stigmatized and discriminated and dismissed on the pretext of his HIV status: "A young Pastor was diagnosed with HIV in Nigeria, without proper inquiry into the reason for it; he was immediately relieved of his pastoral duties and sent to his village to die" (2008:17). Dismissing people living with HIV as mentioned earlier is dehumanizing and also an infringement on one's right; that needs to be resisted from all angles. There are many PLWHIV and are economically disadvantaged, dismissing them is an additional pain inflicted on them. Some HIV infected persons in the country at large were not only stigmatized but were also dismissed from civil service and also relieved from their positions. Ahamefule, a nurse with Imperial Medical Centre, Lagos state used to be employed. But that ended when she tested positive to HIV and was fired by the management of the hospital. Having informed the hospital authority where she served that she contracted HIV while attending to patients who were living with HIV, she was treated with humiliation by a fellow doctor.⁸²

Ahamefule suffered abandonment, but because she was courageous enough and educated, sought the services of lawyers, and consequently was able to win her case. The fact that after 12 years of being traumatized and later won the case through her lawyer, does not take away the psychological and emotional disorder she passed through. But the good thing is that 7 million naira was paid to her as compensation.⁸³ This episode will serve as a deterrent to numerous people who stigmatized against PLWHIV. Many who are financially handicapped like the LCCN members in Todi Diocese cannot employ the services of lawyers only suffer and die in silence. A case of Ahamufule took the intervention of lawyers to restore her lost job. It is amazing for doctors who seem to be enlightened in the society but are also in the forefront in stigmatizing PLWHIV, infringing on their rights. This is what Gennrich describes

⁸¹ The word religiously is often used by Phumzile, the Coordinator of INERELLA to signify that those who are HIV positive should make commitment in taking their ARVs promptly and being conscious of taking the drugs as another form of worship, enables those living with HIV to live normal like any other person.

⁸² Nurse wins landmark case in Nigeria over dismissal for testing positive to HIV.

<http://theeagleonline.com.ng/nurse-wins-landmark-case-in-nigeria-over-dismissal-for-testing-positive-to-hiv/> (Accessed on 6th October, 2015).

⁸³ See: <http://theeagleonline.com.ng/nurse-wins-landmark-case-in-nigeria-over-dismissal-for-testing-positive-to-hiv/> (Accessed on 6th October, 2015).

as violation on the fundamental human rights: “Stigma and discrimination leads to human right violation” (2004:17; (2000:3).

Participants living with HIV admitted that some of them were victimized because they are HIV positive. In these two local governments within the Diocese (Demsa and Numan), when you confide in the office (Local Government Authority) that you are HIV positive, even if they merely suspect that you are HIV positive, they will transfer you to a remote village where you will not have access to medical facilities and when you complain or plead with them, the next thing you will see is a letter of retrenchment; they will not tell you that you were retrenched on the ground of your health, but they will look for unjustifiable reason and attach to your retrenchment. The issue of human right does not work here; the more you employ the services of lawyers the more you continue to suffer injustice (FGD with fathers LWHIV, 2016).

6.6.2 Denial of school admission and church wedding

People whose HIV positive status has been known or exposed were denied the privilege of securing admission in various schools in the county. In responding to the above question, it has been revealed that in Todi Diocese, women suffer disproportionately after the demise of their husbands. The children face discrimination from Sunday schools and government schools as well. The group of mothers living with HIV complained that, *women suffer stigma and discrimination more than men. When we lose our husbands, most especially when they were suspected to have died from AIDS related diseases, our children are denied admissions in various schools of learning. They demand that we bring their medical certificate which we don't have and they will use that to say that there is no admission available now. While other children were admitted without those requirements but they make our case difficult simply because our husbands were suspected or sometimes confirmed to have died from AIDS related diseases. Some teachers openly told us that they wanted to train those who will grow up and become useful to the society* (FGD with mothers living with HIV, 2016).

Some teachers in various institutions in Nigeria do stigmatize against the PLWHIV. This stigmatization results into denying those who are seeking for admission. Some of them hardly openly say they are not admitting those who are HIV positive, but will demand for HIV test result which they most at times use to deny admission to the prospective students. It is not

realistic that any child who lost one parent or two to AIDS related diseases automatically has HIV. Research has shown that there are quite a number of parents who were HIV positive but have children who were born HIV negative. Teachers should desist from concluding that the children of those who lost their lives to AIDS related disease are equally HIV positive. These attitudes do not encourage youth to voluntarily go for HIV testing. Many universities in Nigeria as noted by Balogun et al compulsorily required HIV test for prospective candidates seeking for admission and this has denied several of them admission to schools of their choice (2007). Those at the school age with intention to actualize their dreams were denied the opportunity because of their HIV status. When a child could not gain admission in the school of his choice and has nothing to do so many thoughts do criss-cross in the mind of such a person and at times can lead to an unimaginable act.

Agarau and Fashola report the case of Gloria who was also denied admission into a university owing to her HIV status: After passing all that is required to secure her admission, when Gloria was later tested and found to be HIV positive, she was labelled as a threat to other students and thereby denying her admission which almost caused her to commit suicide (2010). This denial of admission to those who were found to be HIV positive pose a threat to their lives and community, hence they were not engaged in schools, the only option for them is to be purveyors of the virus. In Todi Diocese, members who were found to be HIV positive were denied wedding in the church. This is one of the justifications for PLWHIV to keep their status undisclosed.

As mentioned above, a group discussion with pastors admitted that, in the LCCN, no HIV infected person had ever been joined with someone who is HIV negative or even if both of them are HIV positive, the church will not encourage their union, because if the church does that, then it is an indication that the church is contributing to the spread of HIV. Two HIV positive persons will definitely give birth to a HIV positive child. If the church continues to do that, then it should be responsible for the backlash of their involvement, in terms of shouldering their financial burden (FGD with pastors, 2016). When the Executive members were asked if it is the church policy not to join two couple if one of them is HIV positive? They responded, *there is no written down policy, but as a church, we don't allow it even if the two consented to be joined together. Are we trying to save life or kill? There is no sense in bringing together both the HIV positive and negative person together or even two of*

them are HIV positive. Those who rebelliously decided to go ahead with their wedding are out rightly placed on church discipline (FGD with DEC members and Pastors, 2016).

For the above reason the researcher argues that stigma and discrimination of PLWHIV starts with the LCCN leaders. If a pastor will suspend a couple intending to get married simply because one of them is HIV positive, the church lacks the qualities of being an HIV competent church. The attitude of both the DEC members and pastors can create an atmosphere of dishonesty in the church. Those who will want to go ahead and get married to each other can manipulate their HIV results to suit their whims. Group of mothers living with HIV acknowledged that due to stigma and discrimination some of them and their daughters who were tested HIV positive before marriage connived with doctors to conceal their HIV status to allow them have their weddings solemnized in the church, because the pastors do not follow us to the hospital (FGD with mothers living with HIV, 2016). Stigma and lack of awareness by pastors have created an atmosphere of dishonesty among pastors and church members.

6.6.3 Forsaking family members to die in isolation

Rejection and dejection of people with AIDS whose health conditions are fast deteriorating is very common in Todi Diocese. The immediate family members will ensure that a secluded place is designated for the person, away from the public view so as to protect the image and prestige of the family. Sometimes the patient will die without the family members knowing instantly. AIDS is seen as the only disease in Todi Diocese where people react to sufferers in this way. Prior to HIV, people that were infected with leprosy were stigmatized and discriminated against. In Todi Diocese, the leprous people have a particular town designated to them called Garkida,⁸⁴ “the home of leprous people”. These leprous people within Todi Diocese are not friendly till this day. If you do not have a family member who lives there with leprosy, you dare not go there; out of frustration they will beat you until you become unconscious. The reason is that you can’t ostracize them from the community and still go to where they live just to laugh at them. Today, in Todi Diocese People with leprosy are cured, leaving only AIDS without cure and this greatly contributes to stigma. In Todi Diocese, people never see anything good left in someone who is living with HIV because of the stigma attached to it. A group of youth suggested that, *in a tussle to eradicate HIV in the society and particularly in the LCCN, it will be proper if those living with HIV can also be*

⁸⁴ Garkida is a town about 7 kilometres away from Numan where people with leprosy were forced to live there.

quarantined pending on the time their conditions improve. Because allowing them to mingle with people, it is hazardous to the health of other people. A land should be allocated to them, if any of them dies he or she can be buried there, because they are accountable for their dilemma (FGD with youth, 2016).

If care is not taking, the way the researcher noticed how PLWHIV were treated in Todi Diocese, out of frustration they may soon become volatile to people who derogatorily called them with humiliating names. The Executive Council members made it clear that the only thing that is saving a clash between those living with HIV and those who are not is that, from the way church members (young and old) are dying indicates that there are some people who are living with HIV, but their status are concealed so they can retain their reputation, if not, one day from what we are seeing and hearing in most of the Divisions, there will be serious problem. Two members who were accused of living with HIV ganged up and assaulted those who accused them; inflicting injuries on them which left them unconscious (FGD with DEC members, 2016). There is a level to where PLWHIV can be provoked. If the DEC members failed to call the attention of pastors and church members to embrace those living with HIV and see the virus like other diseases, the leadership of the church will soon discover that they have directly or indirectly helped in creating animosity among its members.

Health workers are in the vanguard of promoting the proposed isolation of PLWHIV which contradicts their ethical code of conduct. Balogun et al point out that, 60% of health workers advocates that PLWHIV should be isolated from other patients (2008). This finds resonance in the words of Nicolson: PLWHIV experience alienation. Because of what community fears about AIDS they are likely to face discrimination and isolation. They become outsiders. Some HIV patients are driven out of the community and their hut burned to prevent their return” (1995:34).

In Wuse there is a designated place where those born with HIV and their parents are not willing to keep them can take them. Participants confirmed that, *someone came from Abuja and told them that if they are not willing to keep their children who are HIV positive, or tired of spending money on them without improvement, they can comfortably take them to Wuse in Abuja and drop them there, that will save them from unnecessary expenditure and that will also redeem their image in the community. Even though we did not take our children there, but any time they fall sick with nothing to buy drugs with we start thinking*

of what this man came and told us in this village, because we don't have money and our husbands are not alive (FGD with Mothers living with HIV, 2016). Some parents in Todi Diocese who have HIV infected children either take them to where they will be dumped or find a secluded place in the house where they can be kept from public sight. This is where the government of Nigeria has failed in providing health care facilities to its citizens. When people are not empowered to tackle their health challenges, alternatively, children who were to be future leaders would be separated from their parents and may not be taken care of by those who claim to do so. Those who are in the business of taking children to cities in the name of helping them to gain education may end up using them for rituals.

6.7 Conclusion

Chapter six demonstrated how stigma and discrimination is connected directly to the spread of HIV in Todi Diocese; the causes of stigma and discrimination such as viewing sex as the only way of contracting HIV and the manner in which health workers and pastors spread the status of people who underwent HIV testing were discussed. The misconception of viewing sex (which is the most hated sin in the Diocese) as the only channel of HIV transmission has made pastors and church members to neglect those living with HIV to face the consequences of their perceived sexual misconduct. Discussions revealed that lack of confidentiality by health workers, pastors and church leaders is a factor that promotes stigma and discrimination of PLWHIV in Todi Diocese, and Adamawa state at large. Apparently, stigma and discrimination have negatively affected the ministry to those living with HIV in the LCCN.

The stigmatization and discrimination of PLWHIV is not without repercussion; the attitude of people towards those living with HIV has negative impact on them. Those impacts were discussed in three main themes: Loss of employment; Denial of school admissions and church weddings, even to those alleged to be HIV positive and forsaking members whose conditions are deteriorating to die in isolation. The stigmatization and discrimination of PLWHIV in Adamawa state were discussed, and the discussions were narrowed down to Christians in Todi Diocese in order to understand if there are variations among Christians as to why they stigmatize and discriminate PLWHIV when they are supposed to show love to all. In the next chapter (7) the researcher would be discussing the last objective of this study: To discover ways of developing an HIV competent church in the Nigerian context.

CHAPTER SEVEN

DEVELOPING AN HIV COMPETENT CHURCH IN THE LCCN IN THE NIGERIAN CONTEXT

7.1 Introduction

To develop an HIV competent church in the Nigerian context as stated in the theoretical framework of this study, in relation to Sue Parry's concept, will form the basis of this chapter. The various themes that emerged in the course of discussion would be presented. The previous chapters (four, five and six) examined data from the field work to assess the attitude of people who are HIV negative to PLWHIV. From the data gathered, it was revealed among other things that, there is lack of knowledge which was mostly responsible for the stigmatization and discrimination of PLWHIV in the LCCN Todi Diocese. From the data collected, it was indicated that there was a complete inattentiveness from the church as a body of Christ in carrying each other's burden. The research revealed that, there was no commitment from the LCCN Todi Diocese to people dying to AIDS related sicknesses. People were left alone to die, simply because they are AIDS patients, and no one would like to be identified with such a person. These attitudes exposed that there is an increasing gap or contradiction between what the church leaders say and practice (theory and praxis).

Chapter six discussed what the LCCN needs to do to be an HIV competent church in the context of Nigeria. To achieve this objective, various themes that emerged from the field work will be presented. Effort would also be made to investigate the lack of competence of the LCCN Todi Diocese in being compassionate to those living with HIV, in providing competent counsellors who will offer pre-counselling and post-counselling test to HIV-infected persons and even those who were tested HIV negative; the LCCN response to the challenges of stigmatization and discrimination. The discourse among other things will explore why the LCCN is silent on the subject of sex and sexuality. The necessity for the theology of compassion as a substitute for theology of retribution would be discussed. Finally, for the LCCN to play its role as an HIV competent church, it must respond to the HIV epidemics in the same manner Martin Luther did to epidemics in his time and how Luther challenges stigmatization and discrimination of church members who were struck by various health challenges.

7.2 The competence of the LCCN in the context of HIV and AIDS

Questions:

What should the LCCN do to respond to both the spread of HIV and the evils of stigma and discrimination?

Do your Pastors freely talk or preach about Sex and sexualities and HIV and AIDS?

As noted in the statement of the problems in chapter one, the levels of mainstreaming of HIV and AIDS in the LCCN are still at a teething level, yet people, especially the youth are dying with AIDS related illnesses. The competency of the church, especially in the L.C.CN in Todi Diocese is nowhere near congruence with the reality of the HIV. In a youth group discussion, the youth advocated that pastors should stop encouraging people to get married since marriage is of no significance to them. *We have not yet seen a pastor who openly talks about sex and its importance. Pastors avoid this topic completely. They should not bother to talk to us about HIV, because if we are taught on how to go about our sex life, infections through sex will definitely decrease* (Youth group, 2016).

The LCCN seemed unconcerned about the damage the epidemic is ravaging. The LCCN being strategically positioned in Todi Diocese because of its large membership is a formidable instrument to spearhead the battle in dealing with the HIV menace, unfortunately, the church is far behind in the fight against the epidemic. As stated earlier, if the last time the LCCN as a denomination talked about HIV and AIDS is 11 years ago (2004), then the competency of the church is debatable. The LCCN has the numerical capability to win the battle against the spread of HIV in Adamawa state if it can only get involved as stated by Oluduro, if the churches and other religious organisations in Nigeria can translate their strength into action, HIV and AIDS will certainly be exterminated (2010). The strength of the LCCN is misdirected towards other projects devoid of prolonging the lives of its members. As stated earlier, sexual matters are masked in privacy. Due to the evidence gathered during this study on how pastors negatively react to sexual issues prompted the researcher to assume that the LCCN will be comfortable when the term sex is totally removed from church gathering.

Some pastors as confirmed by various groups become offensive when their members approached them to counsel them on sexual matters. The manner in which the LCCN pastors frown at issues of sex and AIDS related issues needs to be challenged in order to pave ways

for voluntary testing and treatment. The church needs to change its traditional and primitive perceptions it used to have about sex and HIV. When these perceptions are redirected, and human lives are accorded more value above other thing, isolation of people suffering with HIV will be drastically reduced (Parry, 2008:8). Attention has been focussed on the religious bodies, particularly the church as a community of believers, responsible for saving lives.

The challenge is, what can the churches possibly do in the face of such a catastrophe? It is most likely that the role of the church will be of central concern to the general public in a secular state. The researcher is of the opinion that with the vigorous participation of religious bodies, the menace of HIV will be stemmed within a shortest possible time. The LCCN Bishops must encourage their pastors to come out with teachings that will widen the mind of church members on sex and sexualities and HIV and AIDS. Members of the church run to pastors when they have marital upheavals because a conducive environment has been created for that, unless the pastors do same in the area of HIV and AIDS, members will continue to hide their identity. DEC members who were mostly pastors were responsible for creating an atmosphere where members are welcome to freely discuss their health challenges and sexual issues.

Some LCCN pastors have not prepared themselves to positively address the challenge of HIV, thereby given members the impression that doctors are responsible for anything that has to do with HIV. Richardson was right to say that “By claiming to be a church, yet not responding in sacrificial ways to the crisis of HIV and AIDS, it will be under judgment. It will be judged by the narrative that should shape its being and inspire its actions” (2009:146). The church cannot continue to remain passive when its members continue to die, then it has not played its God’s given role which is embedded in the scripture, to “Take care of the sheep” (John 21:16). A shepherd does not allow his sheep to revisit areas where one of his sheep was killed by wolves. A church of Christ that does not stand in defence of their members by having the characteristics of Christ is not qualified to be identified as a church. If the church is to be the body of Christ it cannot stand aside in denial of the suffering around it and within its own membership (Richardson, 2009:146). The church leaders were seen by the various group participants to have exhibited half-hearted attitudes towards their members living with HIV. A group of fathers living with HIV lamented that: *Out of ignorance we used to lampooned bishops, pastors and church leaders for neglecting us, but we have come to realize that even among ourselves, we don't have compassion for one another. The*

only few people you see in the church indicating interest to work with people living with HIV are doing so for commercial purposes. We are told that the World Bank is sponsoring HIV and AIDS programmes in the state, but we are not seeing the evidence, only those who work there are the ones driving expensive cars, building magnificent houses, buying acres of land, sending their children to International schools, leaving us in perpetual suffering. They are using us to achieve their selfish motive. The only thing they encourage us to do is to force us to declare our HIV status, so they can get our statistics and as soon as they get that, they only use them to get money from the donor agencies, and abandon us. To our greatest surprise, even our colleagues (PLWHIV) who are now working with World Bank do not see us like human beings any longer, because they are now big men and women (FGD with fathers living with HIV).

There is nothing wrong in knowing PLWHIV, but when attention is focused on statistics rather than compassion, members will continue to live in perpetual suffering. Furthermore, when people engage in HIV campaign for pecuniary reason other than compassion, the sole aim of fighting the spread of HIV will be defeated. The effort of the International community in combating the spread of HIV should not be sabotaged. For this reason as previously pointed out by McCain in chapter four: The devastating spread of HIV is generating a lot of compassion in the international community toward Africa and a great desire to help. Foreign government, the United Nations, NGOs, Foundations, Churches and Christian mission groups and even private individuals are investing huge amounts of money, into the battle against HIV. Unfortunately, wherever there is money, there are greedy people who are more interested in the money than they are in the purpose for which the money has been given. This is certainly the case with HIV battle. Some NGOs have been created because people see opportunities to make money; unfortunately, we have AIDS mercenaries-those in the AIDS battle for the money (2008:174).

