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ISSN 1026-2946

The Church and AIDS in Africa: Towards a Spiritual Answer[1]

by Peter Okaalet (as re-presented by John Chaplin)

Introduction

Psalm 11:3 encourages to me to stay the course with HIV and AIDS work, "What should the righteous do when the foundations are shaken?" (NKJV). This is a direct call for a Christian response to HIV and AIDS. I do not know the whole answer hence the title, "*towards* a spiritual answer."

When I was working as a doctor in Uganda in the 80s, a 24 year old man dying of AIDS asked me, "Are you sure there is life after death?" I quoted from John 11 about Lazarus' resurrection and 1 Thessalonians 4 about being resurrected at the trumpet call of God but he said, "Anyone can quote Scripture. You need to go to school and study theology. I want to hold onto that other life but I need to hear from someone who is trained to say there is that life." That went like an arrow in my heart and so I went to study theology, to add the spiritual dimension to my medical training so I could deal with people holistically – physically, spiritually and psychologically.

I have heard theology described in five lines:

- God formed man,
- Sin deformed him,
- Education informs him,
- Religion may reform him,
- Only Jesus Christ can transform him!

Information is not enough. We may remember some things but forget others. Teaching and training are good but it is better to go through a process of transformation. *"Jesus answered and said unto him, 'I tell you the truth, except a man be born again, he cannot see the kingdom of God'"* (John 3:13). Once I was blind but now I see since I met with Jesus (John 9). We are what we are because of Jesus. He said, "without me you can do nothing" – hence our need of Jesus.

An Exceptional Threat Requires Exceptional Responses

In a 2005 speech, Dr. Peter Piot, the Executive Director of UNAIDS, explained why he thought HIV and AIDS was exceptional as a current crisis and as a long-term threat to humanity.[2] His reasons may be summarized as follows. Firstly, there is no plateau in sight. He said,

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[1] This summary of Dr. Peter Okaalet's lecture on 31st May 2012 was prepared by Dr. John Chaplin from the original PowerPoint lecture. A DVD of this PP lecture is available from Okaalet and Associates Ltd. See also www.okaalet.org.

[2] Peter Piot. "Why AIDS is Exceptional". Speech at London School of Economics, Feb. 8, 2005. See data.unaids.org/media/speeches02/sp_piot_lse_08feb05_en.pdf

> "an 'epidemic equilibrium' or plateau is nowhere in sight – not globally, not at the level of epidemics in most countries, and not over the long term. The pandemic has broken with the general pattern of diseases and natural disasters, which usually create their own brutal equilibrium, eventually enabling societies to cope. AIDS, so far, appears to be doing the opposite."[3]

Secondly, the impact on society caused by AIDS is far reaching. He noted, "in sub-Saharan Africa's worst-affected nations AIDS is steadily wiping out the labour force. How can governments function, public services operate, agriculture and industry thrive, and law enforcement and militaries maintain security, when they are being stripped of able-bodied and skilled women and men?"[4]

Thirdly, the AIDS crisis creates special challenges to effective public action. He declared:

> There is no escaping the fact that the sensitive issues that are at the heart of the pandemic - sex, gender inequality, commercial sex, homosexuality, drug use - have proved to be an enormous barrier to prompt and effective public action, that is action by government and civil society. If HIV were not mainly transmitted through sex and needles used to inject drugs - but through some innocuous means - we would probably not be experiencing the pandemic of today.[5]

Piot insisted that there are three elements, each one essential and insufficient without the others, to ending HIV and AIDS. The first element is exceptional activism and responsible leadership that "must come from across the board, from politics, from civil society, from business, from churches, from the media - from every section of society" and on larger scale and with greater intensity.[6]

The second essential element to ending AIDS is adequate financing that "allows exceptional action on the 'crisis' front - such as swiftly expanding access to antiretroviral treatment and support for orphans - as well as exceptional action on longer-term solutions, such as strengthened HIV prevention and the development of vaccines and microbicides".[7]

The third element is exceptional implementation so that actual on-the-ground action takes place. "Money raised and political will garnered has to be translated into bringing proven, successful services to the people who need them, whether it be treatment, HIV prevention, or impact alleviation."[8]

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[3] Piot, "Why AIDS is Exceptional", p. 3.
[4] Piot, "Why AIDS is Exceptional", p. 3.
[5] Piot, "Why AIDS is Exceptional", p. 4.
[6] Piot, "Why AIDS is Exceptional", p. 6.
[7] Piot, "Why AIDS is Exceptional", p. 7.
[8] Piot, "Why AIDS is Exceptional", p. 8.

