THE ROLE OF THE AFRICA BROTHERHOOD CHURCH IN THE CONTROL OF HIV/AIDS IN CENTRAL DIVISION OF MACHAKOS COUNTY

MA PROJECT

BY:

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A research project submitted to the Department of Sociology and Social Work in partial fulfillment of the requirements of the award of a Master’s of Arts Degree in Rural Sociology and Community Development.

November 2013
DECLARATION

I, Mbati Jennifer Nduku, hereby declare that this research project is my original work and has not been submitted for degree award in any other college or university.

Signature é é é é é é é é é é é é é é é é é é é é .. Date é é é é é é é é é é é é é é é é é é ..

This M.A project has been submitted for examination with my approval as the university supervisor.

Nameé é é é é é é é é é é é é é é é é .. Signatureé é é é é é é é é é é ..
Date é é é é é é é é é é é ..
DEDICATION

This study is dedicated to my late father Mr. Tom Kasivu Suvi for his emphasis on the importance of education and my mother Queen Nzaumi Tom for always trusting and believing in me.
I wish to express my heartfelt gratitude to a number of people who contributed to the completion of my M.A degree.

I am indeed indebted to Dr. Pius Mutie for his invaluable guidance, encouragement, time, patience, and assurances that gave me the impetus to complete this work.

Special gratitude goes to Mrs. Jennifer Birech for her time, guidance and encouragement. Without whom you this study would not have been a success.

I sincerely thank my lecturers in the department of sociology and social work for the priceless knowledge I gained from them which led to the production of this project.

I am grateful to my friends and colleagues, I cannot mention each one of you by name but I thank you for standing with me in my M.A academic journey.

Lastly I would not forget the ABC Church leadership, respondents and all who assisted in providing valuable data and information without which this project would not have taken shape. God bless you abundantly.
ABSTRACT

In Kenya efforts to manage the aftermath of HIV/AIDS involve multiple partners drawn from the Government, FBOs, NGOs, Private Sector and International Development Partners. In this collaborative approach the Church has an important role to play because it commands a large following and stability that places it in a pivotal role in the fight against HIV/AIDS. This study was anchored on the important role played by the ABC Church in the control of HIV/AIDS in Central Division of Machakos County. The study was guided by social exchange theory as postulated by George Homans. The study used a descriptive research design with both probability and non-probability techniques where the data was collected using key informant interviews, household survey, archival research, secondary research and a focus group discussion. The methods of data analysis used were descriptive statistics and qualitative summaries. The study found out that the ABC Church was affected by HIV/AIDS through loss of members, rising number of widows and widowers, diversion of Church resources to manage HIV/AIDS, decrease in tithes and loss of Church leaders due to deaths. Programmes put in place were counseling and testing, support of orphaned and vulnerable children, and capacity building of widowed. From this study several conclusions were made. First there was a general awareness about HIV/AIDS and its effects. That the ABC Church had realized the effects of HIV/AIDS on the local community and it had directed efforts towards management of the disease and that there was a high level of awareness on HIV/AIDS and its major causes. Poverty was the main factor that led people to engage in risky behavior. Finally the Church has made important contributions in the fight against HIV/AIDS by reaching to the infected, the affected and those at risk. The study recommends that support programs for OVC and widows need to be upscaled and delivered in a sustainable way especially economic empowerment. The Church also needs to sensitize its members on the importance of voluntary testing and counselling and strictly adhering to good diet and medication for the sick. This study recommends further research on the effectiveness of orphan and women empowerment programmes as well as a study of the effectiveness of the existing HIV/AIDS policy to establish whether it was enabling or stifling involvement of partners such as the Church in the control of HIV/AIDS.


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ABBREVIATIONS

ABC    Africa Brotherhood Church
AIC    Africa Inland Church
AIDS   Acquired Immune Deficiency Syndrome
AMREF  African Medical Research Foundation
ARV    Anti-Retro-Viral (Drugs)
BIDII  Benevolent Institute of Development Initiatives
CACC   Constituency Aids Control Council
CBO    Community Based Organization
CD4    Cluster for Differentiation
CDC    Center for Disease Control
CRS    Catholic Relief Services
FBO    Faith Based Organization
FGD    Focus Group Discussions
GOK    Government of Kenya
HIV    Human Immune Deficiency Virus
ILO    International Labor Organization
KAG    Kenya Assemblies of God
KDHS   Kenya Demographic Health Survey
KNBS   Kenya National Bureau of Statistics
MAP
Medical Assistance Programme

NACC  National Aids Control Council

NASCOP  National AIDS and STI Control Programme

NCCK  National Council of Churches of Kenya

NGO  Non-Governmental Organization

ORG  Organization

OVC  Orphans and Vulnerable Children

PLWA  People Living With HIV/AIDS

RGC  Redeemed Gospel Church

S/A  Salvation Army

SPSS  Statistical Programme for Social Scientists

STI  Sexual Transmitted Infections

UN  United Nations

UNAIDS  United Nations Programme on HIV/AIDS

UNESCO  United Nations Education, Science and Cultural Organization

UNICEF  United Nations Children’s Fund

VCT  Voluntary Counseling and Testing

WCC  World Council of Churches

WHO  World Health Organization
Acquired Immunodeficiency Syndrome (AIDS) is a disease caused by Human Immunodeficiency Virus (HIV) infection. Genetic research shows that HIV originated in West-Central Africa. The disease was first recognized in the early twentieth century (Center for Disease Control (CDC), 2001). Since the discovery of AIDS more than 30 million deaths have been attributed to the disease as of 2009. By 2010 more than 34 million people globally were estimated to be living with AIDS. With 2.7 million new infections and 1.8 million related deaths every year the disease is considered a pandemic (WHO/Global Health Observatory, 2010).

The fact that there is no known cure has made the disease to be considered one of the greatest challenges facing humanity in the 21st Century. It is this background that has attracted the attention of International Development Partners, Governments, Non-Governmental Organizations (NGOs), Community Based Organizations (CBOs) and Faith Based Organizations (FBOs) who have had various interventions on the pandemic. These organizations have adopted a collaborative and multi-sectored intervention approach to reduce new infections and mitigate the effects of the disease.

HIV/AIDS is a global problem and there are about 36 million people living with HIV/AIDS in the world. Collier (1987) points out that despite scientific breakthrough and the miracles of the modern medicine, HIV/AIDS has continued to find its home in Africa. This region continues to have the highest figures of the infected people compared to other parts of the world, of the 36 million people living with HIV/AIDS, 70% of the adults and 80% of the children live in Africa and in particular Sub-Saharan Africa. (Bryce Son 2003). However HIV/AIDs infection rates vary widely in various regions of the continent. East and Southern Africa is most heavily affected by the disease. As of 2009 34% of all the people globally living with AIDS were to be found in the ten Countries of the Region. West and Central Africa have a relatively low rate of infection. The adult prevalence rate in this Region is estimated to be 2% or lower (UNAIDS, 2010).

According to the International Labor Office (ILO), the economic impact of HIV/AIDS in Sub-Saharan Africa is far more severe than previously thought and will seriously undermine the
Kenya has got its own share of the problem since the AIDS scourge continues to threaten many lives across the country. The Kenya Aids indicators survey (2007) estimated the average HIV prevalence among the general population aged 15-49 at 7.4% while the Kenya Demographic and Health Survey (KDHS, 2008-2009) estimated prevalence for the same population at 6.3%. The difference between the HIV prevalence estimates of the two surveys is not statistically significant given the overlap of confidence intervals. The findings show that Kenya’s epidemic has stabilized in the past few years and that sex differential is more pronounced among young women 15-24 age group who tend to have HIV prevalence four times higher than young men 5.6% against 1.4% respectively (KAIS, 2007) and 4.5% and 1.1% respectively (KDHS, 2008-09). While this stabilization is positive more effort needs to be put in place to lower this prevalence rate and that’s why the Church and other stakeholders are key in participating in order to reduce further spread of the pandemic.

HIV/AIDS has socio-economic significance. In Kenya, most of the people dying of the disease are the productive or people in the prime of their working lives between 15-49 years of age. The economic activity is compromised by squeezing productivity, adding costs, diverting productive resources and depleting skills. Increased absenteeism from work due to sickness or other HIV/AIDS related complications have accounted for 25-54% of company costs. In a bid to train and replace the dead workers, all sectors have recorded high losses and costs. Productivity has declined heavily (Borg 1995). Offering health care services by the companies has become a nightmare. Company costs for health care, funeral benefits and pension fund commitments are likely to rise unexpectedly and also early retirement plus death rise.

According to World Bank report (2002), it is important to note that the overwhelming majority, certainly over 90% of the children orphaned by AIDS in the most affected countries, live with their extended families and community; a fundamental response must be to strengthen the capacity of families and communities to protect and care for their Orphans and Vulnerable
The growth and spread of the Church in Africa is phenomenal and enormous. The Kenyan population is about 80% Christian. Africa is the fastest growing region in the world, with more than 350 million Christians. Roman Catholic Church alone accounts for 116 million believers (Samita 1995).

The Church has a role then to play in the prevention and control of HIV/AIDS spread owing to the great numbers of its populace it commands. The Church involvement underscores the importance and effectiveness of the multi-sectoral approach to fight the pandemic. One of the tools the Church can employ is behavioral change. This is critical because firstly it can empower the people to take control of their lives and make informed decisions. Secondly it can guide the people to develop skills and adopt behavior that prevents infection from HIV/AIDS. Finally it can help to reinforce positive behavior that discourages repugnant practices that bring about the risks of being infected (Peterson 1996:12, Collier 1987:45, Tapia 1988:67).

HIV/AIDS in Machakos County is a major health problem with the prevalence averaging 15%. Majority of the HIV/AIDS patients are found in Machakos town and its environs where the study will be carried out, and in all towns along the Mombasa highway. Important to note is that cases are been reported in the small upcoming towns in the County like Matuu and Wamunyu. HIV/AIDS incidences in Machakos county and along the major highway and upcoming towns are attributed to the long distance truck drivers/touts and the commercial sex workers (Machakos County Strategic plan, 2013-2017). This scenario then justifies this study because Machakos town is the headquarters of Machakos County and is the convergence Zone of all its populace.

The ABC Church was founded in Machakos in 1945 and presently it has over 1.5 million followers. The philosophy of the Church is to give mankind a holistic life geared towards self reliance and service to God. The Church is one of the independent Churches established locally and it has most of its followers from the Counties of Machakos, Makuenei and Kitui. In Machakos County the ABC has six Sub-Headquarters and 249 Churches with an estimated population of 67, 553 members. This is the highest population in any of the Counties of Kenya and is the reason for the focus of this study in Machakos County.
Church in Machakos County it is the assumption of this study that the Church has a niche locally. This means it could be making a substantial contribution in the control and management of HIV/AIDS. Therefore there is a justification in studying its efforts. It is against this background that the main focus of this study will be to establish the role of ABC Church in the control of the pandemic in Central Division of Machakos County.

1.2 Problem Statement

The HIV/AIDS pandemic has been viewed as an annihilating scourge that dwarfs everything that has gone before. In Kenya, it has left behind traces of sadness, hunger, despair and loneliness. It has been acknowledged that the responsibility to control the disease lies with all stakeholders. With this glaring situation in our society, the Government together with other stakeholders such as; WHO, NGOs, CBOs, FBOs, Churches and individuals came up with an ally of interventional programmes aimed at reducing and controlling the HIV/AIDS pandemic. Though this may have contributed to a reduction in the national prevalence rate the prevalence rate in the County is still notably high, in fact the biggest challenge facing Machakos County is the increasing cases of HIV/AIDS in spite of the awareness level of over 85%. It also faces the challenge of providing medical care for the infected and support for the affected (Machakos County Strategic plan, 2013-2017) thus the relevance of the study in Central division of Machakos County.

Samita (1995) argues that the Church is a strong voice in the community and an institution of socialization. Logically, by bringing the Church on board in the control of HIV/AIDS needs no emphasis as the Church commands a strong following and influence in the society. The Church has been considered to be the most stable and most widely dispersed NGO in the Country. The Church has its own structures and systems which enable it to reach the common man in a persuasive way. However, it is important to note that the initial response by the Church to the pandemic was slow and a majority in the Church leadership viewed HIV/AIDS as a curse from God against those who are immoral.