If the church is competent enough and lives up to expectation and maintains its position in the community, it will be in a better position to challenge the performance of statutory health agencies in their responses to HIV and will be a powerful ally to protest organizations and stand as the watch dog to some greedy unscrupulous individuals who formed organisations for their selfish desires. Funds meant to alleviate the plight of those living with HIV were often diverted for projects that were viewed as more important. When the LCCN becomes an HIV competent, it will definitely become a conscience to the communities around it, and it

will curtail some of the excesses of money mongers who masquerade as people working for the good of the masses. The youth group which has some of them working in the two local government (Demsa and Numan) asserted that when local government needs fund to finance its projects, they often write memo to the state government requesting for money in the name of fighting the spread of HIV in the state. As soon as they receive the money, they divert it for other projects which they assumed are more important than the control of HIV in the area (FGD with youth, 2016).

Greed for money is threatening the credibility of the various managements for the control of HIV. Funds provided were not disbursed to the various legally established organisations, but squandered by some staff of the agencies that had immediately set up their emergency NGOs to siphon the funds for their selfish- aggrandizements, while persons living with HIV are suffering in silence. When the church plays it God's given role, it would have the courage and credibility to offer critique where it seems necessary. Such credibility must arise when its communal life and narrative display are an unspoken expression of its moral stance. In such cases what the church is will be at least as powerful a moral witness as what the church does (Richardson, 2009:150).

7.3 The LCCN and the promotion of safer sex methods

7.3.1 The LCCN and abstinence

In a serious determination to bring down the spread of HIV to the barest minimum, the LCCN needs to employ various techniques of safer sex methods in stemming the spread of the virus. Holding to one particular method of avoiding HIV infection is dangerous. Youth group in responding to the question, do you understand the concept of "safer sex?" Asserted that *here in the church we don't have an idea of what safer sex methods are. All the pastors that are posted in this District don't freely talk about HIV or sex. But if they must comment on the duo, they always say, abstaining from sex is the only way you can avoid HIV. Whoever cannot master his sexual urge should blame him/or herself not the church (FGD with youth, 2016)*. In the same manner, the DEC members confirmed that, every Sunday, members are warned to avoid premarital sex and to be abstinent in order to avoid HIV, but all the warnings fall into deaf ears. The church members are not learning a lesson from the death of their friends and neighbours as well to AIDS-related diseases (FGD with DEC members, 2016). The issues of sex and HIV have gone beyond mere threatening of church members. What church members need is teaching of various methods of avoiding direct contact with

the HIV. Advocating only one safer method by the LCCN; abstinence, which is completely no sex at all will certainly not give the church victory over the epidemic. Pastors group contended that *coming out to promote safer methods is an outright approval to sexual exploits in the church and we may later regret our action* (FGD with pastors, 2016). The argument of pastors that exposing church members to safer methods is a recipe for sexual explosion among church members does not hold water. The church members are sexually experimenting whether the church likes it or not, and the members remain uninformed of these safer methods which should have helped them in reducing the rate of infection in the Diocese.

Avoiding HIV infection should not be limited to abstinence alone as argued by Ryan which was stated in chapter two that “the only reliable method of achieving complete protection from acquiring HIV or becoming HIV positive is abstinence from sexual activity” (2014:248). To say the only reliable method of achieving protection from HIV infection is abstinence is quite misleading. Of course, abstinence is one of the reliable methods, but cannot be the only one. As mentioned previously, abstinence from sex does not guarantee that one cannot be infected with HIV. Some people have chosen the path of abstinence; unfortunately, they were infected through other channel (See the case of Sarah in page 39). There are safer sex strategies which the LCCN can employ in fighting the battle against HIV (as will be discussed below), if really the church must be an HIV competent church.

7.3.2 The LCCN and the use of condom as a safer method

For the LCCN to be an HIV competent church, it must accept the reality that the use of condoms (correctly) is another reliable method of avoiding HIV. Holding to a particular method can pose a danger to the battle against the spread of HIV; where abstinence fails, condoms can be of great assistance. The demonization of condom in the LCCN makes teaching around it very difficult. The LCCN needs to move away from stigmatizing condoms, but rather embrace it as a means of saving lives. I think the fundamental reason why a condom is stigmatized by the LCCN is its relationship to HIV which was viewed as an off-shoot of sexual misconduct. Condoms have also become stigmatized by church leaders because of the connotations of HIV and AIDS associated with them. Even when the researcher was trying to explain the significance of condoms against the spread of HIV within Todi Diocese and the LCCN at large, other pastors were of different opinion, and were not pleased that sexually active members are encouraged to use condom. When the pastors

continue to hold tenaciously that HIV is only avoided by abstaining from sex, pastors will continue to fight each other and negate the significant role condoms play in stemming the spread of HIV. Right to say with McCain that, “condoms save lives, and for that we thank God. When people are fighting the same battle he is fighting, he is not going to fight them. The simple reason is that both of them have the same goals. The correct use of condoms saves lives. An old proverb says, ‘the enemy of my enemy is my friend’. Those who are fighting HIV, even though using different means and presenting different messages must not fight each other (2008:176).

The fact that condoms save lives does not mean that it should be promoted and viewed as the only methods of stopping the spread of HIV; other methods must also be given attention they deserve. In most cases, the government always advocate for condom as if it is the only solution to the HIV epidemic. Participants in the youth group in response to the question, do you understand the concept of “safer sex?” revealed that, *for those of us who live in the city, anytime government officials come for workshop, the only thing they encourage is the use of condom which we don't see. And they will talk about it as if it is 100% safe or without imperfections. Beside condoms, they will tell us to take pre and post exposure prophylaxis which we don't know anything about or have access to, but if the church can teach us about sex and sexuality, most of us will make individual determination to be responsible about the manner we handle our sexuality* (FGD with youth, 2016). This is where the church needs to intervene by using what is available within its disposal to engage in the battle against HIV. It took the researcher time to understand what the group was describing, because they cannot pronounce the name “pre and post-exposure prophylaxis”, let alone knowing how it is procured and used. Abstinence and faithfulness are the safest, but people are not in position to follow this, therefore condoms are the next possibility (Moyo, 2015:156).

Some countries provide condoms free through hospitals and clinics as further asserted by Moyo, but realistically, condoms are not within the reach of so many members in Todi Diocese. Many clinics and hospitals contacted by the researcher admitted that condoms are only within the reach of rich people, but most people in the rural areas only hear about it, but many of them have never come in contact with it. Even if the condoms are available, they should not be viewed as exclusively the solution to the spread of HIV because they also fail. McCain rightly upholds that: Sometimes we give people wrong information. We do not state

that condoms fail. We do not state that they can tear or slip off. We do not say that condom can deteriorate through being improperly stored. Because sex is something that is practiced in a highly excited state, condoms are not hundred percent reliable. The recognized breakage rate of condoms is 7percent; in addition, condoms slip off of the penis approximately 4 percent of the time. The recognized rate of failure of a condom to prevent pregnancy is between 12 and 15 percent. Therefore, a conservative estimate of the failure rate of condom either because of defects or improper use is about 10 percent. In light of these facts, the message that sex with a condom is “safe sex” is misinformation. It can certainly be argued that using condoms is “safer sex” but not safe sex (2008:176).

The DEC members stated that they cannot be a party in contributing to the sexual promiscuity of church members by encouraging the use of condoms, even to those who are sexually active. It is our duty to discourage them from immorality, not the other way round (FGD with DEC members, 2016). Condoms still remain one of the viable options to safer sex, irrespective of their failure at times. Condoms can tear and are not 100 per cent safe, especially when they are used inadequately, however, condoms have saved many sexually active men and women from becoming infected with STDs. Coleman asserts that, the arbitrary failure of condoms does not make it unusable. Parachute can tear and don't always work, but would you refuse to use one when you need to jump out of a plane? Remember, condoms are not only to prevent HIV, but also to protect both of you from STIs and pregnancy (2010:44). The use of condoms should not be criticized and demonized by the LCCN, but it should rather be embraced as one of the safer methods which will support the battle against HIV among church members.

7.3.3 Masturbation: another method of HIV prevention

Masturbation is the self-stimulation of the genitals to individually achieve sexual pleasure. Masturbation is recommended by various researchers most especially in the era of HIV in dealing with its spread. Both PLWHIV and those who are negative can employ the practice of masturbation to stay away from other strains and to keep one from becoming infected with HIV. Some youth demanded to know if they can embrace masturbation as alternative to sexual promiscuity. They asserted: *Some pastors preach that those who masturbate will go to hell. For those of us who don't want to engage in premarital sex, are we allowed to have masturbation to keep ourselves from being infected* (Youth group 2016)? The issue of masturbation is not within the power of the secular authority to say whether it is right or

wrong, but the secular authority (medically) can explain its health implications. Even among the LCCN pastors, there are divergent views on the issue of masturbation. However, in dealing with HIV infection, in my own opinion, if the LCCN is to be an HIV competent church, the LCCN needs to embrace masturbation as one of the formidable weapons of fighting the spread of HIV. Masturbation is free from the complications that can emerge when one has sex with someone.⁸⁵

The church which ought to be the conscience of the society is responsible for unveiling the misconceptions around masturbation as to whether it is a sin and is not allowed or not a sin and should be encouraged. Scherrer and Klepacki state that, the safer sex which advocates masturbation as an acceptable form of sexual behaviour for non-married teens is unbiblical and unhealthy. These behaviours go against the scripture, which admonishes us to keep our minds, heart and bodies pure from sexual sin; besides, masturbation threatens to diminish the pleasure and intimacy of sex that God had designed for married partners (2004:140). In the researcher's opinion, the mind is relatively stable in regards to the temptation relating to sex when one embraces masturbation which alternatively gives satisfaction to some level and thereby taking away one's attention from sexual thoughts which naturally surround any normal human being. The researcher is not unaware of the virtue of self control; however. In a situation where one cannot exercise self control, masturbation is alternatively a preferable option rather than engaging in unprotected sex. If masturbation has no health implication, it should therefore be supported by the church and the LCCN particularly. Grodeck contends that "solo masturbation-without physical contact with another person-is one of the only sexual activities that carry no risk of giving or getting sexually transmitted diseases, including HIV. Masturbation is normal and healthy, despite various claims to the contrary. Almost everyone masturbates whether or not they admit it" (2007:96).

Grodeck further argues that, if you have the virus, solo masturbation is a great way of getting sexual pleasure without all the complications that come with another person. Besides, some people masturbate to relieve stress or boredom. Whatever the reason, masturbating is completely safe (2007:96). Masturbation may not generally be accepted, but it is considered one of the safer methods the church can use as another instrument in fighting the spread of HIV as posits by McCain: The message that the faith community has about sexuality is the

⁸⁵ What is masturbation, and how do you do it? <http://sexeetc.org/info-center/post/what-is-masturbation-and-how-do-you-do-it/> (Accessed on the 20th February, 2016).

ideal message for reducing the spread of HIV. The church also has the authority of teaching its members on how to protect themselves from diseases (2008:6-7). For now the church is held in high esteem in regards to knowledge about sex and sexuality; if the church through its leaders can make a conscious determination to equip its members with knowledge on sex related issues and safer methods which are available to halt the spread of HIV, it will absolutely triumph over the menace of HIV infection and averting untimely death in their respective communities.

7.4 The LCCN as an agent of hope and healing to people living with HIV

Christian love is based on faith and hope in the power of Christ's resurrection, but hope has often been in short supply in these thirty plus years of HIV and AIDS. Hope has emerged in the development of anti-retroviral medications (ARVs) but theological hope also must be interpreted in the light of HIV (Rakoczy, 2015:132). Scientifically, research has shown that efforts are on the top gear to find a cure for HIV meanwhile, in the absence of a cure at present, for the LCCN to be an HIV competent church; it must be a healing community where people can run to and receive their healing. Cure and healing are two different things as argued by Mapizela.⁸⁶ While there is no cure for HIV now, the LCCN could serve as a healing agency. Members of the church, who are living with HIV, must run to the church for their healing.

Chitando contends that: For the church to be HIV competent, it must approach the theme of HIV with a sense of humility, and it must accept the fact that it is made up of wounded healers, ensuring that it offers a shoulder to cry on for the bereaved; by doing this, it fulfil its responsibility as a healing community in relation to HIV and AIDS (2007:72).

When orphans who lost their parents to AIDS related diseases are encouraged by the church to continue with their schools by settling their fees and other basic needs, this will indeed bring healing to both the infected and the affected as well. Group discussion with mothers living with HIV lamented that, ***our predominant challenge is two - fold: the inaccessibility of ARVs and the psychological trauma the church members inflict on us. We wish we***

⁸⁶ Mapizela is the Executive Director of INERELA who made a distinction (during a Seminar, 2015) between Cure and Healing, she asserts that though she is still living with HIV without a cure (for now) but has been healed from its grip because any sickness that has solution on how to be managed is no longer a threat to life. Mapizela contends that in the absent of a cure for HIV, the church should play its God-given responsibility by bringing healing to its members who are living with HIV.

could get one of the aforementioned (FGD with mothers living with HIV, 2016). Healing comes in different dimensions: to be compassionate towards those living with HIV is one way of saying to them that the church is commiserating with them in their pains. When the LCCN welcomes its members who are living with HIV and embrace them by showing them love, those who are unwilling to disclose their status will do so without any fear of being side-lined, stigmatized and discriminated. No matter how accessible the ARVs become, love cannot be equated with drugs. ARVs work in the body by controlling the viral load, while love and compassion is a healing of the mind. Participants further narrated their disappointments that, when they approached a church for assistance, either financially or through counselling how to go about their HIV challenge that is weighing them down; *the pastors often complain about insufficient funds that will take care of all the needs of church members, that is why at times we don't want to start what we cannot continue with. We, therefore, encourage those living with HIV to approach their family members who are in a good financial position to assist them and also to look for medical professionals who will be of great help to them. If they cannot financially render us any support, they should be compassionate enough to call us in their offices and homes and counsel us with words of hope* (FGD with mothers living with HIV, 2016).

The LCCN does need experts in dealing with the challenge of HIV, but where there is paucity of such experts, the church as a denomination has something it can use to fight this epidemic. The church must use different techniques within their ranks to fight against the spread of HIV. As a Minister (Pastor) of the gospel; I have a pulpit to contribute my quarter to the fight against HIV. We need to get involved at our various levels as observed by McCain: HIV if not fought from all angles of the society most especially in Nigeria it would do a lot of damage, and McCain believes that when the academic institutions and religious leaders are fully engaged to participate in the AIDS battle, we will be on the road that will ultimately set the African continent free of AIDS (2008:119). Will the LCCN leaders negate their duty to fight the spread HIV without them acting in the appropriate way to help? Will they continue to turn their eyes in the other direction while their members especially the youth continue to lose their lives to AIDS?

Government agencies and other NGOs are not the custodian of hope, because more often they use non-religious approach; but for the church, it is uniquely placed in every community to give hope and this message of hope will have positive psychological impact (healing) to those

who were once devastated by the news of their HIV status (Chitando, 2007:78). In order to compassionately respond to persons living with HIV, the LCCN pastors at all services must consciously endeavour to encourage their members with messages of hope for a positive living. The LCCN on every Sunday has specific texts and hymns that go with the event of the day from January to December. All the various groups in the church are often instructed to present songs that match the text of the day. This is an avenue where various texts and hymns of relevance to the plight of PLWHIV can be chosen to cushion the effects of the epidemic. What kind of a church excludes people with illness? What kind of body of Christ cuts off people (Rackoczy, 2015:141), when the Bible which we (Christians) claim to be our guide admonishes that, if one member suffers, every part suffers with it; if one part is honoured, every part rejoices with it (1 Corinthians 12:26). By doing that by implication we are carrying the burden of one another and thereby fulfilling the law of Christ (Galatians 6:2).

A relevant Hausa hymnal which is always sang in the LCCN (163) can be of great relief to the sick including those living with HIV.

1. Babban Mai magani na nan, Yesu Mai jin tausayinmu Mu je mu nemi warkewa, a wurin Almasihu.
2. Mai ba da lafiya ne shi, cuta fa zunubanmu Mu je mu roki gafara, a wurin Almasihu

The above two stanzas were translated from the English version in Sacred Songs and Solos (S S &S) Number 89. However, the Hausa translation has slight difference. The direct translation of the above is:

1. The great Physician now is here, the Sympathising Jesus. Let us all go and ask Him for healing.
2. Jesus gives good health, for our virus and our sin, Let us all go and ask for healing and forgiveness from Him.

There are various texts in the Bible like the ones stated above and relevant hymns also which can give solace to church members who are living under the yoke of various illnesses. Relevant texts and hymns were always chosen and sang but without due recourse to those living with HIV and other sicknesses.

Church members who are living with HIV should be given opportunities to openly address church members, to enlighten people on the danger of not knowing their status which will enable them access early treatment and which can in turn enable them to live and age with HIV. When this awareness is done by someone who is talking from experience in the manner which Mapizela is doing (as stated above), it will carry more weight than someone who is speaking from accumulated knowledge. AIDS awareness should be accorded more awareness than other illnesses. When Nicolson says that it is very important not to exaggerate the scale of AIDS or ‘privilege’ AIDS above other diseases (1996:5) because more people die of motor accidents than people who die from AIDS-related diseases, and that women die of breast cancer than AIDS. The researcher tends to have a different outlook on his assertion. It is possible that people die from other diseases more than AIDS, however, no family of an accident victim in Todi Diocese has ever been stigmatized like in the case of HIV and AIDS, therefore, HIV and AIDS is to be given more attention to other diseases; because the stigma and discrimination attached to it in many communities especially in Todi Diocese.

A church member who is incapacitated by accident is still held in high esteem than the one who is living with HIV. When he or she speaks, he or she still commands respect, unlike people whose HIV positive status becomes a public knowledge. The researcher is not basing his argument on the statistics of casualties from death caused by AIDS-related diseases and other diseases, but the level of stigma and discrimination that goes with HIV unlike other diseases. If the church must work towards eradicating HIV in Todi Diocese, it must embark on teaching its members on the significance of sex and also unveil the silence surrounding it as will be discussed in the following sub-topic.

