

**EFFECTIVENESS OF PASTORAL CARE SERVICES IN PROMOTING
ACCEPTANCE OF PEOPLE LIVING WITH HIV/AIDS IN PEFA CHURCHES IN
KAJIADO COUNTY, KENYA**

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FOR THE AWARD OF MASTER OF ARTS DEGREE IN
RELIGIOUS STUDIES OF
MOUNT KENYA UNIVERSITY**

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DECLARATION AND APPROVAL

Declaration by student

This thesis is my original work and has not been presented for the award of any certificate in any other University.

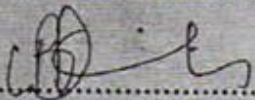
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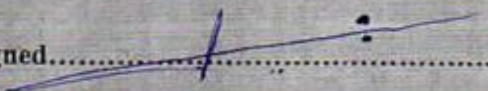
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DEDICATION

I dedicate this work to my lovely wife, my children, and parents.



ACKNOWLEDGEMENT

I wish to sincerely thank my dear supervisors, Dr. Regina Kinuthia and Dr. Simon Nderitu for your guidance throughout this work. I feel mentored, supported and all honor to you. I thank the entire Mount Kenya University and specifically the School of Social Sciences. Those meetings for defense and sharing of my idea were successful because of your support. To my peers, the walk was worth it. Asanteni sana.



LIST OF ABBREVIATIONS

AIDS	: Acquired Immune Deficiency Syndrome.
FBOs	: Faith Based Organizations
HIV	: Human Immunodeficiency Virus
HAAMC	: HIV/AIDs Affected Members of the Congregation
NACOSTI	: National Commission for Science, Technology, and Innovation
PLWHA	: People Living With HIV/AIDs
SPSS	: Statistical Package for Social Sciences
TPB	: Theory of Planned Behavior



ABSTRACT

Despite the role of the church in raising awareness about HIV/AIDS in Kenya, the prevalence remains high in most regions all over the country. Therefore, the main objective of this study was to assess the effectiveness of the pastoral care services on the acceptance of people living with HIV/AIDS in PEFA churches in Kajiado County. The specific objectives of the study were; to examine the biblical and theological foundations of pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya; to evaluate the effectiveness of information dissemination in promoting acceptance of PLWHA in PEFA churches; to examine the effectiveness of pastoral counseling in promoting acceptance of PLWHA in PEFA churches; to assess the strategies by church leadership of implementing pastoral care services in promoting acceptance of PLWHA in PEFA churches. Borrowing from previous literature, this study was guided by AIDS risk reduction Theory and The Theory of Planned Behavior. The study used a descriptive design. The target population was 10 pastors of PEFA churches, 30 PEFA church leaders and about 352 PLWHA in PEFA churches in Kajiado County. Stratified random sampling method was employed to obtain a sample of 190 respondents. Snowball sampling was employed to reach 150 members of PEFA church living with HIV/AIDS. Questionnaires and interview schedules were used for data collection. A sample of 10 respondents, that is 1 respondent per church, was used for pilot study. Content validity of the instrument was improved through expert judgment while Cronbach's alpha generated from internal consistency technique was used to ensure reliability of the research instruments. Data was cleaned and entered the Statistical Package for Social Sciences (SPSS Version 20) for analysis. Quantitative data generated in the study was analyzed by use of descriptive statistics such as means, standard deviation and frequency distribution. Data presentation was done using pie charts, bar charts and graphs, percentages and frequency tables. Qualitative data was qualitatively analyzed using content analysis based on analysis of meanings and implications emanating from respondents' information and comparing responses to documented data on pastoral care services influence on PLWHA. The study found that only fewer of PLWHA received support from their respective churches which contrast the biblical and theological requirements that the needy should be helped. The study also reported no significant relationship between information dissemination and acceptance of PLWHA in PEFA churches in Kajiado County, Kenya, $P(0.679) > 0.05$. However, information dissemination is positively correlated to acceptance of PLWHA. There is significant relationship between pastoral counselling and acceptance of PLWHA in PEFA churches in Kajiado County, Kenya. The key strategies used in pastoral care services included talking to church administrator, counselor, and other leaders, encouraging the PLWHA to be assertive and preaching to the church members to take care of the PLWHA. The results could be useful to the PEFA church leadership for guiding intervention programs related to pastoral care, with the dissemination of information, and addressing impediments in pastoral counseling towards acceptance of the PLWHA.