This mistaken view based on the Church leadership resulted to loss of many lives in the country. Unfortunately, some Church leaders and their followers have not outgrown this view, and thus it
The ABC Church is to meet the challenges of the disease. Any development in carrying out social development work. Thus, the Church can partner with the Government and other stakeholders in the control of the pandemic.

In the past two decades, a lot of energy and resources have been directed to sensitizing people on HIV/AIDS, its treatment and management. While that is good, prevention of further spread of the epidemic is yet to be achieved, thus creating a gap since no cure has been found yet. Unless the spread of HIV/AIDS is tackled, mankind has a threat of extinction especially in the Sub-Saharan Africa where access to good health care services has been a major challenge due to poverty. The second gap that the study sought to fill was the lack of collaborative measures in preventing HIV/AIDS. Over a period of time, the prevention of HIV/AIDS has been seen as the monopoly of the health sector. However, there is need for a multi-sectoral approach in addressing the HIV/AIDS pandemic because the disease cuts across various social, economic and religious platforms.

1.3 Research Questions

1. What is the awareness of the ABC Church on HIV/AIDS?
2. In what ways has HIV/AIDS affected the congregants of the ABC Church?
3. How has the Church reacted to the effects of the disease and with what results?
4. What challenges face the Church in its attempt to control the spread of the pandemic?

1.3.1 Objectives

The broad objective of the study was to establish the role of the Africa Brotherhood Church (ABC) in the control of HIV/AIDS in Central Division of Machakos County.

1.3.2 Specific Objectives

The specific objectives pursued by the study are:

1. To establish the awareness of the ABC Church on HIV/AIDS.
1.4 Justification

The objective of every research activity is to produce actionable information that can be used in solving problems that face society. This study is in no way an exception. This specific study will concern itself with establishing the role of the ABC Church in mitigating the effects of the disease. ABC does this through interventions that are structured as programmes. This study has identified five stakeholders namely Church leadership, programme implementers, beneficiaries, other researchers and the general public that will benefit from information gathered.

Firstly the study will establish the perception of congregants about HIV/AIDS. This will shed light on attitudes of respondents towards the disease. This information will be useful to the Church leadership and programme implementers in devising messages that effectively target behavior change. This information will also help gauge the success of previous behavior change campaigns. Secondly the study will gather information on how the HIV/AIDS pandemic has affected the Church. This information will benefit the Church in planning for the care of orphans and those living with the disease.

Thirdly the study will analyze collected data to identify areas where the ABC Church has achieved success and areas where there may be failures. This information will help Church leadership and programme implementers understand which interventions work or don’t and why? This will lead to better programming and better service delivery to beneficiaries. Fourthly the study will identify the challenges that face efforts to reduce effects of HIV/AIDS and propose measures that can be put in place. This information will be important to not only the ABC programme implementers but also to others undertaking interventions in Machakos County. Finally the study will identify and recommend issues that need further research. This will benefit other academic and applied researchers in acquiring background knowledge on HIV/AIDS in Central Division of Machakos County.
The scope and limitations of the study

The scope of this study was to establish the role of the Africa Brotherhood Church (ABC) in mitigating the spread of HIV/AIDS with special reference to Central Division in Machakos County. The study sought to document awareness of beneficiaries of ABC Church about HIV/AIDS, ways in which the Church had been affected, how the Church had reacted to the disease and challenges the Church faced in fighting the disease. It limited itself to the ABC Church HIV/AIDS programme beneficiaries.

1.6 Definition of key terms

Pandemic — this is an epidemic of infectious disease that is spreading through human populations across a large region for example a continent or even worldwide. A widespread disease that is stable in terms of how many people are getting sick from it is not a pandemic (News-medical, 2001).

HIV/AIDS — HIV is a virus that kills or damages the body's immune system cells. AIDS is the most advanced stage of the infection with HIV. The disease mostly spreads through unprotected sex. It can also be spread through contact with blood of an infected person or during child birth (Medlineplus, 2013).

Congregant — This is a person who is attending religious services or who regularly attends religious services (Merriam-Webster dictionary, 2013).

The Africa Brotherhood Church (ABC) – this is a Church started in Kenya in 1945 which has since then branched to Tanzania, Rwanda and Uganda. The main mandate is to spread the gospel but it also initiates projects like schools, community health centers, environmental protection and HIV/AIDS management (Church World Service, 2013).
Beneﬁciaries – Are those individuals who in one way or another beneﬁt from the ABC members or not (Adapted from Merriam-Webster).

Awareness of HIV/AIDS – this is the giving of information and sensitizing the public on the HIV/AIDS pandemic on its causes, spread, effects, prevention and how to live responsibly if one is infected and affected.
CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Human immune-deficiency Virus (HIV) is the virus that causes AIDS. The virus is mainly passed on through contact with the body fluids such as vaginal discharge, semen, blood and milk of a breast feeding mother of an HIV infected person (Peterson 1996:11, Tapia 1988:14, Collier 1987:24). Health studies have indicated that AIDS as a viral infection disease severely damages the immune system of the body and allows opportunistic infections and tumors to develop and destroy the body completely. There are myriad of the so called opportunistic infections; so called because they take advantage of the already weakened body that has lost its immunity and the capacity to fight any infection. Despite the efforts made to find a lasting solution and cure, so far AIDS has no cure and what is required is either to control its scourge or prevent its further spread (Obbo 1995:16, Saayman 1992).

The historical perspective of the diseases indicates that the first case was reported in America in 1981 while in Kenya it was reported in 1984. Recent studies have shown that children and adolescents in Sub-Saharan Africa have a high prevalence of infection compared to the rest of the world. For those who are less than 15 years with HIV/AIDS, are about 2.5 million which is about 90% of them living in the Sub-Saharan region. A report by the UNAIDS show that those who were newly infected in the world in year 2004 globally were 700,000; of those 88% were from Sub-Saharan Africa (UNAIDS report 2004). This report clearly confirms that Africa as a continent is hard hit by the disease and all deliberate efforts are required to combat it.

The spread of the pandemic is equally worrying in Kenya; results from the KDHS of 2008 indicate that 6.7% of Kenyan adults are infected with HIV/AIDS. The prevalence among the women aged 15 to 49 is 8.7% while for men 14 to 49 is 4.6%. This female male ratio of 1.9 to 1 is higher than that found in other population based studies in Africa (Republic of Kenya, 2005).

2.2 The level of awareness of HIV/AIDS
For effective control and prevention of HIV/AIDS as a disease, there is need for thorough knowledge and awareness about the pandemic. This kind of understanding will go a long way in addressing the silent underlying issues.
2.2.1 Status of HIV/AI DS in Kenya

Since the first case of the disease was reported in Kenya in 1984, it is now close to three decades, the disease among the Kenyan population is a mere fact and any contrary to this is just a denial of the fact. The awareness on aspects of HIV/AIDS among adolescents has been reported to be high in many studies carried out in Kenya. However, a significant number of studies report that most adolescents still hold many misconceptions regarding HIV/AIDS transmission and prevention (NASCOP, 2005). This perhaps explains why the prevalence of the disease continues to rise among the youth as opposed to the aged.

It is worrying that the pandemic continues to spread in the adolescent population without slowing down. This is the category of the populace which holds the vital key for future socio-economic development, if this trend continues then the rate of future socio-economic growth will be in a state of limbo. Various studies also report a number of adolescents considering themselves not at risk of HIV/AIDS infection and a lack of behavior change in spite of the high knowledge levels. This could be because of inability to link knowledge and perception of risk of infection, (UNAIDS 2004).

According to the KNBS (2008), awareness of AIDS is nearly universal among adults, except among women with no education (93%) had heard of AIDS and among adults in North Eastern Province (86% of men and 94% of women). Nationally, nearly 3 out of 4 men and women know someone personally who has AIDS or has died of AIDS. Most Kenyan adults know that abstaining from sex, limiting sex to one faithful partner, using condoms, or both being faithful and using condoms are ways to reduce the risk of getting the AIDS virus. This knowledge is limited, however, in young people aged 15-19, in those with no education, and in the poorest portion of the population (NASCOP, 2005).

The level of awareness is clearly exemplified in the World Bank report (2002). According to the report, nearly all youths and adults surveyed (over 98%) had heard of HIV/AIDS, although the report indicates that the youths had heard about the disease, it does not necessary translate to behavior change. This is a gap which this study intends to bridge. Further the report pointed out that in schools youths were more likely to know the difference between HIV (virusi vya ukimwi)
were out of school. However, less than half of all youth and AIDS (ukimwi) than youth who were out of school. However, less than half of all youth awareness the behavior change has not been significantly realized.

2.2.2 HIV/AIDS Status and awareness in Machakos County

The problem of HIV/AIDS is not selective but it affects all the regions of the country, there is no region which can stand tall to claim that it is free from the pandemic. Similarly the Machakos County has its fair share of the problem. According to some data which was obtained from Machakos NASCOP coordinator it showed that there was a relative degree of HIV/AIDS prevalence in the County. Further the data indicated that the prevalence among women was higher as compared to that of men, as depicted in table 2.1 below.

Table 2.1: Cumulative HIV testing -16 VCTs sites in Machakos District

<table>
<thead>
<tr>
<th>Sex</th>
<th>No. of clients tested</th>
<th>Tested +</th>
<th>%</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3,813</td>
<td>276</td>
<td>7.20%</td>
<td>Fewer men tested +</td>
</tr>
<tr>
<td>Female</td>
<td>4,175</td>
<td>861</td>
<td>20.60%</td>
<td>More women tested +</td>
</tr>
<tr>
<td>Totals</td>
<td>7,988</td>
<td>1,137</td>
<td>14.20%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Ministry of Health integrated monitoring and evaluation report form 2005, No. MOH 727 NASCOP – Machakos District

This kind of information is not restrictive to a given category of people, therefore the church population is part of the statistics. There is no way the church can claim that its members are HIV/AIDS free.

So far there is no known cure for the pandemic. In order to effectively address the challenges of the disease, there is a need of a broad approach, this therefore warrants the practice of a multi-sectoral approach in combating it. In essence every person needs to be brought on board, hence, the need for the Church to be involved in the control of HIV/AIDS. In spite of this requirement, it is lamentable the kind of attitude the Church showed over the decade where the Church continuously refused to recognize the use of condoms as a preventive measure and emphasized on behavior change which has not been effective because the disease continues to spread, also
to see the HIV/AIDS disease as part of their problem. However, the pandemic in the past decade was alarming.

It is important to note that with the pandemic having been declared by the Kenyan Government as a National Disaster in December 1999, the Church can no longer sit on the fence and watch other players combat it (Republic of Kenya, 2004). It is needless to commonly continue to associate the disease with hospitals because we are being warned that the health sector is already overwhelmed and there is a greater need than ever before to complement its efforts. By the year 2006, it was estimated that the people occupying hospital beds with HIV/AIDS related complications were about 33% and it was projected to rise up if the status quo remained (AVERT.ORG, 2001:12). If this percentage is something to go with, then it is clear that the pandemic is quite a challenge.

2.3 Effects of HIV/AIDS

Globally, the pandemic has emerged as one of the greatest destroyers of human life (Gitome, 2000:191). Even though the pandemic was reported in the 1980s, the human toll related to the diseases is alarming. UNAIDS (2004:124) a report on the Global AIDS epidemic shows that there is an estimate of 35.9-44.3 million adults and children living with HIV/AIDS. Of this number, 25.8 million people infected with HIV/AIDS live in the Sub-Saharan Africa; this is about 60% of the people living with HIV/AIDS globally. This is very worrying because only 10% of the World population lives in Sub-Saharan Africa. UNAIDS (July 2003) gave the following summaries comparing Sub-Saharan Africa and the rest of the world.

Table 2.2: HIV/AIDS Globally and in Sub-Saharan Africa

<table>
<thead>
<tr>
<th></th>
<th>Globally</th>
<th>Sub-Saharan Africa</th>
<th>World excluding Sub-Saharan Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult infected</td>
<td>37,100,000</td>
<td>29,131,000</td>
<td>7,969,000</td>
</tr>
<tr>
<td>Children infected</td>
<td>3,000,000</td>
<td>2,200,000</td>
<td>800,000</td>
</tr>
<tr>
<td>AIDS Deaths in 2001</td>
<td>3,000,000</td>
<td>2,200,000</td>
<td>800,000</td>
</tr>
<tr>
<td>AIDS Orphans</td>
<td>14,000,000</td>
<td>11,000,000</td>
<td>3,000,000</td>
</tr>
</tbody>
</table>

Source: Aids epidemic update UNAIDS July 2003
From Table 2.2, it can be seen that Sub-Saharan Africa is overweighed by HIV/AIDS than any other region of the world. This kind of trend can be blamed on the harmful cultural practices and taboos. Consequently, policies and programmes are needed to help break the silence and protect our children (Costick, 1987).