7.5 Eliminating the culture of Silence on Sex and sexualities in the context of HIV and AIDS in the LCCN Todi Diocese

The researcher considers an open discussion on sex and sexualities and practicing Christian religious principles about it (sex) is one of the best guarantees of avoiding HIV as argued by McCain: If people openly discuss sex and sexuality, AIDS would gradually disappear from the face of the earth (2008:108). The DEC members when responding to the question: What is their understanding of sex and sexualities in the context of HIV in Todi diocese? Confirmed this and asserted that, *if there is a topic that the pastors find difficult or hate to freely talk about is sex and sexualities and HIV and AIDS. Both pastors and members shy away from the above topics. To be a responsible pastor and to be considered mature in*

mind, the word sex should only come to mind in the night when everyone is sleeping. He or she who talks freely about sex is not only seen as a loose person but is therefore considered not eligible to be in a leadership position (FGD with DEC members, 2016). As mentioned above by the participants; to be suitable for leadership position, pastors must maintain their distance from openly discussing issues pertaining to sex, or else they will be embarrassing people in the church with “Maganar banza or maganar yara.”⁸⁷ Talking about sex is considered an exhibition of childishness. It is a topic that can be discussed by the elderly not to the children. If an old man dares talks about sex, he is called, “Tsohon banza (useless old man)” (FGD with DEC members, 2016). Hence pastors are eager to become leaders and desire to be branded as people of maturity shun discussion on sexual issues, consequently leaving their members in obscurity. According to mothers living with HIV, women from the age of 55 and above were assumed not to be engaging in sexual intercourse. A woman at that age who mistakenly says her husband always denies her sex would be seen as a prostitute because a normal and sensible woman of her age should be talking about something else, not sex. Participants stressed that, *it is culturally an abomination when our daughters or sons got married and start having sex and children, while at the same time our husbands will still continue to approach us for sex, they will find it hard to accord us some respect* (FGD with mothers living with HIV, 2016).

The participants further stressed that, *when a woman is matured, she does not need to be reminded; for a woman of 55- 60 years asking her husband for sex means something is definitely wrong with her consciousness. It is embarrassing to hear that some women can tell their husbands that they are not satisfied sexually. Even if you are below 50 years of age, it is culturally wrong for a woman to open her mouth and say, “I want more of sex”, except if she had had her up- bringing in another culture, but not in Mayah culture* (FGD with Mothers living with HIV, 2016). When the researcher inquired, how old some of the participants were, they said 52 to 56 years. These attitudes towards sex from women after 50 years as argued by the participants, lead their men counterparts to seek for sexual satisfaction outside their homes as previously mentioned. The DEC members who were mostly men responded differently. They used an African adage to describe their desire for sex. They asserted that, no matter how old a gorilla is, his age doesn’t stop him from climbing a tree (FGD with DEC members, 2016). This indicates that for men, age is not a barricade to sex.

⁸⁷ Maganar banza literally means useless talk and Maganar yara, mean childish talk.

This reason prompted the researcher to presume that this cultural orientation has led many men to seek for sexual satisfaction outside their matrimonial home which in turn has resulted in men getting infected with HIV and consequently infecting their wives within the Diocese. All this mentality is exhibited because members of the church lack teaching on sex and they therefore see it as only for procreation, and if one has enough children, there will be no reason for engaging in it any longer.

The above mentality finds resonance in what Mbuy-Beya says; that a woman is not expected to seek sexual satisfaction for herself, she is only anticipated to be passive during sex or else she will be suspected of having extra-marital affairs (1998:40). Some LCCN leaders and members as well were ashamed of talking about sexual issues to the extent that people describe it in Mayah language as, ‘Pe men bere’ literally meaning a shameless act. Participants confirmed this and said, it is wrong for any responsible person to talk about sex and even perform it in the day time. *We should not allow the white men mentality to relegate our upbringing. God made sex to be done in the night, because night was made for resting after sex. That is why people are not supposed to talk about sex openly. People are supposed to be in their farms, not in their rooms in the day time. Having sex in the day time is a sign of laziness* (FGD with fathers living with HIV, 2016). It is from this mind-set that when a pastor in his sermons or regular discussions mentions sex in the day time and or in the church, members burry their heads in shame, because the church is a place which is considered to be filled with the presence of God where unspiritual issues such as sex and HIV should not be discussed.

Commenting on the silence surrounding sex, Bala argues that: We have a serious challenge: the absence of a constructive language for sexuality. A conspiracy of silence therefore continues to surround HIV and AIDS. Women have found it difficult to overcome this barrier and have not been able to freely discuss the matter with their partners or pastors or even with their peers. The women are not well informed of the pleasure of sex. With such an entrenched and deep rooted knowledge base, how then can messages of safer sexual practices to prevent HIV make an impact that can foster a process towards positive behaviour change (2001:18)?

It is not only women who have been constrained in talking about sex as mentioned by Bala, but men as well. A group of women debunked Bala’s position and claim that men are responsible for the huge silence surrounding sex; when our partners need sex, they don’t

discuss with us about it, they just act it; while you are deeply asleep, you will hear someone tapping you at the back or dragging your feet, when you wake up, they will start removing your cloth silently. Sometimes we assume they are our husbands, because it is in the dark, only to discover later that it was a different person, either their younger brothers or neighbours (FGD with mothers living with HIV, 2016). This is where communication plays an important role in sexual affairs between partners. In Todi Diocese as earlier mentioned, over 70% of the population live without electricity and also live in houses that have no gates, people, therefore, take advantage of this and go into many houses and disguise themselves as husbands and sleep with women who are not their wives. The same women group complained that men do not want to sleep in the same room with them. If we are together, other men will not have the courage to do what they are doing to us. When you are alone, and someone comes in the night without saying anything, you assume it is your husband (FGD with mothers living with HIV, 2016).

Communication is very essential to ascertain whether the woman is sick or having her menstruation. She may even be healthy, but may not be in the mood of sex, and that will make the intercourse a one-way traffic or only for the man's satisfaction. When husbands and wives as seen above hardly communicate with their partners about sex, then it is evident that they cannot freely talk about it with their children. Owing to the sensitive nature of sex and sexuality, parents, church leaders and the community at large leave their children to go about their relationships without direction as a result of this negligence; young people face great pressures towards sexuality from their peers. According to Garland, most Nigerians cannot talk about sex with their partners as well as their children, and consequently find it difficult to talk about AIDS. If parents want to safe the next generation, it must openly talk about sex (2003:119). For the LCCN to be an HIV competent church, it must be actively engage in creating avenue for sex discussion in the family and among its worshipers, as it is often said that, 'charity begins at home'.

Every year, the LCCN in collaboration with TEKAN media prepares a Spiritual Guide called, "Abincin Ruhaniya"⁸⁸ which all the church members were encouraged to use. Abincin

⁸⁸ Abincin Ruhaniya is translated as 'Daily Spiritual Diet': This is prepared annually for all the members of the church; even those living outside Nigeria, sent for their copies during the annual convention. Through this spiritual guide, members can be taught issues relating to sex and sexuality. Unfortunately, year in year out, one hardly sees or hears anything related to sex and sexuality, and HIV and AIDS in the Guide, owing to the fact

Ruhaniya is translated as ‘Daily Spiritual Diet’: This is prepared annually for all the members of the church; even those living outside Nigeria, sent for their copies during the annual convention. Through this spiritual guide, members can be taught issues relating to sex and sexuality. Unfortunately, year in year out, one hardly sees or hears anything related to sex and sexuality, and HIV and AIDS in the Guide. Various topics are discussed, but topics on sex and sexualities and HIV and AIDS are always side-stepped. These are topics that need to be seen occupying most of the themes, which our members need most; if not for our sake as parents, our children need them. If the LCCN leaders are not comfortable with their sexuality, their children should not be neglected as rightly argued by Nicolson: “We are uncomfortable with our own sexuality. We are even more uncomfortable with the sexuality of young people. AIDS makes us face the reality of our own sexuality; if the communities around us are shy to talk about sex and sexuality, but the church of Christ cannot remain silent” (1996:19).

In the course of this study, the researcher investigated to know the level of knowledge the members have on different sexualities; participants deny that other sexualities such as: homosexuality, lesbianism, bisexuality were causes of the spread of HIV in Todi Diocese. The DEC members were of the opinion that such a topic as homosexuality is not common in the Diocese, there is therefore no need to attribute the spread of HIV to homosexuality and other practices of sexualities and should therefore not be part of the focus group discussion so as to keep church members from becoming exposed to other sexualities (FGD with DEC members, 2016). The fact that the above-mentioned sexualities are not so prevalent among church members in Todi Diocese does not mean that they are non-existent.

In the same vein, some pastors apportioned blame to researchers including myself that there are some things that are hidden and no one knows anything about them and when researchers start calling those things by name, that will create curiosity by church members to go further in discovering what those things are, and that is how they (homosexuality, lesbianism and their likes) will soon become a practice. Therefore, they advised that such aforementioned topics be kept from public hearing (FGD with pastors, 2016). Some pastors and DEC members are still living in the past; different sexualities are no longer hidden things. They can keep those topics “hidden” by not talking about them, but the church members have gone beyond where they are presumed to be.

that, the topics are considered by pastors who prepare the guide to be areas which need medical experts to handle.

The youth disputed both the pastors' and DEC members' position by saying that a middle age man was almost killed when he was reported to be having sex with another man. People were organized to kill him but he escaped death by the whisker and that was how he left the village for over eight years now, no one knows his whereabouts (FGD with youth, 2016). Killing someone on the ground of his sexual orientation is an outright infringement on the fundamental human right of such a person, and also for a family to lose a young man who would have been of great assistance to his family is uncalled for. If the LCCN is to be an HIV competent church, it must embrace its members who were either born or chosen to practice other sexualities of their choice. As humans, we all have our individual likes and dislikes; one should therefore not use his or her own way of life to dehumanize another person on the ground of his preference. The LCCN should not continue to remain in silence on issues of sex and sexuality, rationalizing that its silence is helping in issues at hand unexposed. The LCCN has joined the rest of the world (those who feel embarrassed to talk about sex) to remain silent on sexual matters and HIV and AIDS as they are considered unhealthy topics to discuss.

Wolk rightly argued that, for some churches, HIV and AIDS are not a special and high priority theme; the two themes are not accorded any place in the liturgy, they are not on the agenda when paramount issues that concerned the church are discussed (2015:166). When the researcher visited the National Headquarters of the church, to find out if there are HIV and AIDS related programmes going on, the Director of Mission (Rev. Timawus Giyap), confirmed that, "The last time the church talked about HIV and AIDS was in 2005" This is related to the words of Ward, he asserts that, from the look of thing the church leaders, have in conformity with the rest of society, answered the challenge of the epidemic with silence and denial, exhibiting shame, embarrassment in matters of sex and HIV. The silence has added to the stigma surrounding the virus. Church leaders are thus seen as being judgemental of those infected, treating them with an 'us and them' approach (2009:158).

Sex should be viewed like any other thing that God has created to be enjoyed by humanity and the church should be proud to openly talk about it, in spite of its association with the HIV epidemic. Usdin corroborates: The linking of an incurable disease with sex-already a taboo subject in many part of the world, adds to the silence around HIV and AIDS, reinforcing the myths that perpetuate the stigma (2003:62). The researcher keeps on emphasizing that the

LCCN in Adamawa state stands in a better position to come out and teach its members both young and old about sex and sexualities. The LCCN being the first church that was established in 1913 in Adamawa state (Pwedon, 2005: 17) and has one of the largest congregations can spearhead and influence the state government to initiate the teaching of sex and sexualities in various schools in the state. Sex and sexualities and HIV and AIDS are not incorporated in our school curriculum, which is dangerous to our children, as they continue to be denied knowledge on the aforesaid topics. Right to say with McCain: Hence the Bible talks about sex, rather than being embarrassed about this subject and viewing the discussion of sex as negative thing, the Nigerian church leaders are well positioned to eradicate the silence surrounding sex and the HIV epidemic. The AIDS crisis is giving the faith community the opportunity to talk about sex in a positive and wholesome manner, like God intended it to be. Christians in Nigeria must take the initiative and make sure that they are presenting a positive and wholesome message about human sexuality. The AIDS crisis gives the religious community the opportunity of addressing issues about sex which we have largely been silent. It gives us the opportunity to correct many misunderstandings about sex even among married people (2008:64).

Churches which ought to have been an instrument of enlightenment have played a major part in creating a culture of silence about sexuality, and need now to play a major part in breaking it down (Nicolson, 995:73). Hence sex is shrouded in secrecy, and sex is predominantly accountable for the spread of HIV in Todi Diocese, those infected were seen as perverting the moral standard of living and should therefore be stigmatized or discriminated. In another way round, stigma is one of the drivers of silence surrounding the open discussion of sex and sexuality; hence sex also drives the epidemic.

7.6 The LCCN and the Challenge of Pre-test counselling and Post-test counselling to the HIV infected persons in Adamawa state

The researcher considers pre-test and post-test counselling to the needy as one of the entry points for HIV intervention. Unfortunately, lack of both pre and post test counselling found to be another area of concern for the LCCN members in Todi Diocese. The LCCN members don't just fear to go for HIV testing, but the fear of not having someone who will identify with them by consoling them in the case where their HIV testing result becomes what they dread or least expected. For LCCN to be a HIV and AIDS competent church and positively respond to health crisis, it is imperative that the church has people who are trained to counsel

people before test and after test, regardless of the results. Adegbeye asserts that for a church or community to have someone who voluntarily discloses his or her HIV status should be seen as an asset rather than a danger to public health. Such a person can be instrumental in the ongoing battle against HIV. The real danger lies in the groups of people who for one reason or the other refused to make their HIV status known and also engage in exposed sexual relationship (2015). All campaigns for people to go for voluntary testing will not yield much desired positive result if people are not prepared to accept their HIV testing result in a manner that will not lead them to depression and frustration. All the HIV infected persons in the focus group discussions attested to the fact that they had never been counselled before and after their HIV testing.

When participants were responding to question: Why are the HIV infected persons find it difficult to disclose their status? Mothers living with HIV asserted that: We lack people who can give us counselling before and after HIV testing. Almost all of us, have never heard or seen anyone whom we can rely on to tell us what to expect when our result is confirmed to be positive; at the same time, when our results were positive, there was no one to tell us what to do next. We are only left at the mercy of those who stigmatize and discriminate us. Even some of us who have health workers in the family, when you disclose your status to them, they start asking unnecessary questions as to how did you get it? Who did you sleep with? You don't have sympathisers but only those who will aggravate your predicament. As soon as they leave your presence; they spread the news of your HIV positive status to the church members (FGD with mothers living with HIV, 2016).

In response to the above question, other participants lamented that, Here in our clinics, some health workers will carry out HIV testing on their patients without seeking their consent and also without pre- or post- test counselling, and after the HIV testing, once they find out you are HIV positive, even when the test is not confirmed, they will carry their cell phones and call your husband or wife immediately and tell him or her to be cautious of his wife or husband, because she or he is confirmed HIV positive. If they will not tell your husband or wife directly, they will call a family member and inform him or her without your consent. They will say they are protecting their brother or sister from becoming infected. Here, the fear of health workers is the beginning of wisdom (FGD with mothers living with HIV, 2016).

When church members become apprehensive owing to the unethical misconduct of health workers, voluntary testing will continue to suffer a huge setback. At times, a single HIV testing does not give sufficient evidence to draw a conclusive report on one's HIV status; therefore, calling a family member in regards to one's infection without (confirmation) will sometimes send a false signal. Even in some cases where the person is confirmed to be HIV positive, the health workers ought to demonstrate professionalism by keeping the result of their clients confidential. Due to lack of professionalism in the health sector the Federal Ministry of Health in Nigeria cautions that, it is mandatory that all patients undertaking HIV test should ensure that both pre-and post-test counselling are carried out and the test should not be conducted without their consent. The health workers should ensure that the results are kept confidential (2010). These directives by the federal government are frequently flouted by the health workers most especially in Todi Diocese. This contributes immensely to the stigma and discrimination in the Diocese, when people are not counselled before the test and after the test and worse of it all their results whether confirmed or not were made public against their desire. For the LCCN to be an HIV competent, it is required to provide a pre and post test counselling professionals to those seeking for HIV testing to cushion the effect of their results especially when it is positive.

The above discussions find similarity in the words of Attah, who contends that: One reason that pregnant women and people in Nigeria shun testing is health workers. There is lack of pre and post test counselling before HIV test and after the test the result is divulged to the public. This attitude causes many patients to go to hospitals that are distant from where they live. Worst of it all, some health workers avoid any direct contact with HIV positive men and women, for fear of contracting the virus (2014). When health workers who were trained could not differentiate between casual contacts and exchange of vagina fluids and exposure to infected blood, they will find it challenging to counsel those seeking for HIV testing, because, people may be misinformed.

Participants argued that most women in Todi Diocese are scared to go for HIV testing when they are pregnant, except those who want to risk their marriage relationships. *If you are found to be HIV positive, your husband will immediately tell you to go to your parents' home and deliver the child there; if you refuse to go home, within a twinkle of an eye, he will disappear from home, or bring another woman under your watch, simply because you are HIV positive, and most times, they are accountable for our infections, either directly or*

indirectly; directly by infecting us, and indirectly by instigating us to do what we don't want to do in order to sustain our families (FGD with mothers living with HIV, 2016). If the LCCN is to be HIV competent, members would be counselled to know that those who are pregnant and were infected with HIV can still give birth to healthy children without necessarily infecting their unborn children if the necessary steps were taken.

The primary reason of testing should be to offer assistance to those who are HIV positive especially women to seek for medical attention, so as to prevent other opportunistic infections and to assist those infected with the virus to deliver their unborn babies free from being infected.

For the LCCN, to be an HIV competent church, needs to instruct its health workers who are mostly Lutherans as stated earlier to be more professional when dealing with pre and post HIV testing, and the outcomes should be kept confidential. HIV is not like malaria or typhoid fever that people who are tested positive can merely accept the result as one of the health challenges that many people in the community are living with. One does not get shocked when tested positive of any disease that has a cure and is not life threatening. It is pathetic that in the LCCN the process of pre and post-test counselling have been relegated to the background and people often get tested and given the result without any recourse to the negative impact the shocking news will have on the client.

Participants in focus group discussion with mothers living with HIV lamented that at Todi Diocesan convention, some medical doctors were invited to carry out HIV testing. Members were not informed, neither were they counselled on how to handle their HIV result, most especially when tested positive. On the day the HIV tests were carried out, the convention was almost brought to a close, because many who were tested HIV positive could not continue with the convention (FGD with mothers living with HIV, 2016). This is not the right way to conduct HIV testing; those who were not prepared psychologically will find the result devastating. HIV test as noted by Van Dyk, is not the same with other tests. It has emotional, psychological, and social implications for the patient. The test should therefore never be done without proper counselling (before and after) as this will prepare the patient to accept the result confidently (2012:268). Both the pre and post- test counselling are not only essential to those who are potentially HIV positive, but also to those who may be tested negative. They

also need to be counselled on how to protect themselves from becoming infected in the future.

The HIV and AIDS epidemic has accentuated the need for Christian counsellors. Due to the stigma attached to it, some people who are not certain about the HIV status do not feel free to use the more traditional ways people have been counselled, and seek advice in those ways. When people are in distress, they may want to be given direction; if they are truly not able to make good decisions for themselves at that time, we may need to (Upson, 2004:2). The HIV infected persons who have not received pre and post-test counselling and are not prepared to psychologically accept the fact that they are infected can be frustrated when they discover that they are infected. Their frustration can subsequently lead to sorrow. The infected may have contributed to his or her HIV infection, and if carefully handled, this can be an opportunity to lead them to the saving grace of Christ. When people are sorrowful over their attitude which had led them to contracting a disease, and if they are properly counselled, they may resolve to draw nearer to God. However, counsellors should not take advantage of one's status just for the purpose of converting such a person to what the counsellors believe and practice.