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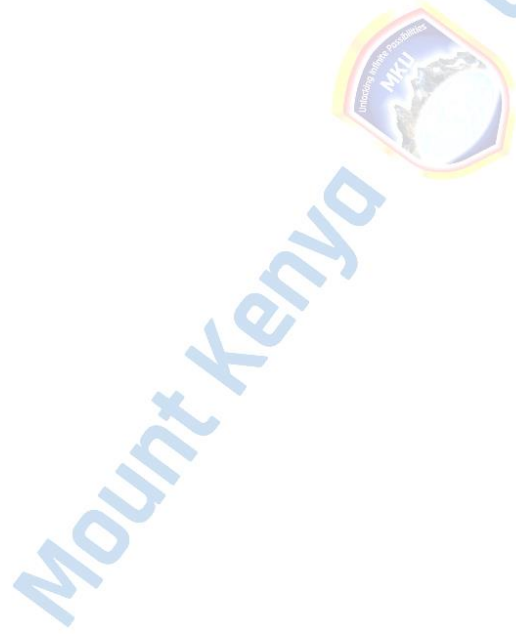
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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Roesin (1998) observes the religious institutions' potential in strengthening the national HIV/AIDS prevention and control programs. Kagimuet *al.* (1998) attributes the importance of religious institutions to the fact that religion is a strong ingredient of the national heritage in most countries all over the globe and that most religious leaders are highly regarded in the community. Thus, cooperation with religious leaders and use of their voice in getting to the population has great prospective in HIV/AIDS prevention and control programs, particularly in areas where access to accurate information is limited. However, the role played by religious organizations in combating HIV/AIDS so far has elicited mixed reactions. These perceptions are further argued out in Kejela (2002), who perceives that some religious institutions have stepped up their efforts concerning prevention and patient support and care in different parts of the world despite persisting stigmatization in faith-based institutions. On the other hand, Feiruz and Mirgissa (2000) criticizes religious organizations for their failure in rising to the challenge.

With the widespread disease in the USA, the role of the church for people living with HIV/AIDs cannot be underestimated. Research in the USA by Burke (2013) discloses that the country is less susceptible to external forces, such as the church, than other less developed nations. Despite this fact, it's not resistant to millions of its citizens being members of a certain religion and the strength of that religion's resources and non-profit, charitable institutions. For instance, the Catholic Church that launched the Catholic AIDS Network to take good care to patients with AIDS, their family members and those that are

important to them in the United States Nationally. As 2008 approached, as stated in Stahl (2008), Catholic Charities in USA had close to 1,600 agencies who give services to those suffering from AIDS, not forgetting services involving housing as well as mental health services. William *et. al.*, (2014), further outlines the of churches purpose in the prevention of HIV/AIDs for African Americans, the race with the most severe burden of HIV of all racial groups in America, as offering screening for HIV effects, interpreting Prevention of HIV as an Issue of a Social Justice, giving education to leaders of faith as well as members of the congregation, together with investigators and other HIV focused social institutions and Serving as a Network of Support for groups that are at a high risk.

The arrival of AIDs in Australia saw the sisters of Charity, a Catholic Based Organization, being the first to accept people that had the untraceable new disease (Sisters of Charity, 2012). Despite the negative perception regarding HIV/AIDs in Australia, Power (2011) states the importance of the church as the most remarkable thing about the fight against this stigmatization against HIV/AIDs patients in Australia. Power further states that the church movers and shakers came up with a stage extricate image of the public concerning HIV/AIDs from prejudice against homosexuals but to challenge the fear of homosexuals more in general. The church brought together all HIV responses that included relationships that were strategically fostered with concerned reporters and provided regular, reliable as well as information the is consistent concerning medical as well as scientific features of AIDs to them.