The effects of HIV/AIDS scourge are quite immense and have caused a great universal suffrage. The daunting effects have affected all the sectors of human life. A study of a commercial agricultural estate in Kenya showed that AIDS-related medical expenditure exceeded projected expenses by 400%. Funeral costs are also provided by a number of employers in Africa and they are rising sharply (AVERT. ORG, 2006:6). AIDS has the potential of creating severe negative economic impact in a country. It causes reduction in the size and experience of the labor force, increases health care expenditure, raises the costs of labor and reduces savings and investments. It is different from other diseases because it strikes people in the most productive age groups and is essentially almost 100% fatal.

In the social and family perspectives, orphans and vulnerable children (OVC) are a major concern, nationally, regionally and internationally. The 2003 UNAIDS report indicates that an estimated 14 million children who have lost either one parent or both due to AIDS are living across the globe. Out of this figure approximately 80% which is about 11 million are from the Sub-Saharan Africa. It is estimated that by 2010, in five countries of Eastern and Southern Africa, over 30% of all children under age fifteen will be orphans, largely due to AIDS if the trend is not reversed (Bryce Son, 2003).

Kenya has experienced an upsurge in the number of orphans due to the high number of deaths from HIV/AIDS-related infections. Half of the 3.5 million people in Kenya are children under 18 years. Though there has not been a comprehensive assessment of the OVC situation in the country, it is estimated that 1.5 million people have died of AIDS leaving approximately 1.6 million orphans (Republic of Kenya, 2005:61). The numbers are evidently too high and the need for care is great.
The Church following in Kenya is large, indeed 80% of the Kenyan population are Christians. Potentially, the Church has a weekly audience of about 14 million people. The Church is an established active institution in Kenya, with structures, personnel, large membership, facilities and activities throughout the country. It has membership in all sectors of the population thus the Church should mobilize human, materials and financial resources, channeling them towards effective strategies for controlling the spread of HIV/AIDS. With such big numbers and well established structures, the Church can form a very strong partnership in the crusade against HIV/AIDS (Pietla, 1999).

2.4.2 Church and VCT services
Voluntary counseling and HIV testing (VCT) is an essential component of an effective response to the AIDS epidemic thus an important strategy for prevention of further spread of HIV/AIDS. It is a powerful weapon in the fight against HIV/AIDS since it is associated with behavior change that reduces HIV transmission and serves as a point of entry into care for those testing positive. VCT plays a crucial linkage between the care givers and the care seekers. The process empowers a person to undergo counseling to enable decision making which then enables the person to make informed decision to undergo testing to know his/her HIV/AIDS status. Change of behavior and attitude will lead to reduction of HIV/AIDS prevalence. Thus, VCT centers can act as tools to bring about the behavioral change in that when people are tested and know their status, then they can take charge of their life. Those tested positive will want to prevent further infection by adopting responsible sexual behavior while those who test negative will take a lot of precautions not to become infected (UNAIDS, 2000).

Apart from the voluntary testing, VCT centers offer counseling services. These come in the following components;

1. Pre-testing counseling. This helps the person to know the risks that can come with the testing. One can suffer violence from his partner or family, stigmatization, ostracism, loss of
The person is prepared to know the dangers that can come with the testing. The Church can establish the VCTs for such purposes. Knowing his/her status, there are psychological problems that a person experiences and call for some counseling. For example; anger, shock, denial, depression and acceptance.

3. On-going counseling.

This acts like a follow up. The counselor monitors and evaluates how the patient is doing. Is he/she accessing ARVS? Are the opportunistic infections being treated? Is he/she getting support from the relevant institutions like Church, family, community etc? Where any of the above is not being done the counselor steps in to help out. During the on-going counseling stage, any of the long-term psychological problems can be dealt with. These include problems like; suicidal ideation, self-harm, depression, and bitterness and conflict. By focusing on such problems, then he/she will be able to avert long-term psychological problems (Mukholi, 2001).

The VCT is able to render those services because being put up in the community; it operates in a relevant area and environment. VCTs can reach out to the people in a friendly way. Studies have shown that not many are accessing the VCTS for lack of courage or realizing the need (Republic of Kenya, 2004). Joint effort by the Kenyan Government, International Donors and Partners, NGOS and Faith Based Organizations have resulted in a rapid increase of VCT sites from 3 sites in the year 2000 to 555 sites by May 2005. Over the same period annual VCT services uptake increased from about 1000 to 380,000 (Republic of Kenya, 2005).

The importance of VCT sites cannot be over emphasized, such sites can play multiple roles for example, supply of ARVs, counseling and treatment of some infections that make people more vulnerable in contacting HIV/AIDS, these are like sexually transmitted infections (STIs), such can be handled at the VCT sites and where the infections are severe then referrals to bigger treatment sites can be made. So far VCT has been a major success story in Kenya and the eagerness of Kenyans to take advantage of this service is an indication of this success as a fore-
of the noted rapid increase in the numbers of VCT sites in
main, as can be deduced from table 2.3.

Table 2.3: VCT site coverage by province (December 2004)

<table>
<thead>
<tr>
<th>Province</th>
<th>Pop. ≥ 15yrs (2004)</th>
<th>Estimated adult HIV prevalence (%)</th>
<th>VCT sites in 2004</th>
<th>Pop. Per VCT site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nairobi</td>
<td>1,839,953</td>
<td>9.9</td>
<td>73</td>
<td>25,204</td>
</tr>
<tr>
<td>Central</td>
<td>2,919,049</td>
<td>4.9</td>
<td>49</td>
<td>59,572</td>
</tr>
<tr>
<td>Coast</td>
<td>1,502,575</td>
<td>5.8</td>
<td>41</td>
<td>36,648</td>
</tr>
<tr>
<td>Eastern</td>
<td>3,291,815</td>
<td>4</td>
<td>46</td>
<td>71,561</td>
</tr>
<tr>
<td>North Eastern</td>
<td>314,244</td>
<td>&lt;1</td>
<td>4</td>
<td>78,561</td>
</tr>
<tr>
<td>Nyanza</td>
<td>3,186,210</td>
<td>15.1</td>
<td>62</td>
<td>51,390</td>
</tr>
<tr>
<td>Rift Valley</td>
<td>4,363,464</td>
<td>5.3</td>
<td>79</td>
<td>55,234</td>
</tr>
<tr>
<td>Western</td>
<td>2,140,670</td>
<td>4.9</td>
<td>46</td>
<td>46,536</td>
</tr>
<tr>
<td>Total Kenya</td>
<td>19,557,980</td>
<td>6.7</td>
<td>400</td>
<td>48,295</td>
</tr>
</tbody>
</table>


As observed in table 2.3, Eastern and North Eastern provinces have the lowest access to VCT (70,000 to 80,000 adults per site). This gap apparently calls for more establishments of VCT sites in the Churches, which are locally placed and accessible by the communities.

2.4.3 The Church and Mainstreaming of HIV/AIDS

HIV/AIDS Mainstreaming is a process of bringing HIV/AIDS to the center of the Church’s agenda. The concept was introduced in the late 1960s in reference to the assimilation of the children with disabilities into regular classroom settings. After that, the concept has been extended more generally to refer to ways of modifying operational practices to address socio-environmental challenges. When applied to HIV/AIDS, the concept and practice means making sure that the HIV/AIDS concerns are put at the centre stage of the Church’s activities. According to Femnet (1994) mainstreaming HIV/AIDS will require the Church to consider;

1. The institutional activities that may cause HIV or fuel its spread.
2. How the pandemic may affect the institutional goals, objectives and mission.

3. Reviewing of the institutional advantages to respond to the pandemic.

4. Setting on the action to take to control the spread of the pandemic.

5. What policies, strategies and actions need to be put in place to minimize the negative and enhance the positive impact.

6. Focusing on the vulnerabilities and risk individuals

In its attempt to mainstream HIV/AIDS, the Church should develop its own programme, one of the weaknesses in controlling the spread of HIV/AIDS is duplication of programmes. Home grown programmes have a lot of originality and easily reflect relevance (UNAIDS, 2004). Mainstreaming will be easy if the Church can come out strong in its own assessment of HIV/AIDS status. Only when its known how the Church has been affected by HIV/AIDS related illnesses and deaths, then will it be able to know what measures to take in mitigating the effects.

2.4.4 Collaboration with the Educational sector

The Church in Kenya enjoys unlimited access to all institutions of learning. It either comes in as the sponsor or by using special officials like Chaplains, Priests, Nuns, Sisters and Brothers. These Church officials can make use of the pastoral instruction hour, where well-tailored programmes can be mounted and taught to the students. Such instructions can contribute to the prevention of the spread of HIV/AIDS especially through behavioral and attitude change, which is so far the most effective means of controlling the disease. Knowledge of facts about HIV/AIDS, without behavioral and attitude change among sexually active people, will not improve the HIV/AIDS situation. Knowledge and positive attitudes alone do not necessarily lead to behavior change. This should be supported with the willingness of individuals to accept that change is necessary and possible (MAP International, 1996, AIDSCAP, 1996).

A mistake in the past has been seeing the youths as followers, however, time has come to involve the youth in the control of HIV/AIDS (Samita, 1995). With this in mind, some of the youths can be trained and developed to become peer counselors. These in turn can be used to reach out to their fellow youths. As a matter of fact, in schools we have children who are affected and
Besides the students, the schools can serve as avenues where adults like teachers, workers and parents can be reached. Counseling can be given to the teachers who are either affected or infected. From the known cases of the affected children, then the Church can move swiftly to reach the sick parents or guardians. Finally, the Church can come up with a friendly curriculum. Some decades ago, many Churches in Kenya refused the curriculum on human sexuality on moral grounds. Rather than leaving the students to the wolves, the Church should come up with a curriculum that can be accepted by the Church and Government (NCCK REPORT, 2002).

2.4.5 Observing AIDS Day
Because the Church is an established and active institution in our country, with structures, personnel, large membership, facilities and programmes. It has all the potential needed to mobilize AIDS day (AIDSCAP, 1996:19). One of the things that can help the Church to break the undue silence blanketing the Church is the continual observance of the AIDS day. Using the AIDS day, the Church can end discrimination against the people living with AIDS. It gives the Church a unique day to address the pandemic. AIDS day can be used to get across preventive education that brings about behavioral change. This is encouraging because AIDS has no cure as of now; behavioral change is the only hope in controlling HIV/AIDS (Costick, 1987). During the AIDS day, preventive education can be facilitated through drama, music and art. Themes like love, sexuality, relationships and media like print materials, billboards and TV drama can be used to pass information on HIV/AIDS (World Bank, 2002). People can move into groups where they can inspire discussions about HIV/AIDS within their culture and age groups.

This enables people to open up and discuss issues in depth; other scholars referred to it as community dialogue. In this way, group friendly information in quest of behavioral change can be facilitated with an aim of prompting the people to assume new attitudes. Also it is possible to promote aggressive awareness. Key themes to be addressed during the AIDS day are like
AIDS Day can be used to dispel myths about HIV/AIDS. Demystification is important because it creates ways for proper education about youth. There are people who hold onto the myths that having sex with young girls will either cleanse them from HIV/AIDS or will protect them from any infection. This explains the current rise in the wave of children rape (Republic of Kenya, 1998). Baker and Ward, et al. (1989:13) show that building communication capacity will enhance behavioral change as people access correct information, such communication need not be verbal, the following can be used as media to carry the needed messages: T-shirts, caps, posters and banners.

2.4.6 Community Involvement

Over the decades, the Church took a rather isolationist stance in relation to HIV/AIDS. Slowly this is changing, now we have literature published by Churches and such organization like Church oriented NGOs, CBOs and FBOs. The Church in its attempt to control the spread of the disease has realized the importance of networking with other stakeholders who are involved in the control of the disease (Tapia, 1998). Involving the community will solve the current danger of leaving HIV/AIDS pandemic for the paramedics only. When HIV/AIDS is left to the health sector, it becomes too heavy for it. There are far too many HIV positive people seeking medical services, as eluded earlier; it has been shown over 33% of the hospital beds are currently occupied by patients with HIV/AIDS complications. The hospital staffs are overwhelmed and may not give quality treatment.