So we must meet this exceptional threat with exceptional responses. The challenge of AIDS calls for a forthright and faithful response from Christians and the Church.

HIV and AIDS: Africa's Burden

Africa is carrying the biggest burden of HIV in the world. Swaziland has the highest prevalence where nearly 1 in 3 people are infected. This is mainly younger people who will carry it with them for life. What does this mean for that country?

Why does Africa have the highest prevalence of HIV? One of the reasons is the slow response by some countries. In Uganda there was a response in the 1980s but in Kenya it was not until 1999 that AIDS was declared a national disaster. It is not easy to find accurate data on North Africa, but AIDS is there.

Life expectancy has fallen in many African countries because of AIDS. For example, in Angola average life expectancy fell from 41.3 years before AIDS to 35 years in 2010. In Botswana life expectancy was 74.4 before AIDS but fell all the way to 26.7 in 2010. Life expectancy in Lesotho fell from 67.2 years to 36.5 years; in Malawi from 69.4 to 36.9; and in Mozambique from 42.5 to 27.1.

In Kenya the national prevalence is between 6-7% but it is 7.9% at the coast, 9% in Nairobi and 15.3% in Nyanza next to Lake Victoria. The high prevalence around Lake Victoria tells us something about the lifestyle. Around the lake there is fishing and exchange of sex for money and fish and trade. There are also cultural issues like wife inheritance where a widow is inherited by a close relative. If the death of the man was due to AIDS and the widow is infected, then inheritance encourages the spread of HIV into another family group. This high prevalence is telling people to change their lifestyle and risky cultural practices. Kenya has yet to reach its peak of those infected with HIV which is predicted to be over 1,500,000 in 2015. Kenya's vision 2030 may not be realised due to AIDS. New infections through Kenya's mode of transmission study showed that the highest new infections were in stable relationships.[9]

- ❖ **Heterosexual sex within marriage/regular partnerships** 44.1%
- Casual heterosexual sex 20.3%
- MSM and prison populations 15.2%
- Sex Workers and their clients 14.1%
- Intravenous Drug Users 3.8%
- Health facility related 2.5%

Church leaders must pay attention to these studies. We marry young people; we must ensure good pre-marital counselling that includes discussion about AIDS and prevention and the need for pre marital testing. If both are

[9] *Kenya HIV Prevention Response and Modes of Transmission Analysis*, p. iv. See http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/KenyaMOT22March09Final.pdf

negative, to bring HIV into the marriage one of the partners must be going outside the relationship, usually the man. We need to address this before marriage as well as once people are married.

Dealing Responsibly with the Impact of the HIV and AIDS Epidemic

What is the impact of AIDS? As a result of HIV and AIDS African countries and communities experience deepened poverty, slowed economic growth, reduced life expectancy, and increased infectious diseases. Women and children are the worst hit: 60% of those infected in Africa are women, and increasing numbers of children become vulnerable to these impacts.

There are diverse approaches to tackling AIDS. A strong human rights-based approach is one that uses human rights to identify desirable outcomes such as non-discrimination, privacy, education, information, health, and social security. This approach also seeks to identify permissible and desirable processes to reach such outcomes, processes that are participatory, inclusive, and non-discriminatory.

In addition, a rights-based approach to the epidemic seeks to strengthen the capacity of individuals (known as *rights-holders*) to claim their rights in the epidemic, and both state and non-state agencies (known as *duty-bearers*) to fulfill their obligations regarding such rights in the response to the epidemic.

The first time the UN met to discuss HIV at a global level was in 2001 when governments adopted the Declaration of Commitment on HIV/AIDS, including the agreement to take action on AIDS and human rights. Over 92 countries signed the Declaration which included this sentence: “Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response.”[10]

The UN has formulated eight Millennium Development Goals (MDG)[11] and numbers 4 to 6 are health related:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. ***Reduce child mortality***
5. ***Improve maternal health***
6. ***Combat HIV/AIDS, TB, malaria and other diseases***
7. Ensure environmental sustainability
8. Develop a Global Partnership for Development

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[10] Declaration of Commitment, UN General Assembly Special Session on HIV/AIDS, June 2001 on http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub03/aidsdeclaration_en.pdf

[11] These are listed on http://www.un.org/millenniumgoals/reports.shtml with much more information on each as well as many progress reports.