The primary reason the LCCN is required to be HIV competent, is to reassure its followers that when HIV is detected earlier through test, immediate precaution can be taken so as to prolong the life of the infected as argued by Grodeck who posits that, knowing one's status as early as possible can also help one stay healthier, longer through lifestyle modification and early treatment of opportunistic infections (2007:13). In responding to the question: Should the Church and the Government make HIV test reluctantly or voluntarily? Participants in the youth group asserted that, *the government or the church cannot force us to have HIV test, because you cannot force us when you don't have drugs to give us and worse of it all, no one to comfort us. They should leave the testing as it is (voluntarily), except if they want to cause a war between those who tested positive and those who are negative. Presently, the stigma is a serious challenge in Todi Diocese, but when people are not sure of their HIV status, they are cautious of stigmatizing those who are HIV positive. However, when people are forced to be tested and are found to be HIV negative, stigmatizing and discriminating those who are found to be positive will be more than what it is today* (FGD with youth, 2016). The group further asserted that, the LCCN leaders need to come out with counselling programmes which are aimed at encouraging its members to go for voluntary HIV testing.

Leaders can also lead by example. It is not a matter of ‘do as I say, but not as I do’. Pastors do not want to go for HIV testing and that is why they do not encourage members to do so, and those who want to go are not encouraged (FGD with youth, 2016).

The above attitude discussed towards HIV test was also confirmed by the bishop of Todi Diocese (Dogo) that his pastors shun HIV testing, and all effort to persuade them proved abortive.⁸⁹ The Nigerian HIV experts revealed that, out of over 3.4 million living with HIV in Nigeria in 2014, 2.9 are not on treatment. For fear of stigma and discrimination, those infected are presently leaving in hiding. They are not only at risk of losing their lives from AIDS but they are also potential purveyors to other innocent people. This indicates that only five hundred thousand people are on treatment in the country.⁹⁰ On this evidence, the researcher is of the opinion that by the time Nigeria pharmaceutical companies are able to manufacture its ARVs and is made available to the common man on the street, the HIV testing can be made compulsory. People will have no excuse to give for not having HIV testing. But for now it is not in the interest of the common man and woman. When the researcher was seeking for permission to do a research in Todi Diocese, telephonically Dogo laments the attitudes of his pastors who were always advised to go for HIV testing, but no one was willing to do so for fear of becoming stigmatized and discriminated against by the members of the church including their colleagues when found to be HIV positive.

There are incidences where people in Nigeria started HIV treatment, but could not continue because of the non-availability of drugs and that made the condition of many people more severe and resistant to ARVs. When people are conscious of the fact that there are no enough ARVs to take when their HIV status is disclosed, they will develop cold feet to go for HIV testing. Knowing that when they are tested positive, their status will only be publicized by health workers and pastors who cannot keep their status confidential and without drugs to pacify their pains. Those infected will prefer to endure one pain at a time of having the disease rather than amplifying their agony by being stigmatised and discriminated. When the LCCN becomes an HIV competent church, it will come out with guidelines on how to

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⁹⁰ 2.9m HIV positive Nigerians not on treatment www.vanguardngr.com/2015/12/2-9m-hiv-positive-nigerians-not-on-treatment-experts/ (Accessed on 1st December, 2015).

counsel its members who are willing to go for HIV testing and also counsel them after their results are out, whether positive or negative.

The LCCN counsellors should be well informed among other things not to capitalize on the factor (s) that might have led to the person getting infected than looking for the way forward. Counselling of this nature can demoralize a client, because it will unnecessarily remind him or her of all the mistakes that were made in the past. The LCCN counsellors need to take into cognizance that the cause or the factor (s) that led one to contract the virus should not be a matter of concern, as it seems irrelevant at the moment to the infected.

The participants discussed that, when some of them approached their pastors about their HIV status at different times, their pastors spent a lot of time asking them what could have been accountable for their infections. They declared that most times they left the pastors' offices disappointed; because there were no words of comfort and hope from their mouths (FGD with fathers living with HIV, 2016). Right to say with Sunderland and Shelp: the appropriate response to PLWHIV is one of listening to expression of grief, manifest in feeling of hurt, confusion, anger, and perhaps, betrayal and despair. The source of infection ought not to be an issue, since our concern is not how clients or patients became HIV infected, only that they are ill and their sickness is a claim upon our care and compassion (1990:72). Knowing the root cause of one's infection is of no importance. The attention should therefore be geared towards assisting the person to come out of his or her depression.

7.7 The Necessity for theology of compassion and not Judgment in the LCCN

The inactiveness of the LCCN seems to suggest that the church leaders associated HIV and AIDS with sexual immorality and therefore explain its occurrence and prevalence via a warped theology of divine retribution and punishment. One could argue that such theological reading of HIV and AIDS constituted its kind of response to the epidemic. To judge someone living with HIV on ground of immorality can send them away instead of drawing them nearer to the community of believers. The competency of LCCN will be manifestly seen when it learns to commiserate and accept those living with HIV instead of condemning them. Compassion draws them nearer, but condemnation drives them away. This goes in agreement to what the participants said when responding to the question: Have you been stigmatized and discriminated against by the Church or in your place of work? The group asserted that, *we are not only been stigmatized but we are always condemned by the church leaders. Some of*

us were removed from church position because of our HIV positive status. There are members in the church, who were caught stealing, and some people have committed murder and many other sins, but they were not condemned like us. What makes sex different from other sins? If the LCCN pastors and leaders are to determine who goes to heaven; people like us will never make it to heaven. Because a pastor said in his sermon that “what we bind on earth is bound in heaven” therefore, if we are condemned here, even in heaven we are not relevant (FGD with mothers living with HIV, 2016). Christians need to stop using their knowledge of the Bible to find proof of God's judgment on sin. Those who were known to be sexually promiscuous should not be seen the worst sinners in the church. For the church to be HIV competent must be conscious of how PLWHIV are treated; instead of condemning them for the role they might have played which resulted in their infection with HIV, compassion should over ruled all judgement. Compassion can only be exhibited when pastors and members are humble enough to realize that no individual is without imperfections and if God should mark all iniquity who could stand (Romans 3:23; see: Psalm 130:3)?

In this period of the HIV, Christians need to respond to the profound and complex needs generated by the epidemic. For church is a broken body ministering to other broken bodies. Far from judging and condemning their broken bodies, through compassion and care the church can rediscover the ministry of Christ, the brokenness of Christ's own body, and thereby recover its own essential nature and purpose. This is a church in the sense of both act and being-it does what it is, and it is what it does (Richardson, 2009:151-152). There is need for theology of compassion not theology of retribution. Christianity teaches its adherents to be compassionate toward the sick and needy. Jesus is the master example; he spent much of his public life ministering to those who were sick, weak, hurting and hungry. Jesus' example is a powerful motivation for Christians to become involved, supporting and caring for PLWHIV.

The church which is the image of Christ needs to exhibit its characteristics and not be judgmental upon those who are living with HIV. Our judgmental attitude further promotes stigma and discrimination and consequently the escalation of the virus. Bloomquist has cautioned churches against a moralistic approach to HIV and AIDS. He stresses that PLWHIV were already pervasively stigmatized and often labelled as sinners or even worse, their affliction was viewed as God's punishment (2004). Bloomquist further notes that, in

many cases, it was the people affected by HIV who had been considered as the worse sinners, as their families and society subjected them to lack of love and justice. Moralistic approach, he cautioned, would only drive those affected further away from the churches, he added that, such approaches contradicted what is at the core of faith the Lutherans profess (2004). The linkage of HIV and AIDS with judgement has significantly promoted stigma of PLWHIV. The assumption is that HIV infection is proof that the person has been immoral and is therefore under the judgment of God; this can be a terrible blow to the self-image of anyone living with the virus (McCain 2008:242).

Participants ridiculously declared that, the LCCN had printed stickers, labelled, “The Church that cares” and members are encouraged to buy them and put on their door frames, on the screen of their cars, in their offices, but paradoxically, if you approach them and disclose to them that you are HIV positive and in need of help, they will give you a date to come back when they know that they will not be in the office for that week. Who are they deceiving with these stickers? (FGD with HIV fathers, 2016). Church members listen attentively to sermons preached in the church, and when things that are said in the sermons are not practiced, members will want to know why the church is living in contrast to what they say? The church should imbibe the command given by Christ not to judge that we also may not be judged (Matthew 7:1-3).

Effort from the pulpit and communities of believers should be geared towards discouraging those who sit in judgment over those infected with HIV. They might be responsible for their predicament, but the church has no right to judge them. Malloy asserts that, our major challenge in the battle against the HIV epidemic is to get those who sit in judgment to see individuals who are hurting and exhibit compassion towards them (1990:118). Responses from people to HIV generally have been filled with all manner of judgment and exclusion. Most of the responses especially from faith communities have been moralistic. The question which remains on people’s mind is “how do you get it”? Question of this nature is demoralizing and always leaves the HIV infected with a sense of guilt. Such a question is inappropriate. It is a question, which seeks to find an answer to an unmentioned question – “Are you sure, you are not guilty”? The question on the minds of most Christians is; “Is HIV and AIDS from God”? “Did HIV and AIDS come into being as a result of a sin committed?” These are questions and many more that need answers.

Garland asserts that to be HIV positive may not be connected to sin. Some people got infected innocently; to pass judgement in condemnation of PLWHIV is inappropriate (2003:186). Garland's argument goes in agreement with Nicolson who opines that in Africa; increasingly the greater numbers of those who die are women, faithful wives whose only 'sin' is to have married a man who has not always been faithful. Increasingly too, the number of babies who die of AIDS is growing. Therefore, if it is a punishment from God, it means it is a punishment which hits the innocent as well as, even more than the 'guilty' is a very strange justice (1996:32). If we accept the fact that HIV carries along with it punishment from God, the society will end up punishing the innocent along with the wrongdoers and finding a lasting solution to stigma and discrimination which stimulate the epidemic would become a mirage.

7.8 LCCN's response to the challenges of stigmatization and discrimination of its members

As at the time of conducting this research, the LCCN does not comprehend the theological implications and the ethical implications of the HIV menace. The initial responses from the church as indicated previously showed evidence of misconception and misunderstanding of the true nature and effects of HIV and AIDS. The LCCN has a duty to bring to an end the issues of stigma and discrimination in the church as similarly argued by Gennrich: Part of our work as Christians is to speak out about HIV and AIDS to enhance awareness and banish stigma and discrimination. Clergy have a captive audience who listens to them every Sunday and within the week and can use any available platform to promote love and caring attitude to PLWHIV (2004:58). In responding to the challenges of stigma and discrimination the church must acknowledge that they are not only trying to help PLWHIV, but should rather see their response as doing it for members both within and outside of the church.

The researcher will like to draw the attention of the Lutherans to emulate the compassionate standard of living of Martin Luther when he was faced with epidemic in his time which the researcher views to be similar to the HIV and AIDS epidemic. Luther in his context dealt with epidemic in his time and preached against stigmatizing and discriminating those who were infected.

7.8 Lessons from Martin Luther

If the LCCN must positively respond to the HIV epidemic it must emulate the behavioural approach of Luther to some cardinal issues of life, most especially on epidemic (bubonic plague). The Lutherans in Nigeria embrace the teachings of the person the church was named after (Luther) as argued by Reynolds: “The LCCN as an institution subscribes to Luther’s teachings as expressed in his writings and taught by the Lutheran Church globally” (2012:3). The pastors and by extension, the leaders in the church are fond of saying, “Anything that Luther did not approve and practice is not accepted” DEC members in the course of interaction in a group discussion confirmed that, the reason why DEC members cannot formulate policies that will protect those who are living with HIV is that, Luther did not support immorality, so making policy to protect PLWHIV is going against the principles of Martin Luther (FGD with DEC members, 2016). In other words, teachings and practices that Luther engaged himself will be furthered by members and leaders of the church. There is no justification that all PLWHIV got infected through immoral behaviour; therefore, for the sake of the few innocent ones, policies should be formulated to protect PLWHIV.

We will therefore look at few things Luther did in his lifetime, predominantly his reaction to epidemic, which need to be inculcated among the Lutherans in Todi Diocese and the LCCN at large.

In conclusion to Luther’s argument as clearly stated in chapter two (see pp. 44), for those who can not protect themselves, the outcome of this negligence, they were responsible for their neighbour’s death and can also be labelled as murderers. Luther uses the house fire analogy to caricature their offences. Those who refused to protect themselves are acting like people who allow burning house to go up in flames doing nothing to stop it or to protect other homes. They allow the flames to grow into a city conflagration, their rationale being, “if it is God’s will he will preserve the city without water and without quenching the fire (Tappart, cited by Brill, 2007:251) It is certain that Luther was not referring to HIV when he said that one needs to protect himself from its infection, but his discussion draws a lot of resemblance to HIV epidemic; those who refuse to protect themselves during sex by using barrier methods are not only killing themselves but others likewise. This is an indicative that if Luther were alive, he would have done the following:

- (a). Luther will not have tolerated the way PLWHIV are stigmatized and discriminated;
- (b). Luther will ensure that members of the church are well counselled before and after HIV test;

- (c). the Lutheran church worldwide would have been a church denomination spearheading the fight against stigmatization and discrimination of PLWHIV and will also ameliorate the plight of those who are living with HIV;
- (d). Luther would have promoted the use of condom to church members who are sexually active and cannot control themselves and more significantly, open discussion on sex and sexualities would have been Luther's priority.

7.9 Conclusion

Chapter seven discussed various principles where the LCCN lacks competency in dealing with its members who are living with HIV in Todi Diocese. The silence that pervades issues of sex and sexualities in Todi Diocese which primarily precipitated the silence on HIV and AIDS were discussed. The discussions have brought to limelight why pastors and church leaders are not comfortable with matters of sex and HIV which has made a lot of members in the LCCN ignorant of the epidemic and are not willing to voluntarily go for test simply because there are no counsellors in the church who could carry out pre and post- test counselling to its members. People in the Diocese see HIV testing as going for firing squad, where their HIV positive results will be made known to them, and if it is positive or negative, no one is there to counsel them on what to do thereafter.

Another area that was discussed is the need for the necessity of the theology of compassion instead of judgement to PLWHIV in the Diocese. Indications were made that stigma and discrimination would continue to devastate church members, when instead of compassion, PLWHIV are continually judged and condemned for their alleged role which led to their infection with HIV. The focus group discussion revealed the kind of judgement meted against PLWHIV which has literally created a barrier between 'them' and other church members who were perceived to be HIV negative. From the discussions, participants from various groups lamented lack of compassion from their fellow members, a conduct which was supposed to have drawn them nearer to the church, their friends, family members, but condemnation created unnecessary bridges between them and those who claim to be without the HIV infection. From the discussion above, when the LCCN becomes an HIV competent church, by learning from Martin Luther when responding to epidemic, it will be in a good position to respond positively to the challenge of stigma and discrimination.

CHAPTER EIGHT

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

Chapter eight is the final chapter which provides the concluding summary based on the findings of the research and attempt was also made to pinpoints areas for further research and to point out what level the objectives of this research have accomplished. In summary, the prospect of faith based organizations to provide conduits that can enhance the longevity of life of PLWHIV cannot be overemphasized. This is manifested when congregations at different levels are willing to face squarely the imperativeness to get involved in the battle against HIV in the LCCN by confronting forces influencing its spread, chiefly among them is stigmatisation and discrimination of PLWHIV. When members in the church are ravaged by sickness, consequently, the church is equally sick. More essentially, congregations need to come to terms that they have a huge role to play as faith community to be compassionate to PLWHIV.

The study established that the church is called to be compassionate to one another as compassion is seen to be one of the major characteristics of the head of the church (Jesus Christ) in his earthly ministry as demonstrated in one of the theoretical frameworks of this study (see chapter 3). The lessons learned in this study are essential guides for advance study on the topic (HIV and AIDS) in the LCCN in order to proffer lasting solution to the practical situation on ground; the high level of stigma and discrimination of PLWHIV which fuel the spread of HIV unrestricted. Having recognized the challenges that stemmed from this study, the primary aim is to map out strategies that will assist in addressing the gaps as well as enhance future research in this neglected field by the LCCN.

8.2 Summary of findings

Chapter one introduces the study and provides guides to the rest of the study: Background to the research problem, the geographical location of the area of research (Todi Diocese), the socio-economic structure of the people of Todi Diocese. The brief historical background of the LCCN particularly of Todi Diocese were provided, the motivation for the study was also discussed, statement of the problems, Questions, objectives, the significance, the methodological limitations of the study were also pointed out, the planned structure of the

dissertation were indicated in this chapter. Chapter two discusses the issues of Sex and sexualities from the religious perspective. The chapter discusses how sex is viewed both by secular and religious leaders. With the paucity of drugs in the country, particularly Todi Diocese, few people that were privileged to have access to the ARVs do not adhere strictly to the rules of treatment was explained. This chapter explains how focus is being shifted to prevention in an effort to truncate the spread of HIV in the absence of cure. The modes of transmission of HIV through sex, blood transfusion, mother to child were discussed. Safer practices such as abstinence, the significance of other safer methods were discussed. Stigmatization and discrimination directed to PLWHIV which makes it difficult for those infected to seek medical attention was discoursed. The chapter also shows that stigma and discrimination is not only common in the secular world, but also among communities of believers who profess to be their brother's keeper. In chapter two gaps were identified and finally the conclusion.

Chapter three discussed the research design, qualitative empirical research, research site and the procedure to gain access, research methodology, the procedure of data collection, tools for data collection, research sample and participation, data analysis; procedure and methods of data analysis the need for confidentiality were discussed and conclusion.

Chapter four dealt with one of the objectives of this study: to unveil how cultural, socio-economic and political developments impact on sex and sexualities in the context of HIV and AIDS in Todi Diocese. Therefore, chapter three basically discusses the aforementioned topic under the following themes: The impact of culture on sex and sexuality, the socio-economic impact, the political development and its impact on sex and sexualities in the context of HIV and AIDS in Todi Diocese. Corruption in the country which has led to the high level of unemployment has plunged many citizens into commercialization of sex was also discussed. As a result of corruption many citizens were plunged into abject poverty; effort was therefore made in this chapter to demonstrate how poverty is directly or indirectly linked to the spread of HIV in Todi Diocese.

Chapter five discussed the various factors discovered to have been responsible for the spread of HIV in Todi Diocese under the following themes: Multiple concomitant of sexual partners; Gender Inequality, Lack of basic knowledge on HIV and how it is transmitted, which constitute a serious problem between the “self-acclaimed HIV negative persons” and

PLWHIV was discussed; The attitudes of Nigerians and denial of being HIV positive was investigated and discussed. Another area discussed in this chapter is the various claims of possible cure by Nigerians which create a nonchalant behaviour in the manner in which the church members handle their sexuality, especially among the youth were also discussed: the role that the law enforcement agents play in the spread of HIV was discussed and finally the conclusion.