2.4.7 Empowerment of the infected

Research has shown that, many of the infected actually die from the impact of rejection, isolation and discrimination. They would live longer if they were shown love, acceptance and support. This will preserve their dignity and rights. The Church can make the necessary interventions for meeting the special needs for the infected. One of the ways the Church can
emPOWER the infected is by establishing clubs for the people living with AIDS. In these clubs, sharing in such setups can encourage people to open up as (Kenya AIDS Newsletter, 1992:8).

The groups/clubs can be used as easy avenues to dispense ARVS to the People living with AIDS. Whenever one does not access the drugs the body develops a resistance that makes it hard to benefit from the drugs in the future. But in a group, one person can reach out to them and give out the drugs. Besides the drugs, other services like facilitating on proper nutrition, how to live responsibly though HIV positive can be done (Irea, 1994:7, Knight, 1989). Instead of the people living with HIV/AIDS being idle, the Church can help them to establish small scale businesses that can help them occupy their time. Such income generating activities can be a very good way of empowering them. It makes them to live productively and it saves them from being totally dependent; some little income makes them feel productive and independent to some degree (World Bank, 2002).

The Church can help the infected to access National policies which spell out their rights. As of now, most institutions have a policy in place which serves to show the way forward for the infected people by outlining their rights. This is the advocacy role which the Church can offer to the infected to avoid rejection, stigmatization and discrimination against the people with HIV/AIDS (NCCK Report and Strategy Plan, 2002:32).

2.4.8 Training of Peer Counsellors

There is no limit to what peer counseling can do to the infected or affected in alleviating their sufferings. When serving the affected, counseling can be used to help end depression. This is a psychological disorder many affected or infected people find themselves in, left unattended, a person in depression simply cannot cope with life and many tend to be suicidal (Wasonga, 1994:17). When one declares the news of being positive to the family, conflict and bitterness may ensue. Such an environment becomes very hostile for the person with the disease. The Church can step in through the counselors and bring peace through counseling the affected to accept the infected back as one of them. Where there may be feelings of being cheated,
The Church can use the counselors to carry out outreach in the surrounding institutions. Such institutions are like Schools, Hospitals and Polytechnics. Awareness and preventive education can be facilitated. Where cases of infection are known, tailored programmes to the infected can be facilitated. Distribution of pamphlets and show of video recordings can be done to still facilitate the message on the control of HIV/AIDS (AIDSCAP, 1996, MAP International, 1996, World Bank, 2002). When it comes to the visitations of the infected, the role of these counselors is indispensable. During their visitations they can make follow up on the infected, dispense ARVs and facilitate on nutrition. Such services are critical to those who do not have a lot of energy due to the disease. There are possibilities of partnering with the paramedics during their visits and do some simple activities (MAP International, 1996, Costick, 1987).

Counselors are also effective in reducing stigma, it is one of the causes of death for many people who are infected with HIV/AIDS. This is well captured by (Wasonga, 1994) He states;

“Stigma is the silent killer decimating our continent and is spreading disease. We should call for an end to stigma and discrimination against those who are HIV+ and their families. Our sisters and brothers living with AIDS experience silence and rejection. Silence feeds denial and shame. This, too, is stigma. We know the Church has been complicit in silence. That silence is ended! Our Church has declared stigma as a sin before God and Human kind. We will uphold the dignity and worth of all people as children of God, especially those living with AIDS.”

2.4.9 Collaboration with other Partners
Most of the organizations dealing with HIV/AIDS have been carrying out their activities without involving other stakeholders. The stakeholders need not view each other as competitors but they should play a complimentary role. Such networks can share information, pool resources together, exchange of ideas with a view to fronting a common voice in the fight against HIV/AIDS (Samita, 1995).
The stakeholders will be more effective if they have homegrown approaches. What seems disturbing is that most of these agencies are either foreign or local but almost additively dependent on foreign goodwill in terms of funding. These poses worrying future projections in terms of self-sustainability of efforts towards addressing the challenges of AIDS in Kenya particularly, with the growing trend of donor fatigue. Meaningful combat of AIDS must reflect serious involvement of Kenyans themselves, including PLWAs, Churches all over rural and urban. The kind of networking required must traverse religious confines and political affiliation. The Church must be ready to work with Government and all other well-intended agencies (Shorter and Onyancha, 1998).

2.5 Achievements of the Church in fighting HIV/AIDS

2.5.1 Collaboration with Faith Based Organizations

Many international donors consider faith based organizations (FBOs) to have an important role, especially in the response to HIV/AIDS. Some of the advantages of the FBOs as laid down by UNAIDS (2002) are;

The believers meet on regular basis (usually weekly) therefore can be targeted with information on HIV/AIDs. Faiths based organizations employ staff, receives external donor support and are answerable to a group broader than the Church. The can also be easily established locally and further homegrown ideas and approach because they can solicit funds locally in that their budgets are small and most of their activities can be voluntary.

Donors are beginning to understand that faith is critical in the lives of poor people, this is the language easily talked by the FBOs. Besides this, the FBOs tend to have a huge reach, they are in most cases the only civil society organization present in remote areas, able to reach where Government have not. They have an understanding of and acceptance by the communities, often because of a long standing presence. This initiative has brought permanent impact resulting to changes.
The Church can have a positive influence over the FBOs because the same members of the FBOs are also Church members. This enables the Church to give guidance, encouragement, training and financial assistance to the FBOs. The leaders of the FBOs can be trained by the Church for the purpose of building their capacity. Where the FBOs do not have a policy, the Church can assist in formulation of a relevant policy to help in their daily running (Kenya Red Cross Society, 2005:14). FBOs function inadequately due to lack of funds; as earlier mentioned most of their services are voluntary. Given the scale and depth of the need arising from the HIV/AIDS pandemic, they are not likely to give full support needed by the affected households in order to function adequately.

The Church could then raise the needed funds to boost the capacity of the FBOs in their attempt to control the pandemic. Although we take pride in the fact that most of the FBOs are funded locally and that this acts as a cushion against donor fatigue, however, giving from within is inadequate to meet the needs, thus putting congregants under financial strain. The Church, on this basis can intervene through partnering with NGOs which are able to finance big programmes (World Bank, 2002).

2.5.2 Collaboration with Non-Government Organizations

NGOs have the potential to work with the Church in a more complex partnership than the CBOs or the FBOs in the control of HIV/AIDS. Some of the programmes mounted by the Church can be expensive. Some of the NGOs have the financial capacity to fund the Church. This working relationship enables the Church to effectively carry out its programmes. For many Churches, transport is the big issue that needs input. Means of transport like bicycles, motorbikes and vehicles can be provided by the NGOs (AMREF, 2005).

Personnel who can carry out the projects are critical. The Church can train such personnel with the help of the NGOs funding. Such personnel include the Trainer of Trainers (ToTs), community nurses and other staff who can be trained and empowered to run mobile clinics and size up to the demands of controlling HIV/AIDS. When there is an active partnership, the results will be rewarded by a decreased prevalence of HIV/AIDS, UNAIDS REPORT (1998) shows that
This approach was very successful in Uganda. The partnership identified and established ways to deal with the pandemic. Examples of the problems they dealt with were:

- Early marriages, safer sex behavior in schools/institutions, counseling both the infected and the affected, preventive education on HIV/AIDS and care and support for both infected and affected.

The approach was found to have lowered the rate of infection both in the rural and urban areas. Gitome (1998:197) gives the statistics of the reduced prevalence as follows. Prevalence among women aged 15-24 fell from 28% in 1987 to 11% in 1996 and in the rural areas, prevalence among women in the same age group fell from 10% in 1997 to 3% in 1996.

“This is a sign that humankind is not powerless in dealing with the HIV pandemic” (World Bank, 2002).

UN Report (2004) gives an example of those countries in North Africa and Middle East which generally cherish very conservative social and political attitudes; the issue of HIV pandemic is less serious there. They have recorded only 200,000 people living with HIV/AIDS, this is only 1% of the world total. An articulate moral theology must be upheld in dealing with contemporary issues like HIV/AIDS; when theology is livable that is solving people’s problems, then there are all the reasons to embrace it. A challenge to the Church in our times and an opportunity for the Church to show its credibility (NCCK Report, 2002).

2.6 Challenges facing the Church in its efforts to fight the HIV/AIDS

In spite of the efforts made by the church and its endeavours to contribute to eradication and prevention of HIV/AIDS, the church is still faced by some challenges. Key among the challenges are, lack of adequate resources that is both financial and human, inadequate skills and knowledge, negative attitudes, persistent adherence to cultural practices, traditions and taboos.

2.6.1 Lack of adequate resources

Effective eradication and prevention of HIV/AIDS disease has been harbored by lack of adequate resources. These resources are in form of both financial and human, presently the
The number of people suffering and being infected has been increasing thus putting a strain on the already scarce financial resources, this kind of situation has seen the economic activities become compromised by squeezing productivity, reducing costs of production, diverting productive resources and depleting skills (Borg, 1995).

Borg further reports that due to the disease, there is increased absenteeism from work due to sickness or other HIV/AIDS related complications which have accounted for 25-54% of company costs. There are no adequate resources to train and replace the dead workers, it is sad to note that all sectors have recorded high losses and costs (Borg, 1995). Most organizations the church included have found it difficult to offer health care services and where they are attempting to do so, the costs for health care, funeral benefits and pension fund commitments are likely to rise unexpectedly and also early retirement plus death rise (World Bank 2002).

2.6.2 Inadequate skills and knowledge

In order to control HIV/AIDS effectively it requires that the practitioners must possess or be equipped with the prerequisite skills and knowledge about the disease. Unfortunately this is not the case and those who have such knowledge and skills are few. Consequently, the Church has found itself in the same dilemma and finds it difficult to handle the issues of HIV/AIDS effectively. Even most people lack adequate knowledge about the disease thus posing a challenge in terms of dealing with it. According to NASCOP, most Kenyan adults know that abstaining from sex, limiting sex to one faithful partner, using condoms, or both being faithful and using condoms are ways to reduce the risk of getting the AIDS virus. However this knowledge is limited to young persons who are aged 15–19 and also to those with no education or the poorest portion of the population (NASCOP, 2005).

This is a global problem but has manifested itself in most countries in Sub Saharan Africa. Kenya has not been spared by this problem either since the AIDS scourge continues to threaten many lives across the country. According to NASCOP report of 2003, it is estimated that 1.2 million Kenyans are now living with HIV infection out of this number, very few know whether
2.6.3 Negative attitudes

Negative attitude or fear of stigmatization has been a serious challenge to the efforts made towards HIV/AIDS control. Most people are living in a state of self-denial about the disease, majority are unwilling to go for VCTs, to them they feel or think they are okay. It is worth noting that knowledge about HIV/AIDS without behavioral and attitude change among sexually active people, will not improve the HIV/AIDS situation, (AIDSCAP, 1996). It is for this reason that the report by MAP International and AIDSCAP (1996) indicated that knowledge and positive attitude alone does not necessarily lead to behavior change but rather should be supported with the willingness of individuals to accept that change is necessary and possible.

2.6.4 Cultural practices, traditions and taboos

Most ethnic groups are still tied to certain cultural practices, traditions and taboo such as widow inheritance, female genital mutilations (FGMs) among others. These practices are common among such ethnic groups like the Luos, Maasais, Somalis, Luhyas, Turkanas, Kalenjins and to some extent the Kamba among others (Peterson, 1996). These practices are a serious threat to HIV/AIDS control. One of the tools the Church can employ to overcome this challenge is the attitudinal and behavioral change. This is important because it can empower the people to take control of their lives and make informed choices in terms of decision making, it can also guide the people to develop skills and adopt positive behavior that prevent infection from HIV/AIDS and lastly it can help to reinforce positive behavior that can be useful in discouraging unacceptable cultural practices, traditions and taboos that bear the risks of one being infected (Peterson, 1996:12, Collier, 1987:45, Tapia, 1988:67).

2.7 Theoretical Framework

2.7.1 Introduction

A theory explains how and why events occur. Kerlinger (1964) defines a theory as a set of interrelated constructs (concepts) definitions and propositions that presents a systematic view of
Theories are constructed with elements like concepts, variables, statements and formats. Theoretical statements then imply how concepts in a theory are connected to one another to exhibit a theoretical framework (Turner, 1991). This study will be guided by one theory namely, the social exchange theory as postulated by George Homan in exploring the role played by the ABC Church in the control of the spread of HIV/AIDS in Machakos district.