In relation to number six and in conjunction with the MDGs, the UNAIDS global goal is “mobilizing all” to work towards achieving three very difficult aims by 2015: zero new infections; zero discrimination; and zero AIDS-related deaths.[12] The UNAIDS call is for all people and organizations to work together to achieve these goals. The first may be possible; the second may be a bit more challenging; and the third is very challenging. We need to talk about these things in the Church. As people of faith we need to be relevant, speaking the language the rest of the world is talking about. Let us contribute to what is going on.

The Church and the Human Rights-Based Approach

A strong human rights-based approach is important and useful but should that be the Church’s approach? What is the Church’s perspective on human rights? Churches have had an historic and long-standing involvement in human rights. However, fully integrating human rights in the churches’ witness for justice has in some contexts proved difficult, including in relation to the HIV challenge and response. Different perspectives on human rights have themselves sometimes presented significant obstacles in ecumenical relations and cooperation. The relationship between Christian faith values and the rule of law must itself be interrogated in this context, in the light of historical and contemporary initiatives to embody faith principles in legal precepts. We need to negotiate and find ways to talk about human rights and what the Bible says.

Why are the marginalised running away from the Church when they would have run to Jesus when He was on earth? What is the missing link? Where are we falling short? Are we following the New Testament Jesus? Why is it that sometimes more love and compassion is shown to those with AIDS by nonChristians? If we really applied the love of Christ as He did, we would do more! For example, men who have sex with men (MSM) have their human rights, but the Church knows that the choices we make have consequences, both physical and moral consequences. When these men come to us, the love of Christ should constrain us to reach out to them.

Even dealing with less emotive examples is still very difficult for us. Reverend Canon Gideon Byamugisha, an Anglican priest, was the first major religious leader in Africa to reveal that he was HIV positive. He almost died of AIDS but has regained his strength and remained healthy because of ARVs (antiretroviral drugs). His first wife died and he married a second wife who was HIV positive so he would not infect another person. They have prevented re-infecting themselves by using condoms. But they wanted children and, by the results of scientific research and with God’s help, they have been able to have

[12] UNAIDS, 2011 - 2015 Strategy: Getting to Zero, p. 7. See the following pdf on the UNAIDS site. http://www.unaids.org/en/aboutunaids/unaidsstrategygoalsby2015/; (jc2034_unaids_strategy_en.pdf)

2 HIV negative children.[13] People talk about the ABC of AIDS prevention - Abstinence, Be faithful and Condoms. In Christian circles we say C stands for Character but there is a need to talk about condoms and where it is appropriate, to use them.[14] Byamugisha uses a different acronym - **SAVE**.

Safer practices. This includes abstinence, faithfulness, condoms, PMTCT etc.

Availability of ARVs. If taken consistently they can reduce transmission by 96%. They can also be used in "treatment as prevention", though this is an expensive strategy.

Voluntary Counselling and Testing. Though now Provider Initiated Counselling and Testing (PITC) where clinics do not wait for people to volunteer for HIV testing. Provider initiated testing and counseling represents an aggressive effort to do HIV testing on all persons who come to medical facilities for any reason. Some facilities take blood from everyone and then counsel people, encouraging them to know their status. Once a person knows their status (if they are HIV positive or not) then the clinic can plan treatment, management of the disease and give advice on lifestyle.

Empowerment. This is focused on women, children and the marginalised.

Some denominations have hospitals that are geared up to deal with HIV and AIDS with a broad-based response: counselling, laboratory testing, medical treatment and care, support for the family, etc. These Christian-owned hospitals have the opportunity to bring spirituality into the response to AIDS.

UNAIDS recognises that the role of Faith Based Communities (FBOs) is more than service provision and includes spiritual encouragement, providing knowledge about HIV and AIDS, values, compassionate care, moral information, respectful relationships as well as curative interventions and material support.[15] Faith based groups might be coming late to the crisis but may well be needed to take the response to AIDS farther than anyone else can. Christians are playing a key role.

The Challenge: Drivers of the Pandemic

There are different drivers of the pandemic. Some are related to biology such as an immature genital tract, co-existing sexually transmitted infections, pregnancy, stage of HIV in the sex partner, malnutrition, MTCT (Mother To Child Transmission), HIV subtype. For instance MTCT used to account for about 30% of new infections but this has now been reduced to almost zero in some countries so that Kenya is saying by 2015 there will be no MTCT. HIV 1, found in East/Southern Africa is more virulent than HIV 2 found in West Africa hence HIV is more of a problem in East/Southern Africa.