Chapter six dealt with one of the objectives of this study: to demonstrate the link between stigmatization and discrimination of PLWHIV and the spread of HIV in Todi Diocese. In this chapter, data was obtained through the focus group discussions were presented as thus: Stigmatization and Discrimination of PLWHIV in the LCCN; the detrimental language of stigma and discrimination towards PLWHIV in Todi Diocese; the causes of stigma and discrimination and its impact in Todi Diocese, and in Nigeria and the conclusion was drawn

The previous chapter (six) examined the data collected from the field research to measure the level of knowledge people in Todi Diocese have on sex and sexualities and how the evil of stigma and discrimination was connected to the spread of HIV in Todi Diocese. Chapter seven therefore, discussed objective number three and four which discussed approaches that the LCCN in Todi Diocese ought to acquire to be a HIV competent church in the context of Nigeria. The various themes discussed under chapter seven are: the competence of the LCCN in halting the HIV epidemic by breaking the culture of silence surrounding sex in the LCCN Todi Diocese which serves as one of the weapons against the spread of HIV; the LCCN and the challenge of pre and post- test counselling to the HIV infected and affected persons; the necessity for theology of compassion not of judgement in the LCCN, the LCCN's response to the challenge of stigma and discrimination among its members.

Chapter eight comprises the summery of findings and recommendations for further research. In this chapter (eight) the discussions that occurred from the study were highlighted in an effort to answer the research question: why are the Christians who are expected to love their neighbour as they love themselves in Todi diocese are stigmatizing and discriminating PLWHIV? For effective response the way forward in addressing the challenges of stigma and discrimination were projected.

8.3 Conclusions

From the study conducted, it was clear that the HIV epidemic has ravaged the health of many members of the LCCN Todi Diocese. The study indicates that there is a huge negligence by church leaders who were saddled with the responsibility of watching over the souls of its members. The church leaders seemed to be more concerned about the “spiritual concern of its members” while viewing issues surrounding sex and sexuality, HIV and AIDS as topics to be discussed outside the jurisdiction of the church; this has led many members of the church to struggle on their own to discover meanings to their sexuality which most times lead to health hazard.

The research conducted has discovered that some pastors in Todi Diocese remain aloof to the anguish of PLWHIV simply because they viewed HIV and AIDS as an epidemic that has correlation with illicit sex or immorality, therefore, those infected with the virus were conclusively viewed as sinners who were rejected and forced to carry out their crosses which they have designed for themselves. The contraction of HIV has been reduced to the issue of personal morality which deter the communities of believers to extend their hands of fellowship to (Chitando, 2007:20).

The research has also discovered that humiliating languages which are detrimental to those living with HIV are so prevalent that the infected were forced to ostracize themselves and stay away from those who are hell bound to make life miserable for them because of their HIV positive status. Some PLWHIV lost their jobs and other legitimate means of livelihood due to stigmatisation and discrimination. The study indicates that orphans who lost their parents to AIDS were also rejected by both communities and particularly the church to face life’s challenges without any help because of the perceived sins committed by their parents, even when it was uncertain the channel through which their parents got infected, and this has led many orphans who were abandoned and have no access to education resort to nefarious activities which in turn endanger the lives of church members.

From the data collected in this study, indications abound that condoms and other barrier methods which help immensely in halting the spread of HIV are shunned with passion, viewing them as not giving full satisfaction to sex. Besides, church leaders do not give their consent to the use of condoms, others condemned its significance, claiming that teaching and encouraging members about the importance of condoms will lead many to sexual

promiscuity. The research also shows that for the few members who were interested to use condoms and other barrier methods found it difficult to have access to them due to its paucity in Adamawa state and the country at large. It was established in the study that Adamawa being one of the states in the North East affected by Boko Haram insurgencies has left many indigenes as refugees in various Internally Displaced camps (IDCs), where church members who have lost their partners engaged in unprotected (without condoms) sex resulting to the spread of HIV in the state.

The Agency working for the control of HIV in the state (ADSACA) noted than more than 6,000 PLWHIV who were on ARVs in the local governments most hit by Boko Haram insurgency namely: Hong, Mubi, Maiha, Gombi, Michika and Madagali were displaced due to the destruction caused by the insurgents.⁹¹ The researcher in the course of his field work discovered that many of these displaced persons settled in Todi Diocese, which comprises Numan and Demsa local government areas. Research indicates that PLWHIV and have no access to ARVs and condoms were consequently spreading HIV to their unsuspecting victims.

The uncompassionate behaviour of Christians towards their fellow Christians was evaluated in this study. It is often preached by church to “love our neighbour as we love ourselves” however, from the research conducted, PLWHIV were not categorized among neighbours. They were considered sinners who were suffering the backlash of their disobedience. This study therefore discusses how Christians need to shift from this attitude and embrace the attitude of the head of the church (Jesus) who in all ramifications in his earthly ministry did not discriminate against those ravaged by diseases of different kinds, irrespective of the root cause.

The study pointed out various factors that were accountable for the spread of HIV in Todi Diocese. Due to ignorance, some PLWHIV depend solely on their colleagues for drugs. Out of ignorance, ARVs were shared among PLWHIV in the Diocese. The study endeavours to argue in an attempt to make clarifications that AIDS is not a curse as some people insinuate (including the LCCN members) that it is a punishment by God to penalise sinners, therefore, there is nothing a person can do to avoid it. In my view, God does punish people for sin, but

⁹¹ Adamawa SACA Expresses Concern Over Fight Against HIV/AIDS dailytimes.com.ng/adamawa-saca-expresses-concern-over-fight-against-hivaids/ (Accessed on the 16th December, 2015).

the Bible does not categorically declare that certain disease is the punishment for certain sin. The disciples thought that a man who was blind in John chapter 9 must have been blind because of a certain sin, but Jesus said no! The thesis also maintained that if other diseases mentioned in the Bible such as leprosy as terrible as it is; the woman with constant bleeding for years was not as a result of any sin committed, then, in the same vein, HIV and AIDS should also be viewed as one of the diseases that invaded our world, without any peculiar connotation attributed to it.

This study indicated that shepherding the flock of Christ includes counselling people that are infected and affected with HIV. The study indicates that those infected or affected are not accorded any attention through counselling, simply because they got the virus through sex. Certainly, some of them have been infected through blood transfusions. Some may be innocent but because of the unfaithfulness of a spouse, they got infected. It is also possible that some members of the church may have gotten the infection from sexual activities while they fell into temptation which no one can claim to live above it, except by God's grace; these individuals need to be brought to repentance and receive forgiveness. The message of the church is the only message that gives hope in this catastrophe. The study shows that counselling will help persons infected with HIV to look into his or her own challenge and situations in a realistic way in order to find remedy. The thesis called on the pastors to be counsellors in this time of AIDS that people may be encouraged to voluntarily go for testing and consequently for treatment in order to reduce the rate of infections in Todi Diocese. It is the duty of the AIDS counsellor to liberate people from sinful lifestyle, not simply passing condemnation on them. It is the AIDS counsellor's duty to give good news to the infected person, giving him or her hope in the life hereafter.

The researcher drew insight from the Founder of the church (Luther) who against all odds embraced those who were struck by epidemic in his time without minding the contagious nature of the disease, but out of compassion made his house a place for consolation to those who were infected.

8.4 Recommendations

8.4.1 Need for more enlightenment for HIV and AIDS in LCCN

In view of the above findings and conclusions three areas which require advance studies were acknowledged as follows: there is the urgent need for study on the competence of the LCCN pastors who minister in various districts with diverse cultures. The question that needs to be interrogated should be “What is the leadership of the LCCN doing to improve the lives of its members especially women, who are economically unequal with their men counterparts which subject them to indescribable hardship and denied them the opportunity of negotiating safer sex with their promiscuous sexual partners? When women continue to remain under the financial yoke of their husbands or sexual partners, majority of them will find it difficult to escape the menace of HIV. Due to economic disparity between men and women in Todi Diocese, women are subjected to reluctant submission to their sexual partners simply to keep body and soul together. For the above reason, as argued by Dixon, HIV will continue to have a female face in Africa. In a situation where women receive only 10% of the world’s income, 66% of those in the world who cannot read are women and 99% of property owners are men; such economic inequality will continue to fuel the spread of HIV (2010:81).

The LCCN must rise up to this challenge by economically empowering women to have financial stability which will eventually reduce their over dependency on men. Moyo rightly suggests that the church should initiate developmental projects for self-sustenance most especially among women as one way of controlling the spread of the HIV (2015:159). Where a woman depends upon the man for financial support-whether in the form of a one-time payment to a prostitute or ongoing support for a wife or mistress-she is not able to lay down conditions such as, you must be faithful to me; or you must use condoms; it is very difficult, if not impossible, for women in this situation to have any say over their sexual behaviour (Nicolson, 1996:230). Secondly, there is need for further research on the plights of orphans within the geographical location of the research area. The question that needs investigation should be, “what is the future of these children who lost their parents to AIDS-related diseases? If nothing is done to ameliorate the plight of these children, some of them who could not continue with their schools in the cities and were brought back to their villages may become street hooligans and constitute a threat to the society and by extension to the church.

The recommendations below arise from the matters previously identified, which also served as practical consequences of the research. The LCCN needs to adopt new appropriate vocabularies- in describing PLWHIV. Expressions like friends, brothers, sisters etc. are suitable. This single act will go a long way in encouraging voluntary disclosure of those who know that they are living with the virus, and will consequently seek for treatment. Names like skeleton, quarter to go, vagina disease and so on must be discouraged by pastors and other group leaders. Those infected with HIV and those whose conditions degenerated to full blown AIDS will continue to stay away from the church for as long as language of stigma and discrimination continues to be spoken to those infected. The LCCN must come out with a policy that is non- discriminating which is aimed at protecting its members who are living with HIV. The LCCN should ensure that the offenders of such policies are accordingly dealt with. The Bishops in-charge of the Dioceses should ensure that pastors who are directly dealing with the members in various parishes and Districts adhere strictly to the policy. If every Sunday, the LCCN in its liturgy prays for those in government, from the Presidents to the councillors in various local governments (see; the LCCN book of prayer, page 92), there is, therefore, need for the church to pray and include those infected and affected by various diseases especially HIV. The researcher emphasised HIV and AIDS, because the name is hardly mentioned in the LCCN, except when preachers use it to scare people. However, if it is used in prayers compassionately, members will soon develop interest in becoming friendly with those living with the virus.

8.4.2 Revamping the LCCN Health Sector

Another area of particular interest that needs to be sensitized is medical personnel at Christian hospitals. This study has indicated that the LCCN has one hospital, 12 clinics and dispensaries, mostly within Adamawa state. The missionaries that came in 1913 as earlier mentioned who established the LCCN and some of these clinics and dispensaries were not discriminatory in their dealings with those who were struck with leprosy and other diseases, the fact that those infected with leprosy were stigmatized and ostracised, the missionaries comfortably frequently visited them and offered them home based care which has promoted the course of the gospel and made it more accepted by those infected. Right to say with Chitando who observes that the missionaries were placed in a strategic position not only to bring a transforming power to the people but also carried along the duty of giving people physical healing by ensuring that modern medicine were made available. In the same manner for the church to answer its name, it must be at the frontline in responding to HIV and AIDS

epidemic, whether it is in Missionary hospitals or church-owned schools, they can be of immense assistance in making the church become competent in the time of HIV and AIDS (2007:12).

When those working with the LCCN hospitals and clinics see their role as offering an all-inclusive services which comprises both the physical, psychological and spiritual needs of those infected with various diseases, they will be compassionate enough to embrace all and sundry, irrespective of their peculiarities. When stigma and discrimination of PLWHIV is finally eradicated in the LCCN, there will be willingness for members to approach HIV testing with confidence. The LCCN hospitals can be used to admit those who are living with HIV and they will be given more attention both medically and emotionally more than the secular hospitals who know little about compassion.

8.4.3 The need for effective HIV Home based Care within the LCCN

Home based care as the phrase indicates, refers to support rendered to anyone under the yoke of any health challenge in his or her place of abode. It is known as a family care system where the family, friends and church members are the ones that provide the necessary assistance (Magezi and Louw 2006:67). Visitation to people living with HIV is the most difficult area as noted in the study by members of the LCCN Todi Diocese. Visiting those living with HIV is to risk being labeled as ‘one of them’. There is a need to create a group in all the Districts that will be saddled with the responsibility of visiting and praying alone with those living with HIV. When HIV and AIDS patients are visited like any other members who are sick with various kind of diseases, the HIV patients will feel being loved and will have a sense of belonging and those who are in the habit of concealing their HIV status will be more than willing to disclose their HIV status having seen the love being demonstrated to PLWHIV.

Dixon was right when he asserts that, when you visit someone at home, you learn more about them in two minutes than you would in 10 years on a hospital ward, in a clinic or in a day centre. You are instantly touched by their world. Their young children run to you, the dusty floor, the pile of dirty washing, the empty food store may all be signs that he or she needs your assistance. You have become part of her extended family, a trusted, confidant and faithful friend (2010:115). When the members of LCCN develop the habit of being friendly to those living with HIV, it will repent of its negative characteristics of stigmatizing and discriminating those infected. When the church follows the footsteps of its master (Jesus),

who did not mind to inquire from those inflicted with various diseases the root cause of their sicknesses but will compassionately reached out to them, then the church should equally exhibit the same compassion while showing concern about the moral standing of those living with HIV. The Home care based is very strange to the LCCN, but in Southern Africa some groups of women were recognized as “Manyano” found in different denominations. These organizations provide those living with HIV a sense of belonging. They bring succour to them. They contribute their resources to ensure that PLWHIV do not go hungry. Not only that, during the demise of anyone who died to AIDS related diseases, they again contribute from their meagre resources to feed the mourners (Chitando, 2007:11). This study has revealed among other things the cases of those living with full blown AIDS who could no longer control themselves in terms of going to toilet, were secluded and abandoned to die simply, because such person is stinking. This attitude does not portray the image of Christ who did not mind to reach out to the leprosy persons in his days, despite the fact that the disease was contagious unlike HIV. In the absence of a cure, the church ought to be a healing organization as noted by Nixon, What is needed are millions more men and women stirred into action, carrying life-saving messages wherever they go, and showing practical, loving compassion as part of their lives, not grant projects which only touch a small group of people. (2010:98).

8.4.4 Creation of HIV and AIDS department in the LCCN

There is need for the creation of AIDS department in the LCCN, whose duty is to tackle the challenges mentioned especially in chapters six and seven. The challenges which were identified in those chapters, of prominent significance is the paucity of professional counsellors who will be saddled with the responsibility of rendering pre and post test counselling therapy to those who will want to voluntarily go for HIV testing and as well as those who were tested positive so as to ignite hope among those infected beyond their present predicament. Voluntary disclosure needs ethics of confidentiality. Fear of disclosure to friends or family is rooted in concurrent fear of personal rejection, financial resources, and isolation (Gormleyand Hagan 1998:102).The LCCN congregations ought to motivate voluntary counselling and testing (VCT) as an overall prevention strategy. Those who were tested positive deserved to be given the message of hope, helping them to face the reality of living with the virus. Their attitudes towards their infections play a significant role in determining how long or short they will live. They need to be encouraged to develop a positive living and seeing the virus like any other diseases. When the LCCN demonstrates

competency in the field of HIV and AIDS, members will courageously approach its pastors to seek for pre and post-test counselling, and confidentiality will also become their watch word. The prominent and highly respected position of the LCCN in Todi Diocese as well as the entire state (Adamawa) afforded it the opportunity of leading other denominations in stemming the spread of HIV. The leadership of the church can use every available means, especially the pulpit to sensitize its people; hence the society considers church leadership as representative of a credible organization (Chitando 2007:15). It is theologically and morally imperative that the LCCN responds to the crisis of HIV and AIDS by creating a department whose primary assignment would be to tackle all challenges relating to the epidemic. In this way the LCCN can contribute its quarter by joining the national AIDS programmes. To love those who live immoral behaviours and consequently got infected with HIV is a demonstration of Christ-like character. Nicolson states that while insisting on responsible and faithful sexual relationships, churches also need to teach compassion for those who suffer because they have been sexually irresponsible. It is obviously true that people have in some cases contracted the various diseases because of their own behaviour, but this should not exclude them from our compassion (1995:22). Our care should be totally non-judgemental, compassionate and loving.

The researcher will also like to recommend that the LCCN in its determination to eradicate HIV or slow down its escalation, its members should be realistic and accept the fact that condoms play a major role when used effectively; and this can only be understood when the LCCN educate its members on the essentiality of safer methods especially the use of condom. Nicolson is correct in his assessment that, whether we like it or not, there will be casual sex; unless we do promote the use of condoms the death rate will be much higher (1995:53). The LCCN will continue to view casual sex as immoral; but the question is, should the church fold its arms and allows those who are sexually promiscuous to be condemned to death? For this reason, Dixon suggests that, regardless of the huge variations in traditions and cultures, the church needs to play a positive and active part in supporting the use of condoms to save lives in the perspective of wider health messages that includes abstinence and faithfulness (2010:41).

8.4.5 Awareness through preaching/teaching

The LCCN leaders should place the issue of HIV at the centre of its worship and teaching; important steps such as music, drama, poetry and art to teach especially young people about

HIV and AIDS must be necessitated. As noted by Bongmba, songs, prayers, announcements, fellowship times, teaching and preaching ought to include direct references to the epidemic because it is part of people's lives in various ways (2007:96). Often, LCCN congregations avoid getting involved in HIV and AIDS ministry perhaps they feel that what they can contribute or offer is too small. But in an epidemic like HIV and AIDS, no action is too small and any action is better than no action. Winning battle against the spread of HIV entails that LCCN should be vigorously promote in congregations, in confirmation classes, in the Mothers' Union and Women' auxiliaries, and awareness of AIDS, what it is, how it is transmitted, what its effects will be, and how to avoid it. For those who are living with HIV should be rendered assistance through counselling, financially and otherwise (Nicolson, 1995:73). When the church realizes that HIV and AIDS epidemic is its cross, it will do everything possible to bridge the human's gab that was created between PLWHIV and those who claim to be HIV negative by dealing decisively with stigma and discrimination.

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Focus Group Discussion:

Pastors/Ministers, LCCN Bali Cathedral on 14th February, 2016. Focus Group discussion
[Cassette recording in possession of the author]

Youth, male and female LCCN Bali Cathedral on 19th February, 2016; Focus Group
Discussion [Cassette recording in possession of the author]

Self-disclosed HIV infected persons Bali Primary School on 22nd February, 2016; Group
Discussion [Cassette recording in possession of the author]

Executive Council members LCCN Bali Cathedral on 8th March, 2016, Focus Group
Discussion with author on 23rdFebruary, 2016 [Recorded Data in possession of the author]

Appendices

Appendix 1: TURNITIN Originality Report



An exploration of sex and sexualities in a context of HIV and AIDS in the Lutheran Church of Christ in Nigeria (LCCN): A phenomenological study of Christian love and stigmatization in Nigeria – Adamawa by Cletus Haniel Dading
From An exploration of sex and sexualities (Roderick Hewitt)

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Appendix 2a: Informed Consent Letter

School of Religion, Philosophy and Classics,
University of KwaZulu-Natal, Pietermaritzburg
Main Campus, Private Bag X01 Scottville
3209. Republic of South Africa.