### 2.7.2 Social exchange theory

In his analysis of the social exchange theory, George Homans puts more emphasis on people and their behavior. His views about exchange theory were greatly influenced by mainly the works of Talcot Parsons (Ritzer, 2000). Homans early theory was that of psychological behaviorism whereby he likened the human behavior to that of animal behavior responding to a given stimulus, this is what was called operant conditioning by Edward Skinner. Homans later improved his theory from the psychological behaviorism to social exchange theory, whereby he argued that individuals are always oriented to other human beings. This means that the individual’s behavior is conditioned by that of the wider society or the environment around the individual.

It is this later thinking of George Homan theory which is more relevant to this particular study. In essence, the social exchange theory is relevant in exploring the role of the ABC Church in the control of the pandemic since this study is focusing on human beings. Also the problem of HIV/AIDS is affecting the humankind and is a human phenomenal problem emanating from behavior of individuals conferred on others such as sex among others.

The relevance of this theory to this study is particularly based on its propositions and arguments. Homans argues that to understand people, we must first understand their behavior and their
interactional activities which reinforce the spread of exposure of unsafe risky sexual behavior. Through the interaction, remedies emerge because people come into converging consensus that the problem of HIV/AIDS needs to be addressed seriously so as to save human kind. This explains why various organizations and institutions have come up with programmes of controlling and preventing the spread of the pandemic.

It is true that any human behavior is a function of reinforcement, Homans argues that people will continue to do what they found rewarding in the past, while they cease to do what has proved to be costly in the past (Marton, 1980:235) in this argument of Homans, there is relevance of this study in that people involve in risky behavior such as unprotected sex, prostitution, or any other sexual behavior because of the economic implications, which they presume to be more rewarding. Commercial sex has been a major contributor to the problem of HIV/AIDS. As the theory explains in any activity, there is cost implication, it is the failure of human individual to understand this cost implications at the expense of economic implications which has resulted to this widespread problem under study.

To Homans social behavior is an exchange of rewards, costs or punishments between at least two people or more. It is thus, this kind of social behavior that is being explained here which has not been controlled over a period and has led to the witnessed problems such as the problem of HIV/AIDS. It is important to observe that if an individual social behavior at an interactional level is not corrected, eventually that becomes a complex societal social problem as witnessed in the case of HIV/AIDS pandemic.

Homans argues that social interactions are governed by norms, status, and reciprocal obligations within a particular society. This norms and obligations are supposed to guide social human behavior if they are properly regulated and sanctioned, however, it is important to note the weaknesses or the failure to regulate such norms and obligations has led to breakdown of society's social fabric hence the problem of HIV/AIDS. What is also relevant here in this theory to this study is the fact that the social norms and obligations are supposed to be regulated and
sanctioned by the individual, organizations or institutions and the ABC Church is not an exception.

Social exchange theory puts special emphasis on the rewards of any behavior or activity. It argues that, rewards given must be valuable for the actors to continue with the desired interaction in order to get the valuable rewards. In this relation, it is critical to note that, those institutions or organizations which are dealing with the control and prevention of HIV/AIDS need to be positively rewarded/reinforced for them to continue more aggressively to combat the problem. ABC Church being one of such organizations needs to be rewarded for further action since it is in the right direction.

This theory therefore, fits well in this study because the control of HIV/AIDS is all about social behavior, social interactions, rewards, punishments, reinforcements and behavioral change. People cannot change their behavior unless they see the value emanating from the change. The core value of positive behavior change will be HIV/AIDS free life compared to HIV/AIDS ridden life in case of non-compliance to behavior change. Therefore, it is not an understatement to conclude that this theory is relevant to this study.

2.8 Conceptual Framework

Huberman and Miles (1994) define a conceptual framework as a visual or written product that explains using a narrative or graphics important variables to be studied and the assumed relationships between them. For this study the term is used broadly to include ideas and beliefs that the researcher holds about efforts to solve the challenge posed by HIV/AIDS.

This framework is very important in refining the study goals, constructing research questions, choosing study methods and identifying issues that may invalidate the conclusions arrived at by the study. The key issues that have been identified by the researcher are partnerships formed by the Church, efforts put in place by the Church and achievements that have been made. These issues are theorized to be the most important in the fight against HIV/AIDS. Figure 2.1 explains how these issues interact.
Efforts of the church

Achievements

- Reduction of infection rates
- Safer sexual behavior
- Counseling of infected and affected
- Awareness Education on AIDS/HIV

Partners

- Donors
- NGOs
- CBOs
- Educational institutions
- Government
- Local community

The ABC Church

VCT services

Mainstreaming of HIV/AIDS

Collaboration with education sector

Observing AIDS day

Empowerment of infected

Training of peer counselors

Annual conferences for youth, men and women

Economic empowerment of infected

Support of orphans

Support groups established
<table>
<thead>
<tr>
<th>Variable</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception of congregants of ABC Church on HIV/AIDS</td>
<td>Awareness of HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>Percent of people:</td>
</tr>
<tr>
<td></td>
<td>i. Aware of HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>ii. Aware of causes</td>
</tr>
<tr>
<td></td>
<td>iii. Aware of ways of protection</td>
</tr>
<tr>
<td></td>
<td>iv. Aware of HIV related deaths</td>
</tr>
<tr>
<td>Effects of HIV/AIDS</td>
<td>Increase of widows, orphans, deaths and number of people living with AIDS.</td>
</tr>
<tr>
<td></td>
<td>Infection rates, number of deaths, number of orphans, stigmatization of infected, number of widows</td>
</tr>
<tr>
<td>The reaction of the Church to effects of HIV/AIDS and results achieved</td>
<td>Empowerment of infected persons, collaboration with other stakeholders, youth AIDS programmes,</td>
</tr>
<tr>
<td></td>
<td>Number of persons reached, reduction in infection rate, number of support groups formed</td>
</tr>
<tr>
<td>Challenges facing the Church in managing HIV/AIDS</td>
<td>Resources Financial and personnel</td>
</tr>
<tr>
<td></td>
<td>Number of:</td>
</tr>
<tr>
<td></td>
<td>i. Widows</td>
</tr>
<tr>
<td></td>
<td>ii. Orphans to support</td>
</tr>
<tr>
<td></td>
<td>iii. Dead Church members</td>
</tr>
<tr>
<td></td>
<td>Amount of money spent on Church programmes</td>
</tr>
</tbody>
</table>
CHAPTER THREE

E: RESEARCH METHODOLOGY

This study was to answer four important research questions on the role of the ABC Church in fighting HIV/AIDS in Central Division of Machakos County. Firstly the study sought to know the perception of ABC congregants on HIV/AIDS. Secondly the study sought to establish how HIV/AIDS had affected the congregants of ABC Church. Thirdly the study sought to establish the reaction of the Church towards HIV/AIDS and the results that had been achieved. Finally the study documented the challenges that faced ABC Church in its efforts to manage HIV/AIDS.

This chapter explains the research design, site selection and description, and sources of data. Further the chapter explains the study population and sample, units of observation and analysis and units of observation and analysis. Finally the chapter explains the methods of data collection and analysis.

3.2 Research Design

A research design is the blue print that enables the investigator to come up with solutions to these problems and guides him or her in the various stages of the research (Nachmias, 1996:99). The purpose of research design was therefore to describe the process involved in designing the study and to demonstrate how the specific research design that the researcher selected to use helped to structure the collection, analysis and interpretation of data. The study used a descriptive research design as well as probability and non probability techniques which enabled the researcher to collect data from the observation units.

3.3 Site Selection and Description

The study was conducted in Central Division of Machakos County focusing on the Africa Brotherhood Church (ABC). The ABC Church structure in this County consists of six (6) sub-headquarters with eighteen (18) sub-pastorates which have a total of two hundred and forty nine (249) Churches and an estimated population of 67,553 as depicted in the table below.
## Table 3.1: ABC Sub-Headquarters/Pastorates in Machakos County

<table>
<thead>
<tr>
<th>Headquarters</th>
<th>Number of Churches</th>
<th>Estimated population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iveti</td>
<td>Masaku, Kalama, Kiimani, Mutituni (4)</td>
<td>72</td>
</tr>
<tr>
<td>Mitaboni</td>
<td>Kaiani, Mitaboni, Kangondi, Kakuyuni (4)</td>
<td>46</td>
</tr>
<tr>
<td>Kangundo</td>
<td>Kathithyamaa, Kalimani, Kingoti, Katheka (4)</td>
<td>43</td>
</tr>
<tr>
<td>Central</td>
<td>Ngamba, Kalawa, Mwala (3)</td>
<td>32</td>
</tr>
<tr>
<td>Yatta</td>
<td>Matuu, Masinga, Katangi (3)</td>
<td>51</td>
</tr>
<tr>
<td>Athi-River</td>
<td>Athi-River</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>249</strong></td>
</tr>
</tbody>
</table>

*Source: ABC Report February 2013*

The study was carried out in Mutituni and Masaku sub-pastorates which fall under Iveti Sub-Headquarters in Machakos Municipality. This site was selected due to several reasons. First the area is urban and has a high HIV/AIDS prevalence as compared to other areas in the County. Secondly unemployment rate is high in the selected site coupled with high poverty level, further the area is not well endowed with any meaningful income generating activities such as farming or genuine commercial activities.

### 3.4 Sources of Data

The data for this study was collected from both primary and secondary sources. The primary data for the study was obtained by interviewing respondents who are beneficiaries of the Africa Brotherhood Church (ABC) HIV/AIDS programme. The secondary data was from the library as well as use of HIV/AIDS available information from documented reports. A number of materials such as annual reports, project proposals, books, periodicals, journals, newspapers, Government publications and research material were reviewed.
Population and Sample Design

A target population refers to all members of a real or hypothetical set of people, events, or objects to which the researcher wishes to generalize the results of the study. The target population for this study were the beneficiaries of HIV/AIDS programmes of Africa Brotherhood Church (ABC). The term beneficiaries included the Archbishop, the Bishop, Canons, Sisters, Development Workers, Church Members and Church HIV/AIDS established support groups. A sample is a subset of sampling units from a population which does not include the entire set of sampling units which have been defined as population (Nachmias, 1996:194).

Machakos Municipality has four Sub-Pastorates with a total of 72 Churches; two Sub-Pastorates were purposively selected for inclusion in the study. The selected Sub-Pastorates have a total of 36 Churches and twelve Churches were purposively selected for the study.

**Table 3.2: Sample allocation to the 12 Churches in the study**

<table>
<thead>
<tr>
<th>Name of Church</th>
<th>Church population (members)</th>
<th>Respondents selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Kasinga</td>
<td>310</td>
<td>6</td>
</tr>
<tr>
<td>ABC Muumandu</td>
<td>420</td>
<td>8</td>
</tr>
<tr>
<td>ABC Lumbwa</td>
<td>632</td>
<td>12</td>
</tr>
<tr>
<td>ABC Kimutwa</td>
<td>498</td>
<td>9</td>
</tr>
<tr>
<td>ABC Muvuti</td>
<td>892</td>
<td>15</td>
</tr>
<tr>
<td>ABC Mukala</td>
<td>689</td>
<td>14</td>
</tr>
<tr>
<td>ABC Mbembani</td>
<td>469</td>
<td>9</td>
</tr>
<tr>
<td>ABC Katelembu</td>
<td>864</td>
<td>15</td>
</tr>
<tr>
<td>ABC Bomani</td>
<td>983</td>
<td>18</td>
</tr>
<tr>
<td>ABC Show Ground</td>
<td>397</td>
<td>7</td>
</tr>
</tbody>
</table>
One hundred and forty (140) respondents were interviewed from the selected twelve (12) Churches. Proportionate sample allocation was used to determine the number of members to be drawn from each Church as shown in table 3.2. The Church population was used to decide the number of respondents to be selected from each Church. The formula used was \((p/P) \times 140\) where \(p\) is population in each Church and \(P\) is the sum of populations of all the 12 Churches. Selection of the respondents from each Church was done using simple random sampling.

Ten key informants were drawn from the leadership of the twelve (12) Churches. The key informants helped the researcher understand how the HIV/AIDS problem had affected the Church and identified partnerships and efforts that had been put in place by the Church. One focus group discussion was used in the study. Twelve participants in the FGD were selected from leaders of support groups and ABC development staff. The objective of the FGD was to understand how HIV/AIDS had affected the Church and the response of the Church to mitigate its effects.