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[13] See Stephanie Nolen, *28 Stories of AIDS in Africa*, Toronto: Vintage Canada, 2008, pp. 275-286. Byamugisha also uses SSDDIM - Reduce Stigma, Shame, Denial, Discrimination, Inaction and Misaction as a plan for the church's response.

[14] For an expert explanation of ABC, see Edward C. Green and Allison Herling's paper at http://www.ccih.org/ccih-publications/164-the-abc-approach-to-preventing-the-sexual-transmission-of-hiv.html

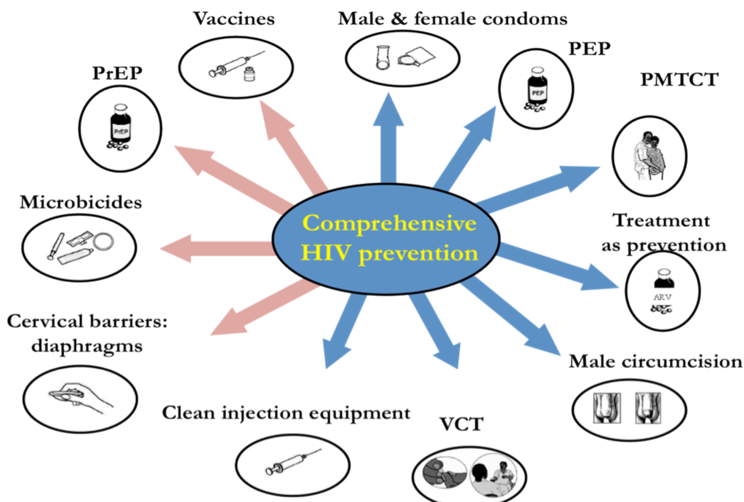
[15] See the UNAIDS report on *Partnership with Faith-based Organizations UNAIDS Strategic Framework* at http://data.unaids.org/pub/Report/2010/jc1786_fbo_en.pdf.

Another driver is behaviour such as unprotected sex, multiple partners, early onset of sexual debut, intravenous drug use, and alcohol abuse. If people change the way they behave the chances of them contracting the virus can be reduced. Some people will not change but we as Christians should not give up. Maybe some of these will come to us by night and ask, "What can we do?" We need to have knowledge – current, accurate, scientific information. ("My people perish through lack of knowledge" Hosea 4:6)

A third set of drivers is cultural practices such as wife inheritance, inter-generational sex, cleansing ceremonies, dry sex and other risky practices, female genital mutilation, submissive sex - the use of money and gifts to entice young girls to have sex with older men.

AIDS: Same Problem, Different Answers

There are a wide variety of prevention strategies but there is a need for comprehensive prevention - using multiple means of prevention depending on the epidemic in that area. These include treatment as prevention, male circumcision, voluntary counselling and testing (VCT), clean injection equipment, cervical barriers (diaphragms), male and female condoms, microbicides, pre-exposure and post-exposure prophylaxis (PrEP/PEP), vaccines, PMTCT (Prevention of Mother To Child Transmission) as well as behaviour change such as abstinence (delay in sexual debut) and faithfulness (reduction in sexual partners).



[23]

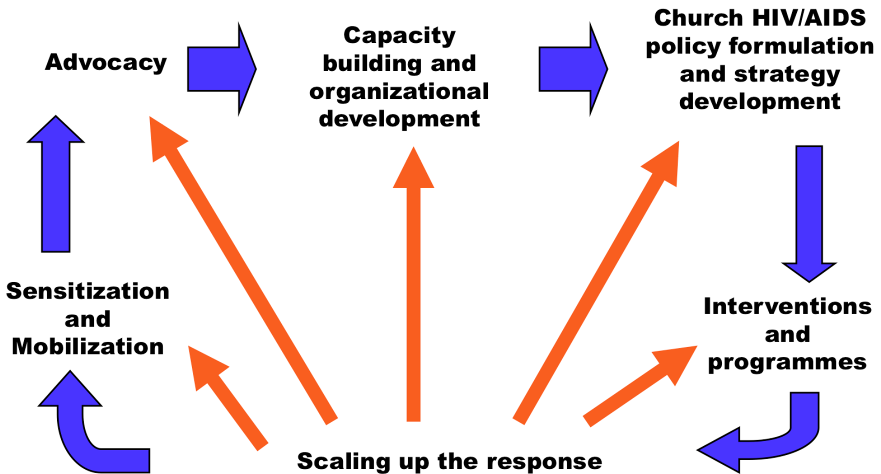
There is no one single bullet that will get rid of AIDS. We need to think of all of them in the context of where we are working and select those that are relevant. What should be the Church's response? A journey of a 1000 miles starts with one step. It is a process. Start small with what you can do.