INFORMED CONSENT LETTER

Dear Sir/Madam

I am doing my Ph.D. study in Pastoral Theology (Ministerial Studies) from the above institution; I need to gather information that will help me in my research. I am going to conduct focus group discussions where applicable. I hope that you will be able to provide me with useful information.

The working title of my research is to explore the lived and embodied theologies, sex and sexualities in the context of HIV and AIDS in the Lutheran Church of Christ in Nigeria (L.C.C.N), as they relate to the growing demise of Church members especially the youth which the Church believes are the leaders of the future Church. The study is motivated by three factors: Firstly, lack of meaningful response to HIV by LCCN. Secondly, the stigma and discrimination of PLWHAs which makes the treatment near impossible. This stigma and discrimination is killing people emotionally and socially. Thirdly, coupled with the above challenges is the lack of voluntary testing and counselling in and around LCCN Todi Diocese.

These are some of the reasons that informed my decision to carry out this research to explore ways of alleviating their plights. The research also aims at encouraging the members of the Church (L.C.C.N) in Todi Diocese to voluntarily avail themselves to HIV test to ascertain their HIV status, so that those infected can immediately start treatment as early as possible. The information you will provide would be of great importance in accomplishing this task.

I need your consent and time to be among the focus group members. The focus group discussions will last for about 40-50 minutes. With your permission I will be using a Digital Voice Recorder during the focus group discussions after which the information will be deleted upon the completion of the project. Your responses will be treated in a confidential manner and that anonymity will be ensured where appropriate, that is, your name will be

disguised and you are free to withdraw from the research at any time without any negative or undesirable consequences on your personality.

For more inquiry, find my contact and that of my supervisor and research ethical office below:

Rev. Cletus H. Dading, Email: dadingc@yahoo.com , +27845236018, +2348036431497,
LCCN HQTRS, PO BOX 21, Numan, Adamawa State

Supervisor: Dr. Herbert Moyo, Email: movah@ukzn.ac.za

Research Ethics Office: HSSRC Ms P. Ximba 03122603587

INFORM CONSENT FORM

If you agree to participate in the focus group discussions, please sign the consent form agreement below)

I..... (Fill in your full names), hereby confirm that I understand the contents of this document and the nature of the research project. I hereby consent/ do not consent to have this focus group recorded.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature of the respondent

Date

.....

.....

Appendix 2b: Takardar neman Izni

School of Religion, Philosophy and Classic (SRPC)
University of Kwa-Zulu-Natal, Pietermaritzburg
Main Campus, Private Bag X10, Scottsville 3209,
Republic of South Africa.

Zuwa ga Madam/Madam

Ina bincike bincike domin digiri na uku a tauhidi a farnin Pastoral Theology. Ina kokarin tara wadansu bayani da za su taimaka wurin yin wannan bincike. Saboda haka zan tambayi jama'a su taimaka da bayani ko kuma samun zarafinsu domin tattaunawa da wadansu cikin ekklesiya. Da fata zaku taimake ni da bayani mafi inganci domin wannan bincike, ina kuma bukatar izinin yin haka daga gare ku. Domin tabbata na kare martabanku in da akwai hatsari gareka, na alkawarta zan boye sunanku domin kada jama'a su gane; kuma kasancewarku cikin wannan tattaunawa bai zama dole ba, duk lokocin da kuna so ku janye, kuna da daman yin haka ba tare da wata cikas ba.

Kan maganr da ina bincike akai shi ne kamar haka: Jim'a'i da rayuwarr jima'i dangane da cutar kanjamau da kuma kanjamau a cikin ekklesiyan ta Lutheran Church of Christ In Nigeria, wato LCCN cikin Diosis na Todi, wadda ta ke a karmar hukumomi guda biyu, wato Demsa da Numan.

Dalili mafi girma da ya sa ina yin wannan bincike ita ce, wariya da wulakanci da ake yi wa wadanda suna da ciwon kanjamau ya kai inda jama'a suna tsoro su fito karara domin a yi masu gwaji domin tabbatar da matsayinsu ko suna da wannan cuta ko babu. Wannan al'amari ya kawo yaduwar wannan cuta a ekklesiyan LCCN da kuma Jiha ta Adamawa gabakiday. Wannan bincike na kokarin kawo gudumawa domin karfafa mutane da su ga masu ciwon kanjamau a matsayin yan'uwansu da abokanensu a maimakon ganinsu mutane zunubi fiye da kowa a cikin al'uma.

Ina bukatarku ku taimake ni ta wurin bani lokocinku domin in yi maku tamboyoyi ko kuma domin tattaunawa da ku. Wannan zama zai dauki lokoci kamar mintoci arba'in zuwa hamsin (40-50). Ina so in shaida maku da cewa, akwai shiri domin yin aiki da kayan na'ura mai

daukar murya domin daukan amsoshi wurin tattaunawa. A sa'anda an kamala wannan bincike zan tabbata na share wadannan amsoshi cikin wannan na'ura domin in tsare mutuncinku.

Hanyoyin sadaswa da zaku iya same ni ko kuma Mai yi mani jagora cikin wannan bincike suna nan a kasa. Ya yiwu kuna da bukatar Karin bayani ko wani tambaya da ta shafi wannan bincike, sai ku kira wadannan lambobin talefo.

Dean, Rev. Cletus Haniel Dading Email: dadingc@yahoo.com Cell phone +277 845236018

Supervisor Rev. Dr Herbert Moyo Email:

Appendix 3a: Informed Consent Form

If you agree to participate in focus group discussions, please sign the consent form agreement below.

I..... (Fill in your full names), hereby confirm that I understand the contents of this document and the nature of the research project. I hereby consent/ do not consent to have this discussion recorded.

I understand that I am liberty to withdraw from the project at any time, should I so desire.

Signature of the respondent

.....

Date

.....

Appendix 3b: Takardar nuna yarda

Idan ka/kin yarda ka/ki kasance daga cikin wadanda zasu tattauna domin wannan bincike sai ka/ki sa hannu cikin wannan karmar takarda a kasa.

Nuna Yarda

Ni.....(Rubuta cikaken suna

nka/ki), na hakikance da cewa na fahimci ababe da ke kunce cikin wannan takarda da kuma yanayi da ta kun ce binciken, na kuma nuna yardana domin in ba da taimakona domin cin gaban wannan bincike, na yarda/ ban yarda a yi amfani da na' ura domin daukan amsoshi da za'a yi lokocin tattaunawa ba.

Na fahimci cewa ina da cikkaken yanci duk lokocin da na ga dama in janye daga wannan tattaunawa idan ina so in yi haka nan.

.....
Sa Hannu

.....
Kwanan wata

Appendix 4a: Takardar Neman Izni Wurin Bishop

School of Religion, Philosophy and Classics,
University of KwaZulu-Natal,
Pietermaritzburg Main Campus,
Private Bag X01 Scottville 3209,
Republic of South Africa.
25th August, 2014.

RT. Rev Clement Dogo,
Bishop, LCCN, Todi Diocese.
Adamawa State, Nigeria.

Dear Sir,

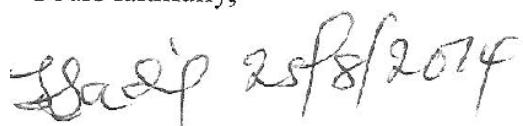
LETTER OF PERMISSION

My name is Rev. Cletus H. Dading, am doing my Ph.D. study in Practical Theology (Ministerial Studies) from the above institution; I am conducting a research on the topic, "An Exploration of Lived and Embodied Theology of Sex and Sexuality in a Context of HIV and AIDS: A Phenomenological study of the Lutheran Church of Christ in Nigeria: A case study of Todi Diocese in Adamawa State. The study explores lived and embodied theologies, phenomenology, sex and sexualities, HIV and AIDS and the Lutheran Church of Christ in Nigeria (L.C.C.N), as they relate to the growing demise of Church members 30 years into the life of the HIV pandemic". As part of the research, I will be going to the field to interview LCCN Todi Diocese Pastors, as well as church members to get data that will help in developing the research.

In order to conduct these interviews and focus group discussions, I need permission from the leadership of Todi Diocese. I therefore write to request your assistance in granting me the permission and all those it may concern to allow me access to premises and persons under your oversight.

Thanks in anticipation.

Yours faithfully,



Rev. Cletus H. Dading.

Appendix 4b:Takardar Yadda daga wurin Bishop

LUTHERAN CHURCH OF CHRIST IN NIGERIA



TODI DIOCESE, HEADQUARTERS BALI

P.O.Box 21, Numan Adamawa State

aay

g-ay

ay

29/08/2014

Rev. Cletus H. Dading
School of religion philosophy and classis,
University of KwaZulu-Natal,
Republic of South Africa.

Sir,

Calvary greeting in the name of our lord and saviour Jesus Christ Amen.

With respect to your letter dated 25/08/2014 seeking for permission to conduct a field interview on your research topic “An Exploration of Lived and Embodied Theology of Sex and Sexuality in a context of HIV and AIDS” in the above Diocese. I am directed by his Lordship the Bishop of LCCN Todi Diocese Rt. Rev Clement Dogo to write to convey the following to you:

- i) That you have been granted the permission to do so.
- ii) That all information required for the success of your work that you may need from us you should not heisted to ask.
- iii) We wish all the success in the conduct of this work and your studies.

Thank you.

Yours faithful

Rev. Jesmiel Dangana
(Secretary to the Bishop)



Appendix 5a: Letter of Request to offer Counselling

School of Religion, Philosophy and Classics,
University of KwaZulu-Natal,
Pietermaritzburg Main Campus,
Private Bag X01 Scottville 3209,
Republic of South Africa.
18th July, 2014.

Dean, Rev. Robert Hammadiko
L.C.C.N Church Headquarters,
Numan, Adamawa State.

Dear Sir,

LETTER OF REQUEST TO OFFER COUNSELLING SERVICES

My name is Rev. Cletus H. Dading, am doing my Ph.D. study in Pastoral Theology (Ministerial Studies) from the above institution; I am conducting a research on the topic, "An Exploration of Lived and Embodied Theology of Sex and Sexuality in a Context of HIV and AIDS: A Phenomenological study of the Lutheran Church of Christ in Nigeria: A case study of Todi Diocese in Adamawa State. The study explores lived and embodied theologies, phenomenology, sex and sexualities, HIV and AIDS and the Lutheran Church of Christ in Nigeria (L.C.C.N), as they relate to the growing demise of Church members 30 years into the life of the HIV pandemic". As part of the research, I will be going to the field to interview and hold focus group discussions with those who suffered loss of their loved ones to HIV related-death, so as to grant the person(s) the opportunity to talk through their experiences of stigmatization and discrimination. I write to seek your consent to assist in the case of any emotional eruption in the course of individual in-depth interviews or focus group discussions to further support such a participant with counselling.

Thanks in anticipation.

Yours faithfully,



Rev. Cletus H. Dading

Appendix 5b: Takardar Nuna yarda domin shawara

Saint John's Archcathedral,
LCCN Headquarters, Numan,
P.O Box 21 Numan,
Adamawa State,
Nigeria.
19/08/2014

Rev. Cletus H. Dading,
School of Religion, Philosophy and Classics,
University of Kwa-Zulu Natal,
Pietermaritzburg Main Campus,
Private Bag X01 Scottville 3209,
Republic of South Africa.

Dear Sir,

RE: LETTER OF REQUEST TO OFFER COUNSELLING SERVICES

I acknowledge with appreciation your letter of 18th July 2014 in which you are seeking for my assistance in attending to cases of HIV and AIDS victims who are passing through societal neglect, stigmatization and discrimination; more to this is to also assist in counseling those that may be emotionally dislodged in the cause of in-depth interviews during your research work as a requirement for your PhD programs with the University of Kwa-Zulu Natal, South Africa.

It is with joy to let you know that I will be available to work with you in helping the affected individuals from their pathetic situations. This exercise is more of a service to humanity and should be accepted whole heartedly trusting that God would go ahead of us in this laudable and noble cause. I therefore, assure you my in flinging support.

My best regards to you and colleagues.

Yours in the vineyard,



Dean, Rev Robert Hammadiko
LCCN Church Headquarters, Numan.



Appendix 6a: Letter of Request to offer Counselling

School of Religion, Philosophy and Classics,
University of KwaZulu-Natal,
Pietermaritzburg Main Campus,
Private Bag X01 Scottville 3209,
Republic of South Africa.

5th September 2014.

Dr. Stanley Joseph Gama
LCCN Referral Center
Demsa, Adamawa State.

Dear Sir,

LETTER OF REQUEST TO OFFER COUNSELLING SERVICES

My name is Rev. Cletus H. Dading, am doing my Ph.D. study in Pastoral Theology (Ministerial Studies) from the above institution; I am conducting a research on the topic, "An Exploration of Lived and Embodied Theology of Sex and Sexuality in a Context of HIV and AIDS: A Phenomenological study of the Lutheran Church of Christ in Nigeria: A case study of Todi Diocese in Adamawa State. The study explores lived and embodied theologies, phenomenology, sex and sexualities, HIV and AIDS and the Lutheran Church of Christ in Nigeria (L.C.C.N), as they relate to the growing demise of Church members 30 years into the life of the HIV pandemic". As part of the research, I will be going to the field to interview and hold focus group discussions with those who suffered loss of their loved ones not-less than two years prior to the interview, so as to grant the person(s) the opportunity to talk through their experience of bereavement. I write to seek your consent to assist in the case of any emotional eruption in the course of individual in-depth interviews or focus group discussions to further support such a participant with counselling.

Thanks in anticipation.

Yours faithfully,



Rev. Cletus H. Dading

Appendix 6b:Letter of Request to offer counselling services

LCCN Referral Centre,
Demsa, Adamawa State,
Nigeria.

9th September, 2014.

Rev. Cletus H. Dading
School of Religion, Philosophy and Classics,
University of KwaZulu-Natal,
Pietermaritzburg Main Campus,
Private Bag X01 Scottville 3209,
Republic of South Africa.

Dear sir,

RE: LETTER OF REQUEST TO OFFER COUNSELING SERVICES

The above subject matter refers to your request to assist in counseling incase of any emotional eruptions that may result (occur) in the course of your research.

I write to inform you that I will within my jurisdiction offer any assistance if need be.

Thank you.

Yours faithfully,

Dr. S.J. Gaman

Appendix 7a: Takardar neman izni domin ba da shawara

School of Religion, Philosophy and Classics (SRPC),
University of KwaZulu-Natal, Pietermaritzburg
Campus, Private Bag X01 Scottville 3209,
Republica of South Africa.

Rev. Mikailu Emmanuel
TCNN Bukuru, Jos.

Dear Sir,

Letter of Request to offer counselling services

My name is Rev. Cletus Haniel Dading; I am doing my PhD in pastoral theology (Ministerial Studies) from the above mentioned Institution. I am conducting a research on the topic: An exploration of sex and sexualities in the context of HIV and AIDS in the Lutheran Church of Christ in Nigeria (LCCN): A phenomenological study of Christian love and stigmatization in Nigeria –Adamawa state: A case study of the LCCN Todi Diocese. I will be going to the field as part of the research to conduct focus group discussions with those who are living with HIV so as to afford the person (s) an opportunity to share their experiences of stigmatization and discrimination. I write to seek for your consent to assist in case of any emotional turmoil that may erupt in the case of group discussions to further support such a participant with counselling.

Thanks in anticipation

Rev. Cletus Haniel Dading

Appendix 7b: Takardar nuna yarda domin ba da shawara

Theological College of Northern Nigeria,
P.O. Box, 64,
Bukuru, Plateau State,
Nigeria
4th, October, 2015.

Rev. Cletus Dading,
School of Religion, Philosophy and Classics,
University of Kwa-zulu Natal,
Pietermaritzburg, Main Campus,
Private Bag X01 Scottville 3209,
Republic of South Africa.

Sir,

Re-Letter of Request to offer counseling services.

Reference to your letter of request seeking for my assistance in attending to the cases of persons infected with HIV and AIDS; who are going through trauma and shame as a result of neglect and marginalization by members of their society.

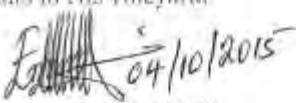
I write to indicate my intention to support you in this noble ministry by providing pastoral counseling and prayers to such people that are found to be in such condition during the cause of your interviews with them.

My door will always be open for you, this is one of many pastoral ministries that God wants us to do for Him; to restore hope to the hopeless, to strengthen the weak and the downtrodden so that they will see the light of the gospel and believe that their roads are not yet closed.

Looking forward to seeing you, and I wish you success and God's guidance in your work.

Thank you.

Yours in His vineyard,


04/10/2015
Rev. Emmanuel Mikaiju

Appendix 8: Approval for Ethical Clearance



26 January 2016

Rev. Cletus Haniel Dading 214528289
School of Religion, Philosophy & Classics
Pietermaritzburg Campus

Dear Rev. Dading

Protocol reference number: HSS/1505/014D

Project Title: An exploration of lived and embodied theologies of sex and sexualities in a context of HIV and AIDS in the Lutheran Church of Christ in Nigeria (LCCN): A phenomenological case study of Todi Diocese in Adamawa State

Full Approval – Full Committee Reviewed Protocol

In response to your application received 4 November 2014, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Dr Herbert Moyo
Cc Academic Leader Research: Professor P Dent
Cc School Administrator: Ms Catherine Murugan

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Gevan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 2487/2488/2489 Facsimile: +27 (0) 31 260 4809 Email: hssrc@ukzn.ac.za / shenuka.singh@ukzn.ac.za

Website: www.ukzn.ac.za

Appendix 9a: Letter from Society for Family Health



MAIDUGURI REGIONAL OFFICE
Suite A7, Kossam Mall,
Giwa Barracks Road,
Box 488, Maiduguri.
Tel/ Fax :076-236632
Mobile: 08023735372;08023793273.
08023733532;08023622674;08036002253
e-mail: sfhmaiduguri @ yahoo.com

Society For Family Health

In association with Population Services International

Plot 2380 Nanka Close,
Off Sultan Abubakar Way (By Heritage House)
Zone 3, Wuse Abuja.
P.M.B. 5116, Wuse
Abuja, Nigeria.
Tel: (09) 5240831-6
0803 3165267
Fax: (09) 5240830
General Email: info@sfhnigeria.org

Date: 04/08/2004

The Arch Bishop,
LCCN Headquarters,
Numan.

Sir,

SPECIAL REQUEST

You may wish to know that we are a registered Nigerian Trust committed to empowering the poor and the vulnerable in Nigeria to adopt healthy behavior. We do this with support from the F. M. O. H., NACA; USAID; DFID and Population Services International (PSI).

The Maiduguri Regional office that cover Adamawa, Borno, and Yobe States have been working through the various radio and Television stations, we conduct interpersonal sensitization programs. We have placed four gigantic AIDS prevention campaign bill boards in each State of the region. In Yola, the bill boards are located at the police headquarters roundabout, airport road and Doubeli day school. In Numan, it is placed at LCCN headquarter roundabout.