3.6 Units of Observation and Analysis

Mugenda defines the units of observation as the subject, object, item or entity, from which we measure the characteristic or obtain the data required in a study, (2003:15). In other words, the units of observations were the sources of data. In this study therefore units of observation were Church members, programme implementers and beneficiaries as well as the Church leadership. Singleton et al (1988) defines units of analysis as the entity around which the researcher seeks to make generalization. Therefore, the units of analysis for this study were the efforts of ABC Church in the reduction and control of HIV/AIDS.
Five methods of data collection namely a field interview, a focus group discussion, archival research, secondary research and key informant interviews were used to collect data.

**Household interview** is a data collection method that involves selecting respondents at a household level to gather information from them using a structured questionnaire. It was used to gather data from the selected 140 respondents. The tool which was used to collect data was a well designed questionnaire with both closed and open ended questions and the data collection method used was interviewing. The designed questionnaire was administered by 4 trained enumerators who interviewed 35 respondents each.

**Focus group discussion** is an interviewing technique used to gather data whereby a researcher involves a group of people usually between 8 and 12 to freely discuss and explore a certain subject. In this study one FGD of 12 participants whose composition were seven females and five males was conducted to gather information from leaders of established support groups and the ABC Development staff were selected for the study. The tool used was an interview guide which was developed to assist the researcher in prompting for the right information from respondents.

**Key informant interview** is a research technique used to gather in depth information from a respondent who is known to have relevant information about the subject. The researcher purposively selected and interviewed ten Church leaders and the ABC Development staffs. This involved engaging in an in depth interview to explore how the Church has been affected by HIV/AIDS and the measures put in place to mitigate the effects. The tool used was key informant interview questionnaire which was developed and used for gathering data.

**Archival research** which is a technique used to gather research data by inspecting original records was used. It was used to gather data on programmes that had been carried out by ABC Church and to measure results that had been achieved. This is a research technique that involved gathering information from original archived records. This technique was used in this study to inspect records of programmes implemented by the ABC Church. Information on programmes
Secondary research is a technique used in data collection which involves reviewing published material. It was used to gather data from books, published journals, published data and the internet. This was important in complementing the other research methods. This involved consulting published material to gather information related to the study. For this study secondary research was used to gather quantitative data on HIV/AIDS that had been published by other researchers and Government agencies.

3.9 Methods of Data Analysis

The chosen methods of data analysis for this study were descriptive statistics, graphs and qualitative summaries. According to Singleton et al (1988) descriptive statistics and graphs are simple statistical methods concerned with organizing and summarizing data to make it more intelligible.

The descriptive statistics used in this analysis were frequency and percentage. The frequency is a count of the number of respondents who responded to a particular question. The percentage expresses the count as part of the total respondents. The frequency and percent were then combined into a cross tabulation to enable easy understanding of the information.

Bar graphs and pie charts were the graphical techniques that were used to visualize data. The bar graph presented data as columns enabling easy comparison. The pie chart presented data as angular sections of a circle enabling easy comparison of different sections.

Qualitative summaries were used to analyze qualitative data from key informant interviews and the focus group discussion. This enabled the researcher to group information gathered from the focus group discussion and key informant interviews into thematic areas. Such grouping of information enabled comparisons and conclusions.
4.1 Introduction

This study sought to answer four important research questions. First it sought to find out the awareness of the congregants of ABC Church on HIV/AIDS. Secondly it sought to find out how the ABC Church had been affected by HIV/AIDS. Thirdly it sought to establish how the Church had reacted to the effects of HIV/AIDS and what results had been achieved. Finally it sought to identify challenges faced by ABC Church in managing HIV/AIDS.

The study utilized qualitative and quantitative techniques for the data collected from respondents using questionnaires. This chapter therefore presents findings obtained by analyzing the data from the questionnaires. Descriptive methods such as tables and graphs were used to present quantitative information while narrative summaries were used to present qualitative information from focus groups and key informants.

4.2 Demographic characteristics of respondents

The quantitative analysis was based on a sample size of 140 respondents from Central Division of Machakos County.

4.2.1 Gender Distribution of respondents

From the 140 respondents selected 74 were male which represented 52.9% of the total respondents while the numbers of females selected for interviewing were 66 which represented 47.1%. From the study it was evident that there was fair distribution of respondents selected by sex. Therefore the findings of the study did not have any gender bias. The information is clearly illustrated in table 4.1.
### Table 4.1: Gender Distribution of Respondents

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>74</td>
<td>52.9</td>
</tr>
<tr>
<td>Female</td>
<td>66</td>
<td>47.1</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### 4.2.2 Age distribution of respondents

The study established that majority of the respondents were aged over 46 years (40.0%) followed by those in age bracket of between 41-45 years (17.1%). These two age groups constituted more than half of the respondents (57.1%). Of the respondents interviewed, 13.6% were aged between 30-35 years. Those respondents who were aged between 24-29 years constituted about 12.9% while those who were on the age brackets 36-40 represented 9.3%. The fewest respondents were from the 18-23 age group (7.1%). It therefore means all the respondents for this study were adults. This information is well visualized in graph 4.1. Further it shows that the respondents for the study were selected from every age category and that the results of the study were representative of all the targeted age groups.

**Graph 4.1: Age distribution of respondents**
Marital status of the respondents

From Table 4.2, it can be observed that 105 (75.0%) of the respondents who were interviewed indicated that they were married, 15 (10.7%) of them said they were widowed and 14 (10.0%) reported that they were single parents. Out of the total number of the respondents interviewed, only a small percent of them 6 (4.3%) who did not respond to the question. It was therefore evident from the study that majority of those interviewed were married or had families and thus it could be presumed that they knew the dangers posed by the HIV/AIDS.

Table 4.2: Summary of respondents’ marital status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>105</td>
<td>75.0</td>
</tr>
<tr>
<td>Widowed</td>
<td>15</td>
<td>10.7</td>
</tr>
<tr>
<td>Single</td>
<td>14</td>
<td>10.0</td>
</tr>
<tr>
<td>No response</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

4.2.4 Respondents’ responsibilities in the Church

The study intended to establish whether the individual members within the Church had some roles they played in the Church.

Graph 4.2: Respondents’ who played some roles in the Church
members of the Church had some responsibilities within the Church (87.9%). It is also evident from this study that 12.1% of the respondents did not hold any responsibilities within the Church. Since a majority of the respondents in one way or another held some responsibilities, it was possible for them to know whether the Church had some specific programs geared towards addressing the issues of HIV/AIDS control.

4.2.5 Respondents’ level of Education

The findings of this study were that majority of the respondents had attained primary level of education representing 44.3% of those respondents who were interviewed. Also of the total number of respondents, 25.7% had attained secondary education while 17.9% had attained tertiary level of education and 10.7% had attained University education as reflected in graph 4.3. These results showed that most respondents had attained some level of education, therefore these results showed that majority of the respondents understood the issues of HIV/AIDS and possibly their dangers.

Graph 4.3: Respondents’ level of Education

4.2.6 Economic status of the respondents

The findings of this study were that, majority of the respondents who were interviewed were gainfully employed (37.9%), while 31.4% represented those who were self-employed, of the
It is evident from the study that at least majority of sampled respondents were involved at least in an Income Generating Activity, this at least could keep them busy not to idle or involve themselves in such other activities which could otherwise expose them to risky behavior. The findings are depicted in table 4.3.

Table 4.3: Respondents’ economic status

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gainfully employed</td>
<td>53</td>
<td>37.9</td>
</tr>
<tr>
<td>Self employed</td>
<td>44</td>
<td>31.4</td>
</tr>
<tr>
<td>Farming</td>
<td>29</td>
<td>20.7</td>
</tr>
<tr>
<td>Casual laborer</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td>No occupation</td>
<td>3</td>
<td>2.1</td>
</tr>
<tr>
<td>No response</td>
<td>5</td>
<td>3.6</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4.3 Main Findings

4.3.1 Awareness of HIV/AIDS by congregants of ABC Church

The first objective of the study was to establish the awareness of the ABC Church congregants on HIV/AIDS. It was evident from this study that almost the respondents interviewed 99.3% were aware that HIV/AIDS was a national disaster, only 0.7% of the respondents indicated that they were not aware. From these findings it was clear that efforts to create awareness about HIV/AIDS could bear fruits since this big number of population could be used to pass/communicate the intended information. However this awareness could not be interpreted to mean success because mere awareness did not imply behaviour change because more infections of the
The positive aspect of this overwhelming kind of awareness could make it easy for the population to embrace mechanism which could assist in controlling or prevention of the HIV/AIDS.

Table 4.4: Awareness of HIV/AIDS as a National disaster

<table>
<thead>
<tr>
<th>Awareness of HIV/AIDS as a national disaster</th>
<th>frequency</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>139</td>
<td>99.3</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

4.3.1.1 Awareness of HIV/AIDS related deaths in the Church.

Figure 4.1: Percent of respondents’ aware of HIV/AIDS related deaths

From figure 4.1 it could be observed that most of the respondents knew of a person who had died of AIDS related disease as portrayed in the high percentage of 84.3%, while 15.7% indicated that they did not know. From the findings of this study, it can be deduced that HIV/AIDS had caused many deaths in the Church and hence a big area of concern.

During the FGD session an array of causes of the pandemic were fronted, major been sexual immorality which was described as adultery and unfaithfulness, the participants also mentioned...
failure to adhere to Mother to Child prevention, one of the Community development worker mothers were still in denial and did not seek proper medication. She further said that some women did not follow instructions of breastfeeding because of fear of being stigmatized and went ahead in breastfeeding their infants even when the Nurses had advised them not to breastfed.

Another significant cause cited by the participants was lack of sex education especially to the youths by their parents and teachers. One of the participants argued that parents shy away from sharing matters of sexuality with their children and leave the responsibility to teachers and the Church which leaves a gap because the teachers and the pastors don't explicitly share matters of sexuality. Another participant had this to say. "When I attempt to talk to my daughter about taking care of herself and how she should not engage in friendship with boys because there is HIV/AIDS and that she could get pregnant she looks away and calls me mum mum and sometimes walks away."  

Another factor mentioned by the participants was that, female condoms were not available in the hospitals and even in the chemists and the few that were in the chemists were expensive so most women could not afford them and they ended up engaging in unprotected sex. The participants in the FGDs suggested that females should be provided with the female condoms so that they can use them for safe sex without necessarily consulting their male partners, especially in cases where conflicts could arise if the females insisted on using the condoms.

Another factor identified as a cause of HIV/AIDS spread was that of poverty and desperation thereof in search of good life. A male Community Healthy worker from Mitituni had this to say. "These young girls are going for older rich men because they want good shoes, expensive phones, nice clothes, want to go for hangs and parties and therefore give in to sexual intercourse a situation which leaves them without power to negotiate for safer sex hence exposing them to risks of infection." These generated a heated debate where some participants argued that even young boys were going out with holder women for the same reasons. A situation which they all agreed and suggested that a policy ought to be put in place by the Government to safe guard youths against such practices.
A key informant respondent pointed out that another cause was lack of distinctive symptoms of the disease in the early stages before it blows up, thus one can not tell who is infected or not and this leads to high chances of engaging in risky behavior with an infected person. He also argued that while the ARVS were helping prolong the lives of the infected, they could also contribute to further spread because the infected look healthy and incase of malice such a person could decide to engage in sex indiscriminatively in order to infect others.

4.3.2 Awareness of the effects of HIV/AIDS in the Church

The second objective of the study was to determine some of the ways in which the HIV/AIDS had affected the congregants of the ABC Church.

Figure 4.2: Respondent awareness of effects of HIV/AIDS in the Church

The study established that a large number of respondents 91.4% had the feeling that the Church had been affected by the HIV/AIDS. Out of the total number of those who were interviewed, 8.6% reported that HIV/AIDS had not affected Church activities as shown in figure 4.2. With this overwhelming awareness, it meant that the Church could seize this opportunity, and pool the members together to address the issues of HIV/AIDS. The awareness can also be used as a tool to assist in coming up with programmes or enhancing the existing one to control further spread of the disease or to support the affected. The number of people who were not aware could not be ignored. This therefore calls for continued creation of awareness so that congregants could be on
The key informants and the FGD fronted various ways in which the Church had been affected. That the Church had lost many of its members due to deaths caused by the diseases. A female Community Health Worker from Mbembani had this to say. "We have lost so many people, relatives, Church members and the leaders have not been spared either. Last week we buried a child whose parents died due to HIV/AIDS related complication and my Church took over the burial preparation until we laid the child to rest." The same sentiments were echoed by most of the participants saying that every week their villages bury members of the community, a scenario they argued was very painful and a big loss to development of the country.