The Curricula for HIV and AIDS – MAP International's Experience

MAP International developed the following five-point response to AIDS which they then took to the Church.

1. Care and support for Orphans & Vulnerable Children (OVC) at the grassroots level.
2. Training of clergy in the areas of capacity and skills building.
3. Integration of 'HIV Education' into theological education: MAP-developed HIV/AIDS curricula are currently being implemented in over 24 theological Institutions in six countries in East and Southern Africa.
4. Policy and advocacy at national and international levels.
5. MAP-developed church-based HIV and AIDS materials.

MAP INTERNATIONAL'S FRAMEWORK FOR BUILDING CAPACITY OF CHURCHES TO RESPOND TO HIV AND AIDS



MAP International's HIV/AIDS Curriculum for Theological Institutions: Choosing Hope

People who are sick need hope. AIDS is affecting every thing about them. They are being pushed away by family, church and society. They need hope. This "Choosing Hope" curriculum consists of ten modules:

1. Understanding HOPE: By knowing facts about HIV/AIDS
2. Discovering HOPE: Through our Biblical foundation
3. Spreading HOPE: By mobilizing the Church towards involvement in AIDS activities
4. Developing HOPE: By changing feelings and attitudes about AIDS
5. Sharing HOPE: Through pastoral care to families affected by HIV/AIDS
6. Offering HOPE: HIV/AIDS pastoral counseling
7. Giving HOPE: To parents and youth for AIDS-free living
8. Ministering HOPE: Home based care to People Living with HIV (PLHIV)
9. Establishing HOPE: Diagnosis of HIV through voluntary counseling & testing (VCT)
10. Supporting HOPE: Through antiretroviral treatment (ARV)

St. Paul's University, Limuru, Kenya offers a Master of Arts degree in Community Care and HIV/AIDS in association with MAP International (East Africa). One African who graduated from this course was a bishop of a Anglican diocese. He is passing on what he has learnt to his clergy and so to the diocese. A study is being considered to look at what impact this is having, using another diocese where such teaching is not happening as a control.[16]

The Church and HIV & AIDS: "Faith in Action"

The problems and solutions surrounding HIV and AIDS are too big for one person, one Church, one nation to deal with, but we can respond in our context, in our congregation. You may not have the answer to a situation but someone else might. Ask yourself what you can do in your own context. For example, start with KAP(B): Knowledge, Attitudes, Practices (Behaviour). New *knowledge* can result in *attitude change* which can lead to change in *practices or behavioural change*. There is power in knowledge if it causes change in attitude and change in practice. How can this happen in real life?

There are four common responses of the church to people living with HIV and AIDS: (1) being judgmental, (2) being anemic or 'weak', (3) being cautious or 'fearful', or (4) wholehearted or holistic. We need to move from judgmental to holistic. One lady who had done a MA in counselling came to MAP for a week-long seminar on counselling in HIV. She said, "What is the point? What will MAP add to what I have already done?" But she was judgmental towards those with HIV. This course moved her from judgmental to being holistic and she is now heading up an AIDS response where she is based.

One church in Uganda, faced with diminishing congregations, divided the area into zones and in each zone the church started to visit and care for those with AIDS. People started asking, "Why are you doing this?" The church members' answer, "The love of Christ constrains us to". People wanted to come to such a church and its numbers have increased four-fold.

Churches and faith-based organisations (FBOs) are in a unique position in sub-Saharan Africa to respond rapidly to HIV and AIDS. They attract large numbers of crowds; they meet regularly; and they have been active in the health and education sectors for years. But is the Church fully awake to the realities of HIV and AIDS in Africa? If I were to critique the response of your church to the HIV and AIDS crisis using the following thirteen criteria how would your church do?