You may recall that Adamawa State with 7.6% tops the list in the HIV/AIDS prevalence rate in the North east zone. It occupies the fourth position nationally, based on the 2003 sentinel survey result.

Foundation Members: Late Professor Olikoye Ransome-Kuti, Hon. Justice (Mrs.) I. C. Nzeako and Mallam Dahiru Walli
Trustees: Hon. Justice (Mrs.) I. C. Nzeako (President), Hajia Kindin Yolah, Dr. Shima Gyoh, Mr. Peter Clancy (USA),
Mr. Clayton Davis (USA), Mr. Timothy McLellan (USA), Mr. Kunle Elebute.
Grand Patron: Alhaji Bilyaminu Othman (Emir of Dass)

Appendix 9b: Letter from the LCCN Administrative Secretary

17th September, 2004.

Mr. Thomas Ngalo,
Regional Coordinator,
Society for Family Health,
Suite A7, Kossam Mall,
Giwa Barracks Road,
Box 488, Maiduguri,
Borno State.

Dear Mr. Thomas Ngalo,

RE : SPECIAL REQUEST

Greetings to you from the Headquarters of the Lutheran Church of Christ in Nigeria (LCCN) in the precious name of our Lord and Saviour Jesus Christ.

I write on behalf of the Leadership of the Lutheran Church of Christ in Nigeria (LCCN) and to refer to your letter on the above subject matter dated 4th August, 2004 with thanks.

As you are aware already that LCCN is involved in HIV/AIDS programme for about two or more years ago, the Church is still positively forging ahead by organizing Seminars and Workshops at various levels to sensitize its members on its effects. Committees were set at various levels. This is to carry out public campaigns and to teach our teeming population and to as well augment Government programmes on HIV/AIDS.

In this regard therefore, the LCCN is glad to be in partnership with your organisation in this area, as this will further strengthen our objectives and to bring about optimal results in the end.

Your suggestions on the way forward is hereby anticipated please.

Sincerely Yours,

Abudu B. Doli
Rev. Abudu B. Doli
Administrative Secretary, LCCN.

CC: Archbishop, LCCN
HIV/AIDS Coordinator, LCCN

Appendix 10a: Statistics fro ADSACA

HET

2013

ID	Indicators	2013 DATA
HCT1i	No. of ind. tested HIV negative: Female - 0-14	1,498
HCT1ii	No. of ind. tested HIV negative: Female - 15-19	3,796
HCT1iii	No. of ind. tested HIV negative: Female - 20-24	8,376
HCT1iv	No. of ind. tested HIV negative: Female - 25-49	15,915
HCT1v	No. of ind. tested HIV negative: Female - 50+	1,702
HCT2i	No. of ind. tested HIV negative: Male - 0-14	1,468
HCT2ii	No. of ind. tested HIV negative: Male - 15-19	2,892
HCT2iii	No. of ind. tested HIV negative: Male - 20-24	6,249
HCT2iv	No. of ind. tested HIV negative: Male - 25-49	18,324
HCT2v	No. of ind. tested HIV negative: Male - 50+	2,737
HCT3	SubtotalA: No. of ind. tested HIV negative	62957
HCT4i	No. of ind. tested HIV positive: Female - 0-14	256
HCT4ii	No. of ind. tested HIV positive: Female - 15-19	185
HCT4iii	No. of ind. tested HIV positive: Female - 20-24	773
HCT4iv	No. of ind. tested HIV positive: Female - 25-49	2,370
HCT4v	No. of ind. tested HIV positive: Female - 50+	278
HCT5i	No. of ind. tested HIV positive: Male - 0-14	126
HCT5ii	No. of ind. tested HIV positive: Male - 15-19	84
HCT5iii	No. of ind. tested HIV positive: Male - 20-24	191
HCT5iv	No. of ind. tested HIV positive: Male - 25-49	1,572
HCT5v	No. of ind. tested HIV positive: Male - 50+	411
SubtotalB: No. of ind. tested HIV positive		6,246
HCT7	Total no. of ind. HIV tested (subtotal A + B)	69,203
HCT8.1	No. of ind. HIV counselled & test & result - 0-14 (female)	1,780
HCT8.2	No. of ind. HIV counselled & test & result - 15-19 (female)	3,930

Appendix 10b: Statistics fro ADSACA

Hei

2804

ID	HCT Indicators 2014	Total 2014
HCT1i	No. of ind. tested HIV negative: Female - 0 -14	7365
HCT1ii	No. of ind. tested HIV negative: Female - 15-19	10249
HCT1iii	No. of ind. tested HIV negative: Female - 20-24	18417
HCT1iv	No. of ind. tested HIV negative: Female - 25-49	36471
HCT1v	No. of ind. tested HIV negative: Female - 50+	4195
HCT2i	No. of ind. tested HIV negative: Male - 0-14	6896
HCT2ii	No. of ind. tested HIV negative: Male - 15-19	7880
HCT2iii	No. of ind. tested HIV negative: Male - 20-24	14865
HCT2iv	No. of ind. tested HIV negative: Male - 25-49	39329
HCT2v	No. of ind. tested HIV negative: Male - 50+	4845
HCT3	Subtotal A: No. of ind. tested HIV negative	150512
HCT4i	No. of ind. tested HIV positive: Female - 0-14	168
HCT4ii	No. of ind. tested HIV positive: Female - 15-19	220
HCT4iii	No. of ind. tested HIV positive: Female - 20-24	757
HCT4iv	No. of ind. tested HIV positive: Female - 25-49	2676
HCT4v	No. of ind. tested HIV positive: Female - 50+	249
HCT5i	No. of ind. tested HIV positive: Male - 0-14	163
HCT5ii	No. of ind. tested HIV positive: Male - 15-19	60
HCT5iii	No. of ind. tested HIV positive: Male - 20-24	235
HCT5iv	No. of ind. tested HIV positive: Male - 25-49	1826
HCT5v	No. of ind. tested HIV positive: Male - 50+	247
HCT6	No. of ind. tested HIV positive	157113
HCT7	Total no. of ind. HIV tested (subtotal A + B)	157113
HCT8.1	No. of ind. HIV counselled & test & result - 0-14 (female)	7532
HCT8.2	No. of ind. HIV counselled & test & result - 15-19 (female)	10469
HCT8.3	No. of ind. HIV counselled & test & result - 20-24 (female)	19161

Appendix 10c: Statistics fro ADSACA

~~2015 DATA~~

Indicator		
	2015 DATA	2015
HCT1i	No. of ind. tested HIV negative: Female - 0-14	8031
HCT1ii	No. of ind. tested HIV negative: Female - 15-19	7316
HCT1iii	No. of ind. tested HIV negative: Female - 20-24	13953
HCT1iv	No. of ind. tested HIV negative: Female - 25-49	31842
HCT1v	No. of ind. tested HIV negative: Female - 50+	4962
HCT2i	No. of ind. tested HIV negative: Male - 0-14	7531
HCT2ii	No. of ind. tested HIV negative: Male - 15-19	8084
HCT2iii	No. of ind. tested HIV negative: Male - 20-24	12538
HCT2iv	No. of ind. tested HIV negative: Male - 25-49	25753
HCT2v	No. of ind. tested HIV negative: Male - 50+	3524
HCT3i	Subtotal A: No. of ind. tested HIV negative	123534
HCT4i	No. of ind. tested HIV positive: Female - 0-14	162
HCT4ii	No. of ind. tested HIV positive: Female - 15-19	198
HCT4iii	No. of ind. tested HIV positive: Female - 20-24	397
HCT4iv	No. of ind. tested HIV positive: Female - 25-49	1920
HCT4v	No. of ind. tested HIV positive: Female - 50+	287
HCT5i	No. of ind. tested HIV positive: Male - 0-14	174
HCT5ii	No. of ind. tested HIV positive: Male - 15-19	157
HCT5iii	No. of ind. tested HIV positive: Male - 20-24	457
HCT5iv	No. of ind. tested HIV positive: Male - 25-49	2166
HCT5v	No. of ind. tested HIV positive: Male - 50+	246
HCT6i	Subtotal B: No. of ind. tested HIV positive	6462
HCT7	Total no. of ind. HIV tested (subtotal A + B)	129698
HCT8.1	No. of ind. HIV counselled & test & result - 0-14 (female)	8195
HCT8.2	No. of ind. HIV counselled & test & result - 15-19 (female)	7534
HCT8.3	No. of ind. HIV counselled & test & result - 20-24 (female)	14409
HCT8.4	No. of ind. HIV counselled & test & result - 25-49 (female)	33552
HCT8.5	No. of ind. HIV counselled & test & result - 50+ (female)	5236
HCT9.1	No. of ind. HIV counselled & test & result - 0-14 (male)	7680
HCT9.2	No. of ind. HIV counselled & test & result - 15-19 (male)	8399
HCT9.3	No. of ind. HIV counselled & test & result - 20-24 (male)	12853
HCT9.4	No. of ind. HIV counselled & test & result - 25-49 (male)	27512

6,164

Appendix 11a: Questions for focus group discussion with the LCCN Pastors

Introduction

My name is Rev. Cletus Haniel Dading; I am doing my PhD in pastoral theology (Ministerial Studies) from the University of KwaZulu Natal. I am conducting a research on the topic: An exploration of sex and sexualities in the context of HIV and AIDS in the Lutheran Church of Christ in Nigeria (LCCN): A phenomenological study of Christian love and stigmatization in Nigeria –Adamawa state: A case study of the LCCN Todi Diocese. I am indeed grateful for giving me your time and subsequently the responses you will provide in the course of these questions. Your contributions will be duly listened to and be used in developing this study as pastors; it will also assist us in understanding your main concern in alleviating the plight of those who are living with HIV so as to develop a positive response that will address the concerns that will be raised.

1. What is your understanding of HIV and AIDS?
2. What are the causes of the spread of HIV in Todi Diocese?
3. Why do Christians discriminate against people living with HIV when they are expected to love their neighbour as they love themselves?
4. What is your understanding of sex and sexualities in the context of HIV in Todi diocese?
5. What should the LCCN do to respond to both the spread of HIV and the evils of stigma and discrimination?
6. How do church members discriminate people who are living with HIV?
7. In your understanding what do you think is the relationship between the Church and HIV and AIDS infected persons?
8. How often do you talk to your Church members about the use of condoms?
9. How often do you as Pastors talk, preach and teach on sex and sexuality?
10. How does the scourge of HIV affects the church?
11. What confidence do people living with HIV have towards church members?
12. What is the Church doing to ameliorate the plights of those infected in the Church?
13. What efforts are Ministers making to ensure that those infected and affected are not stigmatized and discriminated against?

Thank you so much for your time and contributions towards this research

Appendix 11b: Tamboyoyi domin Pastoci

Gabatarwa

Ni ne mai suna Rev Cletus Haniel Dading, ni dalibi ne a sunan makaranta da ke bisa. Ina bincike akan Jima'i da rayuwar jima'i dangane da cutar kanjamau da kuma kanjamau a cikin ekkliсиar ta Lutheran Church of Christ In Nigeria, wato LCCN cikin Diosis na Todi, wadda ta ke a karmar hukumomi guda biyu, wato Demsa da Numan. Ina mai matukar godiya domin zarafin da ka/kin rifta domin bani wadansu bayani da za su inganta wannan bincike. Cikin natsuwa zan saurare ka/ki domin in yi amfani da su domin wannan bincike. Wannan zai taimaka ta wajen samun hanyoyin da zamu dakatar da wariya da ake yi wa yan'uwanmu wadanda su ke da kanjamau.

1. Menene ya sa Krista suna wariya da cin zalin wadanda suna da ciwon kanjamau, bayanda sune ya kamata su kaunaci makwabtansu kamar ransu?
2. Menene ke kawo yaduwar cutar kanjamau a cikin Diosis na Todi?
3. Menene fahimtarku akan jima'i da rayuwar jima'i?
4. Menene ya kamata LCCN ta yi da zai nuna ta yi yunkuri domin dakatar da yaduwar cutar kanjamau da kuma da kuma muguntar wariya?
5. Menene fahimtarka akan cutar Kanjamau da kuma kanjamau da kanta?
6. Kuna da yan ekkliсиya wadanda suna da wannan cuta kuwa?
7. A fahimtarka, menene kana tsamani shi ne dangantaka tsakanin ekkliсиya da wadanda suna da wannan cutar kanjamau?
8. Kuna iya tadi da yan ekkliсиya game da aiki da robar hana daukar ciki?
9. Sau nawa ne ku Pastoci kuna Magana, wa'azi da koyar da yan ekkliсиya akan jima'i da rayuwar jima'i?
10. Zak ku iya cewa alobar kanjamau ta shafi ekkliсиar LCCN ko babu?
11. Wadanda suna da cutar kanjamau suna zuwa gaba gadi wurin ekkliсиya domin neman taimako, ko su fita fili su ce suna da wannan cuta?
12. Menene ekkliсиya tana yi domin ta rage wahalar wadanda suna da ciwon kanjamau?
13. Wane yunkuri ne pastoci suna yi domin sun tabbatar wadanda suna da ciwutar kanjamau ba'a yi masu wariya ba?

Na yi matukargodiya domin kyawawan zarafin da kun ba ni da kuma gudumawanrku

Appendix 12a: Questions for focus group discussion with the Youth

Introduction

My name is Rev. Cletus Haniel Dading; I am doing my PhD in pastoral theology (Ministerial Studies) from the above mentioned Institution. I am conducting a research on the topic: An exploration of sex and sexualities in the context of HIV and AIDS in the Lutheran Church of Christ in Nigeria (LCCN): A phenomenological study of Christian love and stigmatization in Nigeria –Adamawa state: A case study of the LCCN Todi Diocese. I am in deed grateful for giving me your time and subsequently the responses you will provide in the course of these questions. Your contributions will be duly listened to and be used in developing this study as pastors, it will also assist us in understanding your main concern in alleviating the plight of those who are living with HIV so as to develop a positive response that will address the concerns that will be raised.

1. What do you know about HIV and AIDS?
2. Why do Christians discriminate against people living with HIV when they are expected to love their neighbour as they love themselves?
3. What are the causes of the spread of HIV in Todi Diocese?
4. What is your understanding of sex and sexualities in the context of HIV in Todi Diocese?
5. What should the LCCN do to respond to both the spread of HIV and the evils of stigma and discrimination?
6. What is your understanding of abstinence and premarital sex?
7. Do your Pastors freely talk or preach about Sex and Sexuality?
8. Do you understand the concept of “Safe sex”?
9. Should the Church and the Government make HIV test reluctantly or voluntarily?
10. What effort are youth making to stay away from being infected with HIV?
11. How would you help in spreading the message of prevention of HIV among youth?

Thank you so much for your time and contributions towards this research

Appendix 12b: Tamboyoyi domin Matasa

Gabatarwa

Ni ne mai suna Rev Cletus Haniel Dading, ni dalibi ne a sunan makaranta da ke bisa. Ina bincike akan Jima'i da rayuwar jima'i dangane da cutar kanjamau da kuma kanjamau a cikin ekklesiyan ta Lutheran Church of Christ In Nigeria, wato LCCN cikin Diosis na Todi, wadda ta ke a karmar hukumomi guda biyu, wato Demsa da Numan. Ina mai matukar godiya domin zarafin da ka/kin rifta domin bani wadansu bayani da za su inganta wannan bincike. Cikin natsuwa zan saurare ka/ki domin in yi amfani da su domin wannan bincike. Wannan zai taimaka ta wajen samun hanyoyin da zamu dakatar da wariya da ake yi wa yan'uwanmu wadanda su ke da kanjamau.

1. Menene ka sani game da ciwon nan da ake kira Kanjamau?
2. Menene ya sa Krista suna wariya da cin zalin wadanda suna da ciwon kanjamau, bayanda sune ya kamata su kaunaci makwabtansu kamar ransu?
3. Menene ke kawo yaduwar cutar kanjamau a cikin Diosis na Todi?
4. Menene fahimtarku akan jima'i da yauwar jima'i dangane da cutar Kanjamau da kuma kanjamau da kanta?
5. Menene ya kamata LCCN ta yi da zai nuna ta yi yunkuri domin dakatar da yaduwar cutar kanjamau da kuma da kuma muguntar wariya?
6. Menene fahimtarku akan zaman rashin jima'i da jima'i kamin aure?
7. Pastocinku suna Magana a sake ko wa'azi akan jima'i da rayuwar jima'i?
8. Kun fahimci wannan take na jima'i mafi aminci?
9. Yana da kyau ekklesiya da gwamnati su tilasa yan ekklesiya su yi gwajin tabbatar ko akwai cutar kanjamau ko babu?
10. Wane kokari ne matasa suna yi domin su tsare kansu daga kamuwa da cutar kanjamau?
11. Ta yaya matasa zasu yada labarin rigakafin cutar kanjamau ga matasa?

Na yi matukargodiya domin kyawawan zarafin da kun ba ni da kuma gudumawanrku

Appendix 13a: Questions for the focus group discussion with Executive Council Members

Introduction

My name is Rev. Cletus Haniel Dading; I am doing my PhD in pastoral theology (Ministerial Studies) from the above mentioned Institution. I am conducting a research on the topic: An exploration of sex and sexualities in the context of HIV and AIDS in the Lutheran Church of Christ in Nigeria (LCCN): A phenomenological study of Christian love and stigmatization in Nigeria –Adamawa state: A case study of the LCCN Todi Diocese. I am in deed grateful for giving me your time and subsequently the responses you will provide in the course of these questions. Your contributions will be duly listened to and be used in developing this study as pastors; it will also assist us in understanding your main concern in alleviating the plight of those who are living with HIV so as to develop a positive response that will address the concerns that will be raised.

1. Why do Christians discriminate against people living with HIV when they are expected to love their neighbour as they love themselves?
2. What are the causes of the spread of HIV in Todi diocese?
3. How does cultural, socio-economic and political development impact on sex and sexualities in the context of HIV and AIDS in Nigeria?
4. What should the LCCN do to respond to both the spread of HIV and the evils of stigma and discrimination?
5. Why are the HIV infected persons finding it difficult to disclose their status?
6. Does the Church have programmes that meet the needs of HIV infected persons?
7. Do you encourage the sexually active church members to use condoms when having sex or not?
8. What efforts are DEC members making to ensure that those infected and affected are not stigmatized and discriminated against?
9. Does the church executive council promulgate policies in defence of the HIV infected persons?