The key informants pointed out that the Church, Community and families were diverting funds meant for other activities to manage HIV/AIDS. Worth noting was the medication of the infected, catering for burial expenses, ensuring nutritious food for the infected and taking care of the orphaned children in terms of their upbringing, food, clothing and education.

The ABC field Officer reported that caring for orphans and widows was becoming unbearable to the Church. He said that the Church was not even able to cover the four Lower Eastern Region Counties leave alone Machakos County and that majority of the infected and affected had not been reached. He further pointed out that the problem of orphaned and vulnerable children was one of the most visible and devastating effects of HIV/AIDS. That children lost one or both parents which exposed them to the risk of missing schooling or entering the labor market at an early age thus increasing the problem of child labor.

Most of the key informants held the view that tithes and offerings had drastically reduced because most of those who died due to HIV/AIDS related diseases were the rich in the Church who also held leadership positions hence leaving a leadership gap. They also reported that most people who were sick had stopped going to Church because either they were too weak to attend or either they feared stigmatization from the other members of the Church. They also argued that
Pastors were spending more time officiating burials instead of attending to their call hence not taking care of the other members of the Church accordingly.

4.3.3 The reaction of the Church to the effects of HIV/AIDS

The third objective of the study was to examine how the Church reacted to the effects of the disease and the specific achieved results. This section details the various efforts that had been put in place to manage the effects of HIV/AIDS.

4.3.3.1 Awareness of empowerment programmes for the infected and affected.

Figure 4.3: Level of awareness of empowerment programmes for the infected

The study established that majority of the respondents (85.5%) reported that their Church had empowerment programs for the affected persons, of the total number of those interviewed, 11.6% reported their Church did not have any empowerment program for affected persons while 2.9% said they had no knowledge about it as indicated in figure 4.3. Consequently, responses from the respondents and as collaborated by the key informants and Focus group discussion members revealed that the Church had put in place development programmes targeting the infected, widowed, orphans and vulnerable children.

The respondents noted that among the orphans and vulnerable children, two ABC community development programs were being implemented these are the Garden of Hope (GOH) and Catholic Relief Services (CRS). These programs were reported to offer 6+1 services that include:
ion, education, shelter, income generating activities like technical skills with tools. The program also supported education. Among the widowed the program supported capacity building through education and counseling.

Testing was encouraged and the development department liaised with the Ministry of Health and AIC testing and counseling centers for provision of counseling and testing services for widows, youths and the congregants in general. Widows were also encouraged to be self-reliant by forming support groups through which they could participate in Income Generating Activities. Among the infected the program came up with support groups which brought the infected and the affected together to share experiences. The program also encouraged them to come up with IGAs so as to support themselves.

4.3.3.2 Church collaboration with other stakeholders

The study found out that 87.1% of respondents indicated that their Church collaborated with other stakeholders in HIV/AIDS activities, 7.1% did not indicate whether any collaboration took place while 2.1% never knew about any collaborations as depicted in table 4.5.

**Table 4.5: Church collaboration with other stakeholders**

<table>
<thead>
<tr>
<th>Church collaboration</th>
<th>frequency</th>
<th>percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>It does not collaborate</td>
<td>10</td>
<td>7.1</td>
</tr>
<tr>
<td>It collaborates</td>
<td>122</td>
<td>87.1</td>
</tr>
<tr>
<td>I don't know</td>
<td>3</td>
<td>2.1</td>
</tr>
<tr>
<td>No response</td>
<td>5</td>
<td>3.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The key informants and the Focus group discussions further explained how the larger community was involved in HIV programs. Firstly schools and other Churches were involved. Secondly the
community days during which beneficiaries were offered healthcare and psychosocial support. Also they held August annual conferences for both men and women. In these conferences, both the ABC and non-ABC members are invited. Some of the issues discussed during these conferences are matters to do with HIV/AIDS awareness among others.

Further the Focus group discussions identified other stakeholders who the Church collaborated with, they included: Ministry of Health, Ministry of Education i.e. Schools, BIDII, NCCK, Catholic Relief Services, Canadian Baptist Ministry, Provincial administration, Churches-AIC, RGC, SA, KAG, Catholic, Supkem, Local Government and Ministry of Agriculture in economic empowerment.

4.3.3.3 Contribution of the Church in the control of HIV/AIDS

The study established that the Church contributed in the control of HIV/AIDS, 87.9% of respondents indicated the Church had made major contributions in regard while 7.1% indicated the Church had not made any contribution in the control of HIV as depicted in figure 4.4. The overwhelming awareness of the contribution of the Church in the control of HIV/AIDS shows that the congregants are aware of the HIV/AIDS programmes in place and are involved in one way or another. This clearly indicates that the Church congregants were aware of the programmes in place and that such projects were making an impact to the beneficiaries. It is also evident that the beneficiaries were involved in the implementation of the projects which would enhance sustainability of the projects.

Figure 4.4: Contribution of the Church in the control of HIV/AIDS

![Perception of the contribution of the Church in controlling HIV/AIDS](image-url)
and the focus group discussions identified several key contributions. Firstly ABC was supporting awareness of the collaboration with other stakeholders e.g. Donors, other Churches and relevant ministries. Secondly the Church had taken up the responsibility of educating the young generation to help in behaviour change and avoid risky behaviour. This was done in forums such as youth camps held every December in a program called Health Choices. Sensitizing the congregation to be tested for HIV and encouraging disclosure and seeking medication for those whose results turned positive in order to prolong their lifespan as well as getting counseling on living quality life.

Furthermore in an effort to control the scourge, the Development staff in the FGD session reported that the clergy had formed support groups where they encouraged the infected and affected to continue sharing experiences and adhere to ARVs up take. He further reported that seven support groups with 221 caregivers and 325 OVC were created. That the Church was able to reach out to over 1000 OVC in Kalama and Central divisions of Machakos. That ABC supported families affected by HIV/AIDS and who were incapacitated in catering for education, clothing and food.

4.3.3.4 Level of awareness of youth programmes in the Church.

Graph 4.4: Level of awareness of youth programmes in the Church

![Graph showing level of awareness of youth programmes run by the Church]

It was established through the study that the Church ran programs for the youth, 83.6% of the respondents reported that their Church had programs targeting the youth while 13.6% of
respondents did not report any youth program in their Church. 1.4% did not know about any youth program in their Church as shown in graph 4.4.

The key informant interviewed and also the focus group discussions identified several youth programs in the Churches. These included annual December youth camps where, the Church held youth camps every year during which resource people were engaged in addressing matters of HIV/AIDS to the youths. Secondly ABC’s Development Office had a project called ‘Healthy Choices’ that targeted youth in high school and tertiary institutions. The program was implemented in both ABC and non-ABC schools, with the adolescents of ages 10-17 years being taken through a curriculum for a month in a particular institution. The curriculum addressed sexuality, STIs, HIV and abstinence.

4.3.3.5 Results achieved by the ABC Church in managing HIV/AIDS

The study was also to identify results achieved by intervention programmes put in place by ABC Church. Archival research which involves inspection of original records showed that the ABC Church had been running three HIV/AIDS programmes. These programmes were Abstinence and being Faithful, Guardians of Hope and, Orphaned and vulnerable children (OVC). The objectives of the Guardian of Hope project was to build the capacity of guardians by economically empowering them and directly supporting orphans. The programme was able to create seven support groups with 221 caregivers and 325 OVC. Caregivers reached were widows, women and PLWA.

The objective of the OVC programme was to improve the wellbeing of over 1000 OVC in Kalama and Central Divisions of Machakos County. The programme provided several services namely: health, psychosocial support, food and nutrition, education support, child protection, shelter care, economic strengthening of the caregivers and older OVC. The objectives of the Abstinence and Being Faithful programme was to raise awareness on adolescent sexual risk practices, encourage good parenting practices and improve parent communication on sexual topics. The program was able to reach out to beneficiaries as shown in the table 4.6.
Achievements of Ablstinence and Being Faithful programme

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of People Reached/Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Families Matter</td>
<td></td>
</tr>
<tr>
<td>Year 1 (2010)</td>
<td>717</td>
</tr>
<tr>
<td>Year 2 (2011)</td>
<td>2400</td>
</tr>
<tr>
<td>Year 3 (2012)</td>
<td>5500</td>
</tr>
<tr>
<td>Year 4 (2013)</td>
<td>1440</td>
</tr>
<tr>
<td>2. Healthy choices</td>
<td></td>
</tr>
<tr>
<td>Year 1 (2011)</td>
<td>742</td>
</tr>
<tr>
<td>Year 2 (2012)</td>
<td>1280</td>
</tr>
<tr>
<td>Year 3 (2013)</td>
<td>3840</td>
</tr>
</tbody>
</table>

Source: The ABC Development report June 2013

4.3.4 Challenges faced by the Church in managing HIV/AIDS

The fourth objective of the study was to explore the challenges facing the Church in its effort to control the spread of HIV/AIDS.

Table 4.7: Challenges faced by the Church in managing HIV/AIDS

<table>
<thead>
<tr>
<th>Main shortcoming</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem of information flow</td>
<td>81</td>
<td>28.9</td>
</tr>
<tr>
<td>Inadequate finances</td>
<td>107</td>
<td>38.2</td>
</tr>
<tr>
<td>Problem of ownership of HIV/AIDS programmes</td>
<td>19</td>
<td>6.7</td>
</tr>
<tr>
<td>Stigma suffered by victims</td>
<td>40</td>
<td>14.2</td>
</tr>
<tr>
<td>Lack of qualified personnel within the Church</td>
<td>15</td>
<td>5.3</td>
</tr>
<tr>
<td>Lack of HIV/AIDS testing facilities</td>
<td>14</td>
<td>5.0</td>
</tr>
<tr>
<td>Wide diversity in terms of community and age</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Slow rate of initiative formulation</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>280</td>
<td>100</td>
</tr>
</tbody>
</table>
From table 4.7 above it was clear that the greatest challenge faced by ABC Church in the fight against HIV/AIDS was inadequate finances as cited by 38.2% of the respondents. This could be attributed to the large number of orphans and widows who needed support and lack of a sustainable economic empowerment programme to enable the affected and infected start income generating activities. This challenge was further echoed by the key informants and the HIV/AIDS Programme Officer who pointed out that the Church had a big challenge of funding its HIV/AIDS Programme. For example the Officer pointed out that the Department needed between 14 million to 18 million shillings to finance its HIV/AIDS Programmes for 2011 and 2012 financial year but only 7 million shillings was availed. This represented a severe funding deficit that limited the capacity of the Church in mitigating the effects of HIV/AIDS.

Another significant challenge which came up during the FGD session and echoed by 28.9% of the respondents was that of passing information especially to the youths. This could be due to conservative practices that did not encourage open discussions of sexuality issues especially among parents to their children and the parents assume that the teachers and pastors would carry on that responsibility and who eventually don’t discuss such sexuality issues. This leads to inadequate or wrong information being passed by peers.

Key informant interviews and the FGD revealed that stigmatization of the affected and infected was another major challenge that the Church was facing. This challenge was further compounded by 14.3% of the respondents. This existence of stigmatization showed that there was need for more awareness campaigns to educate the congregants. One key informant had these to say. ‘The affected and the infected are actually our own brothers and sisters biologically and in Christ and we should embrace them as our own. He further pointed out that he had lost close family members and that most households had lost their loved ones as well.

The ABC Field Officer pointed out that the project was able to reach out to only 2007 orphans and vulnerable children against an estimated 5,735 OVC in the study area. This represented a coverage of 35% which showed that almost 65% of OVC in the study lacked any support. This problem became bigger when the entire Machakos County was taken into consideration. The county had an estimated 15,000 OVC as at 2011 when they began the programme which placed
13.4%. This showed a coverage gap of 86.6%. He also reported that the ABC Church programmes were only able to support between 180 and 200 about 1,500 widows in the study area. This placed the coverage of widows at 13.3% which left out 86.7% of widows without any support. From this data it was clear that the ABC Church faced a huge challenge of reaching out to all those who needed support.