These thirteen criteria are divided into three broad categories and can be used to evaluate a church's competency of its response to AIDS. The first category is **Foundational** and asks two questions about HIV and AIDS in Africa. First, does your church have a good knowledge of the facts and HIV

[16] See also the chapter on "Curricula" in Peter Okaalet, *Bridge Builder: Uniting Faith and Science Towards an AIDS-free Generation*, Nairobi: WordAlive, 2009, pp. 121-131

and AIDS? Second, how is your church dealing with the issue of sexuality, an extremely important point because churches in Africa have difficulty talking about this topic. The second category measures how competent your church is with regard to the **Strategic Aspects** relating to HIV and AIDS, and has six aspects. What is your church doing in regards to 1) prevention, 2) addressing stigma, 3) advocacy, 4) empowerment, 5) leadership and 6) healing? The third category examines the **Ecclesiastical Aspects** of a church's response to the crisis and it has five aspects: 1) liturgy and sacraments, 2) counselling, 3) testing, 4) caring and 5) networking.

Strategies for Targeting Orphans and Vulnerable Children (OVC)

The church needs to particularly focus on orphans and vulnerable children with the following twelve strategies:

1. Focus on the most vulnerable children, not only those orphaned by HIV/AIDS.
2. Strengthen the capacity of families and communities to care for children.
3. Reduce stigma and discrimination.
4. Support HIV prevention and awareness, particularly among youth.
5. Strengthen the ability of caregivers and youth to earn livelihoods.
6. Provide material assistance to those who are too old or ill to work.
7. Ensure access to health care, life-saving medications, home-based care.
8. Provide daycare and other support services to ease the burden on caregivers.
9. Support schools and ensure access to education for girls as well as boys.
10. Support the psychosocial as well as the material needs of children.
11. Engage children and youth in the decisions that affect their lives.
12. Protect children from abuse, gender discrimination, and labor exploitation.

There is a move away from orphanages as sometimes it is hard getting people brought up in them back into mainstream life. It is better to support the children in the community and only have orphanages if there is no other way.

Healing and HIV and AIDS

Healing has been abused and misused. People have been prayed for and told to throw away their medication and this has resulted in their death. Can God heal? "Is anyone among you sick? He should call the elders of the church… "(James 5:14). God can deliver us from physical sickness and suffering but this is more the exception than the rule. Not everyone who asks for physical healing gets healed. It is estimated that about 10% of those prayed over get physically healed, but does this mean we abandon praying for sick people?

God does heal. When does He heal? It is His prerogative. Do we continue to pray? Yes, but as we continue to work with people, not instead of working with them. We don't measure our answers to prayer only by what we see, for there are other answers, unseen ones. The body and soul are inextricably linked together. That 24-year old man from the beginning of my lecture died a few days after I spoke with him, but he had became a Christian and had a

hope and a glow in his face. This was healing for him - the physical pain was too much.

Conclusion

What are some of the current challenges humanity faces in combating AIDS? Sustainability of AIDS programmes is a major challenge in the face of external donor fatigue and the global economic slow-down in recent years.

> Surveys validate concerns about funding. A 2011 study conducted by the Catholic HIV/AIDS Network (CHAN) found that funding cuts and flat-lining by international donors had caused problems with drug adherence, supply chain, access and adequate nutritional support for Catholic organizations in developing countries.[17]

Other barriers that stand in the way of progress include: the costs of medication and laboratory testing; issues of ARV side effects and drug resistance: societal, cultural and religious beliefs that stand in the way of treatment; reliance on traditional healers[18]; very few children accessing treatment; and poverty and poor governance that give low priority to healthcare have impeded access to treatment. [19]

The Church is still a sleeping giant, only now beginning to wake up. But have we risen totally, completely? May the Lord challenge us to do a little more, otherwise, if help comes from other sources, in fifteen years we might be irrelevant and people may say to us, “When we were sick, where were you?” We might, as in Matthew 25 say, “When did we see you sick?” There are people all around us who need our help. We need to pool our resources. We need to respond with the compassion of the Lord Jesus Christ.

“If the Church of Jesus Christ rises to the challenge of HIV/AIDS it will be the greatest apologetic the world has ever seen.” — Ravi Zacharias, writer and apologist.

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[17] *AJANews* 105, Feb. 2012 at http://www.jesuitaids.net/htm/news/105ENG.pdf, p. 3.
[18] See for example, http://www.nation.co.ke/Features/DN2/Faith-healer-or-prophet-of-doom/-/957860/1690928/-/1m3pwez/-/index.html, and http://www.shout-africa.com/news/tanzania-mixed-reactions-over-loliondo-hivaids-cure/
[19] *AJANews* 105 – Feb. 2012, pp. 3.