Thank you so much for your time and contributions towards this research

Appendix 13b: Tambo yoyo domin Yan Majalisar Ekklesiya

1. Menene ya sa Krista suna wariya da cin zalin wadanda suna da ciwon kanjamau, bayanda sune ya kamata su kaunaci makwabtansu kamar ransu?
2. Menene ke kawo yaduwar cutar kanjamau a cikin Diosis na Todi?
3. Menene fahimtarku akan jima'i da yauwar jima'i dangane da cutar kanjamau da kuma kanjamau da kanta?
4. Menene ya kamata LCCN ta yi da zai nuna ta yi yunkuri domin dakatar da yaduwar cutar kanjamau da kuma da kuma muguntar wariya?
5. Menene ya sa wadanda suna da cutar kanjamau suna same ta da wahala su gaya wa jama'a?
6. Ekklesiya tana da wata shiri musaamman na biyan bukatun wadanda suna fama da ciwon kanjamau?
7. Kuna iya same ta da sauvi ku je inda jama'a suke halarta kamar wurin aure, majami'a, kasuwa da sauransu?
8. Wadanda suna da ciwon kanjamau 76yjmhjhsuna samun hanyar mafi sauvi na samun magunguna?
9. Kuna iya karfafa wadanda basu iya rikon kansu ba su yi aiki da roban hana daukan ciki ko babu?
10. Majalisar ekklesiya ta kafa dokoki domin ta kare wadanda suna da ciwon kanjamau?

Na yi matukargodiya domin kyawawan zarafin da kun ba ni da kuma gudumawanrku

Appendix 14a: Questions for the focus group discussion with mothers/fathers living with HIV

Introduction

My name is Rev. Cletus Haniel Dading; I am doing my PhD in pastoral theology (Ministerial Studies) from the above mentioned Institution. I am conducting a research on the topic: An exploration of sex and sexualities in the context of HIV and AIDS in the Lutheran Church of Christ in Nigeria (LCCN): A phenomenological study of Christian love and stigmatization in Nigeria –Adamawa state: A case study of the LCCN Todi Diocese. I am in deed grateful for giving me your time and subsequently the responses you will provide in the course of these questions. Your contributions will be duly listened to and be used in developing this study as pastors; it will also assist us in understanding your main concern in alleviating the plight of those who are living with HIV so as to develop a positive response that will address the concerns that will be raised.

1. What are the causes of the spread of HIV in Todi diocese?
2. Why do Christians discriminate against people living with HIV when they are expected to love their neighbor as they love themselves?
3. What is your understanding of sex and sexualities in the context of HIV in Todi diocese?
4. How often have you been offered pre and post counselling before and after HIV been tested?
5. What do you advise the LCCN to do to effectively respond to both the spread of HIV and the evils of stigma and discrimination?
6. What do you understand to be responsible for reason(s) why people are stigmatized and discriminated against in Todi Diocese?
7. How free and confident do PLWHIV have to confide to their Pastor about their HIV status?
9. How often do you always receive and take your tiretoviral drugs from any hospital or Non-governmental organizations?
10. What support do you receive from the Church?
11. How do members of the church stigmatize and discriminate against you?

12. What roles do your pastors play in assisting those of you who are living with HIV and to enable you have access to ARVs?
14. What is the relationship between poverty and the spread of HIV in Todi Diocese?

15. Do you have any message of encouragement to the younger generations?

16. How often does your partner use condom when having sex with you?

Thank you so much for your time and contributions towards this research

Appendix 14b: Tamboyoyi domin wadanda su ke da cutar kanjamau

Gabatarwa

Ni ne mai suna Rev Cletus Haniel Dading, ni dalibi ne a sunan makaranta da ke bisa. Ina bincike akan Jima'i da rayuwar jima'i dangane da cutar kanjamau da kuma kanjamau a cikin ekklesiyan ta Lutheran Church of Christ In Nigeria, wato LCCN cikin Diosis na Todi, wadda ta ke a karmar hukumomi guda biyu, wato Demsa da Numan. Ina mai matukar godiya domin zarafin da ka/kin rifta domin bani wadansu bayani da za su inganta wannan bincike. Cikin natsuwa zan saurare ka/ki domin in yi amfani da su domin wannan bincike. Wannan zai taimaka ta wajen samun hanyoyin da zamu dakatar da wariya da ake yi wa yan'uwanmu wadanda su ke da kanjamau.

1. Menene ya sa Krista suna wariya da cin zalin wadanda suna da ciwon kanjamau, bayanda sune ya kamata su kaunaci makwabtansu kamar ransu?
2. Menene ke kawo yaduwar cutar kanjamau a cikin Diosis na Todi?
3. Menene fahimtarku akan jima'i da yauwar jima'i dangane da cutar Kanjamau da kuma kanjamau da kanta?
4. Menene ya kamata LCCN ta yi da zai nuna ta yi yunkuri domin dakatar da yaduwar cutar kanjamau da kuma da kuma muguntar wariya?
5. Kun tabba fuskanci wulakanci daga wurin danginku?
6. Kun taba yin yunkurin bayana matsayin cutarku ga pastocinku?
7. A yanzu haka, kuna karbar magunguna daga asibitoci kobabu?
8. Kuna samun goyon baya ta wadansu hanyoyi daga wurin ekklesiya?
9. Antaba yi maku wariya da wulakanci daga ekklesiya ko wurin ma'aikantanku?
10. Kuna da sako na karfafawa zuwa wurin matasa masu tashi yanzu?
11. Sau nawa ne abokan huldanku na aiki da robar hana daukan ciki?

Na yi matukargodiya domin kyawawan zarafin da kun ba ni da kuma gudumawanrku

Appendix 15: Sample of some transcribed focus group discussion

A. Transcribed focus group discussions with the LCCN pastors

1. Why do Christians discriminate against people living with HIV when they are expected to love their neighbor as they love themselves?

HIV is a disease that is viewed as contagious which can easily be transmitted through casual contact. If someone is therefore infected, the fear is that associating with such a person is disastrous to one's health. Another reason why we stigmatize and discriminate is that we see HIV as a disease that was brought by God to punish sexual offenders. We see the disease as an epidemic that only infects those who are sexually immoral.

2. What are the causes of the spread of HIV in Todi diocese?

Here our major problem is premarital and extramarital sexual misconduct which are major factors accountable for the spread of HIV. If youth would be discipline enough to stay away from sexual waywardness and if the married couples would stick their spouses or partners, the spread of HIV would be reduced significantly.

3. How does cultural, socio-economic and political development impact on sex and sexualities in the context of HIV and AIDS

In Todi Diocese, culture plays a magnificent role in the manner in which HIV is spread. Women, no matter how highly placed are expected to unconditionally succumb to the sexual desires of their partners regardless of their HIV positive status. Economically, women are subjected to be only content with the little resources within the disposal of their partners; restricting women to the full time house wives duty. The economic hardship has rendered some women more vulnerable to the HIV infection. Politically, the government of this country is deliberately mapping out strategies to eliminate the less privilege in the land; because, only little attention is given in terms of enlightenment of the masses on how to stay away from the epidemic.

4. Do you have members of the Church who are HIV positive?

Did you say members or including pastors? There are many members and pastors who are known to be living with HIV. Unfortunately, pastors in the LCCN deny the existence of HIV in their bodies, even when the symptoms are visibly conspicuous. Pastors should lead by

example; if they are reluctant to disclose their HIV positive status, who do they expect to do so? Pastors should do as they preach, so they can serve as good examples to their followers.

5. How often do you as Pastors talk, preach and teach on sex and sexuality?

You know, talking or preaching about sex and sexualitiesis not an easy task. Members are so quick to label any one who openly talks or preaches about sex and sexualitiesas an unspiritual pastor. If you want to maintain your intergrity in the LCCN, stop making any pronouncement related to sex and sexuality.Besides, some of us are not trained to talk about such a topic, and culture demnads that one should zip up his or her mouth when it comes to the matter of sex.

6. How often do you talk to your Church members about the use of condoms?

No No! If one cannot talk about sex and sexuality, how can he or she talk about condom, which has been introduced to encourage the youth to be more sexually perversed? Talking about condom is an outright approval to sexual promiscuity among members of the church. An adage says, “Let the sleeping dog lies”. We shouldn’t start what we can not finish. We observe that any pastor who talks about the use of condoms has a questionable character.

7. Do people who are HIV positive have confidence to approach the church for help or disclose their HIV status?

Church members hardly come to us and disclose their HIV positive status, sometimes they say we don’t commiserate with them in their suffering. Most times, women are more open to us than their men counterparts. Some youth who know they are HIV positive and they are not married will not open up about their status, but will only come for marriage counselling, even when they know that the news of their HIV status is all over the place. We always tell those whom we suspect to go to clinics and bring us their HIV results, so that we don’t make a mistake of joining two different people together (the positive and the negative).

B. Transcribed focus group discussions with the Youth group

1. Why do Christians discriminate against people living with HIV when they are expected to love their neighbor as they love themselves?

The LCCN Pastors are mostly the ones encouraging stigma and discrimination. They often declare in their preachings that to be HIV positive is an abomination, and people who are tested positive should be avoided. Some pastors don’t even want to conduct funerals for people who died to AIDS- related deaths. For those who are willing to conduct funeralsof

such people will say all manner of things that are irritating. The discrimination would be so much that even after the burial one would not want to go to the house of the family of the deceased.

2. What should the LCCN do to respond to both the spread of HIV and the evils of stigma and discrimination?

The pastors are the ones who have the pulpits and can decide what to be preached and what not to be preached. If really the pastors are willing to stop stigma and discrimination, within the twinkle of an eye, stigma and discrimination will stop. Unguided and inflammatory utterances that are tantamount to promoting the evil of stigma and discrimination should be discouraged by the pastors. Pastors should endeavour to teach its members to embrace all and sundry irrespective of one's HIV status and live together as brothers and sisters.

3. What do you know about HIV and AIDS?

HIV and AIDS is a disease like gonorrhoea that men carry from women. HIV is a killer disease that is finishing our church members including pastors. The disease is like plague in Todi Diocese, and people seemed to be doing nothing about it.

4. Should the Church and the Government make HIV testing reluctantly or voluntarily?

If the church and the government are serious about fighting the spread of HIV, they should therefore make the HIV testing compulsory. Voluntarily, no one will be willing to go for the testing. In this country we know the language of force than I beg. So the government should stop treating people politely when it comes to the issue of HIV testing. After the HIV testing, the names of those who tested HIV positive should be made known to the public by publishing and pasting them in our clinics. Human beings are wicked.

5. What effort are youth making to stay away from being infected with HIV?

We are told that during sex, if there is no manifestation of blood from both partners, the possibility of becoming infected with the HIV is minimal. So we always try to have sex with our girl friends softly so as to prevent blood from coming out from either the lady or the man, hence the condom is not seen, even where there are available, there is no money to buy them all the time.

6. Do you understand the concept of “Safe sex”?

Safer sex? No! We told you that our pastors do not talk to us or preach about sex, how will we understand the concept of safer sex? There are few among us who have been to tertiary institutions; we heard about safer sex methoeds, but you know sex with a burier is no sex at all. It is better to live without sex than sex with something barricading you and your partner.

7. What should the LCCN do to respond to both the spread of HIV and the evils of stigma and discrimination?

The LCCN should establish HIV and AIDS offices in the entireDiocese' Head quarters. The LCCN is not showing any vissble concern to the plight of those living with HIV in the Diocese. The only thing pastors say sometimes is that people should go for HIV testing; they do not tell one what to expect and what to do after your result is found to be positive. People who are found to be positive and are known to the pastors become reference point in their daily discussions, warning members that if you they to listen, they will become like so so person. This attitude by the LCCN pastors discourages people from voluntary going for HIV testing.

C. Transcribed focus group discussions with Executive council members

1. Why do Christians discriminate against people living with HIV when they are expected to love their neighbor as they love themselves?

One of the DEC members started with a House proverb that says, “Wanda ya ki jin bari, zai ji oho” which literally means, he or she who refuses to listen, will suffer it alone” Our members are designers of their problem. When trouble is sleeping, they will go and wake it up. We have been warning them of the danger of sexual promiscuity, but they will not listen. For us we view stigma and discrimination as a way of discouraging other membersfrom engaging in sexual behaviours that will further plunge them into such a misery.

2. What are the causes of the spread of HIV in Todi diocese?

If our church members will stop sexual promiscuity (both premarital and extramarital sex) HIV and AIDS will soon be eradicated. Those who are married, live as though they are still singles. Men especially are giving us headache in this Diocese. They are mostly responsible for their wives’ infections. Law enforcement agents are also responsible for the speedy spread of HIV. When they come back from Liberia, Siera Leone, Sudan and other nations where

they were deployed for peace keeping, they only come back with the little money they got and infect our daughters.

3. What should the LCCN do to respond to both the spread of HIV and the evils of stigma and discrimination?

For the LCCN to properly respond to both the spread of HIV and the evils of stigma and discrimination, church members must play their role by side-stepping sexual waywardness. Whatever the response of the church leadership is, if the members have not change their sexual behaviours, HIV epidemic will continue to spread unabated. The LCCN on its part can intensify their enlightenment campaign so that people can know more about the impact of HIV and AIDS in the church.

4. Does the Church have programmes that meet the needs of HIV infected persons?

Here we do not specifically have any programmes that are aimed at meeting the needs of those who are living with HIV. We have welfare committee in almost all the congregations in the LCCN. We always refer PLWHIV to such committees so they can assist them. You know when there is a programme meant for the assistance of PLWHIV, the church will be indirectly encouraging other members to continue in theirwaywardness, believing that the church is there to meet their needs. Therefore, we don't want to create problem unnecessarily.

5. Do HIV positive persons in our church have access to antiretroviral drugs?

We don't know and we don't want to interfere into the affairs of members living with HIV. It is the sick person that seeks for the doctor. We have a lot of responsibiliies in such a way that we cannot concern ourselves with everything.

6. Do you encourage the sexually active church members to use condoms when having sex or not?

We have said it initially that we don't want to embark on any activity or utterances that will promote the spread of HIV. Coming out to tell members that condom is good and should therefore be used, is directly giving them license to engage in sexual promiscuity, and sooner or later they will tell us that we have contributed in spreading the deadly disease, because we have encouraged it by promoting the use of condoms. Even those who have one of their partners infected should consult the doctors how to handle their discordant status. The

medical doctors are not helping matters by promoting the use of condoms, instead of asking the manufacturers of condoms to stop producing it.

7. What efforts are DEC members making to ensure that those infected and affected are not stigmatized and discriminated against?

We will refer you to the first question that was asked (**Why do Christians discriminate against people living with HIV when they are expected to love their neighbor as they love themselves?**). We earlier made our position known that, stigmatizing and discriminating will serve as lesson who living waywardly. When a thief is arrested in this community, we allow him to beaten on a market day, so he or she can be publicly humiliated. The purpose for doing that is serve as a deterrent to other people who are contemplating of committing the same crime. Stealing is prohibited and adultery as well in the Bible; therefore if a thief is always embarrassed, such should extended to those who cannot control their sexual urge.

8. Does the church executive council promulgate policies in defense of the HIV infected persons?

We don't have any policy now in the LCCN Todi Diocese in defense of those living with HIV. What are we going to say in the policy when our children go to Universities and change completely? Defending them when they are HIV positive is another way of encouraging them.

D. Transcribed focus group discussions with HIV-infected Mothers/fathers

1. Why do Christians discriminate against people living with HIV when they are expected to love their neighbor as they love themselves?

That is the question on the lips of many of us who are living with HIV. We expect that if the community outside the church will discriminate against us, the church which is established on the principles of Jesus should be exceptional, but reverse is the case. People outside the faith communities are more sympathetic than our Christian brothers and Sisters. Christians are pronounced to be salt of the world (Matthew 5:13), but our attitudes do not demonstrate that.

2. What are the causes of the spread of HIV in Todi diocese?

We don't know the causes of the spread of HIV, but for us women, men are mostly responsible for our infections. They are the ones that go from one junction to the other, and if they carry it, they will not tell us that they are infected, even when someone whispered to you

that your partner is HIV positive, they will still force you to sleep with them without any barrier. Denying them sex is as equal as committing suicide; because they will deny you food and treat you like lesser humans.

3. Did you receive pre and post-counselling before and after HIV testing by anyone?

No one has ever talked to us prior to our HIV test and after we have been tested HIV positive. Here, you are left alone to carry your cross. We don't have an idea of what the counselling is all about. When you in an effort to seek encouragement from the pastors by divulging your HIV positive status, you will be made to live the rest of your life in perpetual regret. Our nurses are seemed not to be educated in that aspect of counselling people before and after their HIV testing and that has contributed in discouraging many people to go for voluntary HIV testing.

4. Have you ever faced any discrimination from your relations?

At times, dogs were more valuable than some of us. The manner in which we are being treated by family members is shameful to discuss to the public. Sometimes, they chase us away when they know that they want to cook delicious meal. They will cook some thing different and keep for you, when you try to complain why they are behaving like that, they will infuriate you by reminding you that they are not the cause of your infection. They sometimes forced us to stay in a room that has a door facing the street; a room meant for suspicious visitors. When one's health condition deteriorates and the person passes faeces uncontrollably, they remove us from the main house to a round hut.

5. Did you make any effort to confide to your Pastor your HIV status?

Pastors! It is better you tell someone you don't know than confiding in a pastor that you are HIV positive. When you finally decide to confide in a pastor, be sure that you are braced up for the outcome of your decision. When you confide in a pastor, you are equally in a way informing the whole congregation of your HIV positive status. You start hearing members of the church telling you to stay at home instead of coming to public gatherings, so you can save yourself from public humiliation.

6. Do you presently receive any antiretroviral drugs from any hospital or Non-governmental organizations?

Yes we do receive antiretroviral drugs from General hospital Numan, but before you get drugs you will have to endure insults and humiliating languages. When we queue for hours, we become tired and sit down,

but the nurses will stand to the hearing of other sick people around and shout, “Masu ciwon duri, ku zo nan” Meaning, those who are suffering from the disease of vagina, should come and collect their drugs, and you cannot say anything. If you dare say anything, they will pretend as if they did not hear what you said, when it comes to your turn, they will tell you that they have run out of drugs.

7. Do you receive support of any kind from the Church?

Which church? They will announce that all those who are sick should meet the welfare officer for assistance. When you meet the welfare officer, he or she will ask you, what is your problem? He will insist that you tell him or her precisely what your health challenge is. Here we call AIDS “Ciwon Duniya” (The World Disease). When you tell them ciwon Duniya, they will refer you to the pastor, and pastor will start interrogating you how you got infected with the deadly virus. The church has never done anything purposely to assist us. Preferably, we decided not to approach the church for any support.

8. What is the relationship between poverty and the spread of HIV in Todi Diocese?

As you can see, almost all of us are not civil servants; we are daily living at the mercy of our husbands. The fact that some of us were infected by our husband does not make them sympathise with us by meeting our daily financial needs. We are sometimes tempted to look elsewhere for money to even go to hospital. In the course of looking for money we become engage in extra marital affairs. It is unfortunate that some people in this community have been infected by some of us. If we have money we will not engage in this wicked activities; we know it is sin, but what do we do?

9. How often does your partner use condom when having sex with you?

Here we don't have access to condom. Some of us don't even know how condoms look like; whether it is red, white, blue or black, we don't know. Where we collect drugs, they will tell us to always use condom, but they are not providing them for us, and we can not afford buying condom for every sexual intercourse in our chemists because of its exorbitant rates.

Beside that, our husbands vowed never to use condom, even if they are HIV negative, because condom makes the joy of sex unnatural; so condom is not an issue here.