Despite the numerous awareness campaigns on HIV/AIDS the HIV prevalence rate in the county is still high at about 15% of the population. This figure could even be higher in urban areas especially those along the Mombasa highway. This could be an indication that awareness programs are not effectively delivering the message and there is a need to rethink awareness and behaviour change programs. The number of organizations working to reach orphans is very low as only the Redeemed Gospel Church and Pentecostal Church of East Africa are partnering with the ABC Church. From this observation it is clear the ABC Church lacks strong partnerships in the fight against HIV/AIDS.
5.1 Summary

This chapter focuses on the study summaries, conclusions and recommendations which are derived from the findings. This section presents the summaries which have been derived from the study; it provides a brief view of what was established from the discussed findings in chapter four. The demographic characteristics of the respondents pointed out that there was a fair selection of respondents among male and female respondents, while in terms of age of the respondents, majority of them were aged over 46 years this meant that they were mature enough to understand the subject under study.

In terms of marital status the majority of the respondents were married, as of the educational status, majority of the respondents interviewed had attained primary level. The occupation of most of the household respondents who were interviewed was that of gainful employment. Majority of the respondents were holding some key responsibilities /posts in the Church. Further the respondents were aware of the effects of HIV/AIDS and the dangers it poses, some of the effects mentioned included, loss of Church members, rising number of widows and widowers, diversion of Church resources for the purposes of managing the HIV/AIDS disease, decrease in tithes and offerings among others.

In recognizing the effects and the dangers posed by HIV/AIDS, the Church had developed programmes which targeted the infected, widowed, orphans and vulnerable children in order to assist them. While implementing these programmes, the Church collaborated with other partners and stakeholders so as to ensure effective and conclusive implementation.

5.2 Conclusions and Recommendations

This section provides the conclusions and recommendation which were drawn from the study findings in line with the study objectives.
5.2.1 To establish the awareness of the ABC Church on HIV/AIDS.

The members of the Church were aware of the disease and evident that most of the Church members were aware that HIV/AIDS was a national disaster which needed to be compounded from all fronts in an attempt to control it. Further they were also aware of some people who had died of the disease. The respondents named some of the factors which caused HIV/AIDS as Sexual immorality which they described as adultery and unfaithfulness, failure to adhere to Mother to Child prevention mechanisms in this regard they observed that some mothers were still in the state of self denial and thus failed to adhere to medication and instructions of breastfeeding thereby infecting their babies.

Lack of sex education particularly among the youths by their parents, the community, Church and teachers as well as poverty and desperation in pursuit of good life such as good shoes, phones, clothes, parties, etc, among young girls and boys make them give in to sexual engagement with older richer men and women. This kind of states of affair, left them with little power if any to negotiate for safer sex exposing them to risk of infection. Lack of distinctive symptoms associated with AIDS at initial stages was also a major cause since one cannot tell who is infected or not. This kind of scenario lead to high chances of people engaging in risky behavior with infected persons without knowing.

The study recommends that there is need for more open discussion on sexuality between parents and youth. Therefore programs that encourage this need to be put in place by the Church. This will promote behaviour change thus reduce the risk of infection. Sensitization programs on mother to child need to be put in place as it was observed some mothers were not putting into practice safety measures to protect children. Availability and affordability of female condoms was a challenge therefore the government and other partners need to roll out programs to overcome this problem.
In the study area as respondents reported there was a large number of vulnerable children, orphans and widows. OVC were not able to attend school while widows were not able to care for themselves and their dependants. Sickness had reduced the frequency of attending Church and the amount of money given to the Church. Death of Church members and leaders had placed the future of the Church in uncertainty.

The study recommends that support programs for OVC and widows need to be upscaled and delivered in a sustainable way especially economic empowerment. The Church also needs to sensitize its members on the importance of voluntary testing and counselling, and strictly adhering to good diet and medication for the sick.

5.2.3 To examine how the Church reacted to the effects of the disease and the specific achieved results.

Further the study aimed at examining whether there were any contributions made by the Church towards the control of HIV/AIDS. A conclusion could be made to the effect that the Church had made some contributions in prevention and control of the disease. Among the contributions made were that the Church had developed projects which targeted the infected, widowed, orphans and vulnerable children in order to assist them as well as provision of awareness services and psychosocial support for the infected and affected. Also support groups had been formed which encouraged the infected and affected to continue sharing experiences and continued to encourage each other on adherence of ARVs.

The study recommends further expansion of its programmes in order to achieve more results, to upscale its behaviour change programme and reach out to other demographic sections of the population besides the youth, orphans and the windows by coming up with tailor made behaviour change programmes for different sections of the population. The empowerment of widows and support of orphans needs more focus to ensure these vulnerable groups are well protected. Finally the Church needs to incorporate monitoring and evaluation activities in its programs.
5.2.4 To explore challenges facing the Church in its efforts to control the spread of HIV/AIDS.

It was clear that the greatest challenge faced by ABC Church in the fight against HIV/AIDS was inadequate finances as cited by 38.2% of the respondents. This could be attributed to the large number of orphans and widows who needed support and lack of a sustainable economic empowerment programme to enable the affected and infected start income generating activities. This challenge was further echoed by the key informants and the HIV/AIDS Programme Officer who pointed out that the Church had a big challenge of funding its HIV/AIDS Programme. For example the Officer pointed out that the Department needed between 14 million to 18 million shillings to finance its HIV/AIDS Programmes for 2011 and 2012 financial year but only 7 million shillings was availed. This represented a severe funding deficit that limited the capacity of the Church in mitigating the effects of HIV/AIDS.

The Church should develop viable strategic mechanisms of fundraising and especially collaborate with other stakeholders like the Government and International Organizations who fund organization to implement activities on their behalf at the community level. The Church should also develop home grown strategies to raise funds locally from their membership because this is the only sure way of ensuring sustainability of the programme even after funding bodies pull out.

5.3.5 Recommendations for further research.

This study recommends further research on the effectiveness of orphan and women empowerment programmes as well as a study of the effectiveness of the existing HIV/AIDS policy to establish whether it is enabling or stifling involvement of partners such as the Church in the control of HIV/AIDS.
REFERENCES


Magazines, News Papers and Electronic Sources


Church World Service, 2013.


Church leaders and AIDS. In Christian Voice. CPK Magazine, Issue


INTRODUCTION

Good morning/afternoon/evening?

My name is __________________________from ______________________ Am conducting an academic study on HIV/AIDS in your Church and I kindly ask if you can answer the following questions for me. The purpose of the study is to explore the role of your Church in HIV/AIDS control and it is my desire that this study will add value to your HIV/AIDS programme.

Section One: Demographic Characteristics

1. Name of respondent (optional)______________________________________________
   Religion /Denomination_______________________________________________________
   Date of Interview ______________________Place of Interview_______________________

2. Respondent sex. Male □ Female □

3. Age
   18-23 □ 30-35 □ 41-45 □
   24-29 □ 36-40 □ over 46 years □

4. Marital status?
   Married □ Separated □ Widowed □
   Single □ Divorce □

5. Do you have or have you had any responsibility/post in your Church set-up?
   Yes □ No □ If any specify? __________________________

6. Level of Education
   University □ Primary □
   Tertiary □ Not gone to school □
7. Occupation?
   Gainfully employed ☐ Hawking ☐
   Self employed/business ☐ Farming ☐
   Casual Laborer ☐ No occupation ☐

Section Two: Awareness of HIV/AIDS in the Church

8. Are you aware if HIV/AIDS is a national crisis?
   Yes ☐ No ☐

9. Do you know people in your Church who have died due to HIV/AIDS related illnesses or who are HIV positive?
   Yes ☐ No ☐ No response ☐

10. If yes to No. 9 above, what do you perceive to be the main cause of HIV/AIDS?
    Sexual immorality ☐
    Being unfaithful ☐
    Blood transfusion ☐
    Godâ€™s punishment ☐
    I donâ€™t know? ☐
    Others (state) ____________________________________________
Section Three: Effects of HIV/AIDS in the Church

12. Has HIV/AIDS affected your Church in any way?

Yes [ ] No [ ]

13. If yes to No. 12 above, how has it affected?

- Has made many congregates stop coming to Church [ ]
- Has affected the Church’s offering/contributions [ ]
- Has made the Church to have many HIV/AIDS orphans to care for [ ]
- The Church’s population is decreasing drastically due to deaths related to the disease [ ]
- It is making the Church to direct resources for other activities its programmes to address HIV/AIDS [ ]
- The image of the Church is tainted [ ]

Any other (specify)__________________________________________________________
14. Does your Church participate in control and prevention of HIV/AIDS?  
Yes [ ]  No [ ]  No Response [ ]

15. If yes to No. 14 above, what activities or programmes has your Church put in place in order to control and prevent HIV/AIDS?

- Opened VCT centers [ ]
- Enhanced its pastoral teachings to encompass HIV/AIDS teachings [ ]
- It has nutritional programmes for the infected [ ]
- Encourage adherence to ARVs [ ]
- It has established some Home Based care centers [ ]
- Involve the community in HIV/AIDS activities [ ]

Others (specify) __________________________________________________________

16. Do you have specific HIV/AIDS activities for the youths?
Yes [ ]  No [ ]  I donât know [ ]

17. If yes to No. 16 above, what are these activities?

- Creating awareness on the pandemic [ ]
- Established HIV/AIDS youth clubs [ ]
- Established HIV/AIDS theatre shows [ ]
- Encourage voluntary counseling and testing [ ]
- Peer group therapy [ ]
- Others, Specify__________________________________________________________
19. If yes to No. 18, how does it empower them?
   - Established support groups for information sharing
   - Encourage them to start income generating activities (IGA)
   - Advice them about the importance of VCT Centers
   - Financing them to meet their basic needs
   - Any other (specify) _______________________________________________________

20. Does your Church handle HIV/AIDS control alone or does it collaborate with others?
   - It does not collaborate
   - It collaborates with other stakeholders
   - I don't know

21. If the answer to No. 20 above is yes, what are the other stakeholders with whom you collaborate with?
   - Other Church organizations
   - Ministry of Health (MOH)
   - Non-Governmental Organizations (NGO)
   - Faith Based Organizations (FBOs)
   - Ministry of Education (MOE)
   - United Nations AIDS Control programme (UNAIDS)
   - National AIDS/STI Control programme (NASCOP)
   - Constituency AIDS Control Fund (CACC)
   - Others (specify) _______________________________________________________

Section Five: Achievements of the Church in the Attempt to Control HIV/AIDS

22. Has your Church contributed to the control of HIV/AIDS among its congregants?
   - Yes
   - No
   - No response
If the answer to No. 22 above is no, why?

- The Church leaders are not serious
- The Church is faced with many other challenges
- The Church has no capacity to handle the pandemic
- I don't know
- Others, Specify

Section Six: Challenges Faced By the Church in Managing HIV AIDS

24. What do you consider to be the main shortcomings/challenges of your Church in its effort to control HIV/AIDS? Please tick only two.

- Problem of information flow
- Inadequate finances
- Problem of ownership of HIV/AIDS programmes within the Church
- Stigma suffered by the victims/failing to open up
- Lack of qualified personnel within the Church
- Lack of HIV/AIDS testing facilities
- Wide diversities in terms of communities and age
- Slow rate of initiative formulation and implementations by the Church clergy/leaders
- Others, specify

Closing Remarks

Thank you very much for your time and cooperation, whatever was shared by yourself will be held in confidence and your names will not be featured anywhere.

Thank you.
1. Is the Church aware if HIV/AIDS is a national crisis? What role is the Church playing in its control and management?

2. What do you perceive/think to be causes of HIV/AIDS within your congregation?

3. Do you have some development programmes, which specifically address the problem of HIV/AIDS among the youth, OVC, windowed women and the infected? If yes, what are the programmes and what are their components?

4. In this programmes, do you involve the wider community? If yes, how?

5. Considering that HIV/AIDS requires a multi-sectoral approach, do you collaborate and network with other stakeholders/partners in this noble venture? If yes, with whom do you collaborate with?

6. Do you have an elaborate VCT strategy, and is it effective?

7. HIV/AIDS being a social phenomenal problem, has it had any effect within your Church? If yes, what are those effects?

8. What other interventions do you think your Church could put in place to enhance the control and management of HIV/AIDS?
APPENDIX C: FOCUS GROUP DISCUSSION GUIDE

1. What intervention programmes has the ABC Church put in place to manage the effects of HIV/AIDS?

2. Which people do these programmes target?

3. How have people responded to your efforts to manage HIV/AIDS?

4. What challenges have you faced in implementing HIV/AIDS programme?

5. What kind of support would you like to receive from the Church Leadership?

6. What achievements have you made in controlling HIV/AIDS?