The Canadian AIDS Society (CAS) (2014) selected and took an approach to health that is holistic, insisting that physical, mental, emotional, and spiritual well-being in Canada, encompasses good health. By realizing that the HIV experience lived is mostly felt a lot

physically compared to socially, CAS commits itself to increasing equity, decreasing stigma as well as other factors that are socially affecting the epidemic by partnering together with FBOs. In recent years, CAS has seen rising interest in work concerning HIV from Communities of faith in Canada and organizations that are based on faith. In efforts to deal with the mark of infamy, discrimination, fear of homosexuality, and other issues of social justice affecting the HIV high occurrence in Canada, FBOs have developed diverse partnerships with different organizations interested to this situation for instance media and Organizations that are not owned by the government, to communicate openly the wants of the community of HIV/AIDS in Canada, and to find out ways to support those persons living with and also those affected by HIV/AIDS as well as the work of our organizations based on community.

With a population representing about 60%, Shahabudin (2012) confirms that Asia is a continent of many different people using many different languages and belonging to diverse lifestyles, faith and religions, living in a excess balance of political, economic and social situations. The extremely large difference in Asia leads generalization about HIV/AIDS to lack meaning because it blocks the gratitude of the specificity of the HIV spreading in the social context locally, and the sensitivity of culture that help strategies to be effective in one setting but of no use in another. For instance, a report by Global Health Council (2005) shows that India, the world's largest democracy in the number of people living with HIV/AIDSs and hosts about 80% of all people with the virus in south and East Asia is second to South Africa. The potential magnitude for this prevalence rate may be staggering for a country whose population is larger than that of Africa combined. In comparison to churches, health services are neither offered nor "personal" problems discussed by Hindu temples or

priests at all costs. Hence, in India, issues of faith-based organizations are yet to be made one within the care system of the patient who is infected with HIV or affected populations are likely to get to easily.

With the second highest AIDs prevalence globally, many Caribbean nations report growing epidemics. However, the complexity of the population structure in the Caribbean makes AIDs surveillance difficult. For instance, Trinidad & Tobago has about 104 groups that are religiously represented, thus differences in religion give a complicated social environment for the transmission of a disease that is sexual infection like HIV/AIDS. Religious leaders are regarded with respect in Trinidad & Tobago's society, and they can promote HIV/AIDS awareness, fight infamy mark, as well as discrimination, not forgetting to exercise compassion for people living with HIV/AIDS (PLWHA) by use of their position and time after time interaction. Some groups that are religious have commenced programs of HIV/AIDS education in their membership, but the studies before showed that in many religious organizations HIV/AIDS remains a stigmatized infection. A good example is that of 2001, when the Regional Ecumenical Organization of the Caribbean the, Caribbean Conference of Churches (CCC), brought 120 leaders of the church and workers of the church from across Trinidad & Tobago together in an act of consulting in order to raise consciousness about the fear, refusal, lack of money, discrimination and pain that PLWHA might come across in society of Trinidad's (Caribbean Conference of Churches, 2005).

Having the biggest HIV/AIDS epidemic all over the universe, the role of church in HIV/AIDS fight in South Africa as discussed by Dennis (2011) has been guided by the spirit of infinite love for all as well as their care. Union of South African churches invites the persons trained and ordained for religious service to come together in their pastoral program, all the persons

that live with and are affected by HIV. Some of the examples of the role of the church in the fight against HIV extreme spreading in South Africa include formation of FBOs that offer compassionate care for the people infected with HIV and be a shoulder to the orphaned and children that are really exposed to HIV. The FBOs give a response that is religious to HIV and work contrary to social disgrace as well as discrimination over them. Responses on religion come from the continuum of care, protection as well support, getting treated and rights, and their nature is holistic, attending to the visible dimension, social dimensions, emotional as well spiritual dimensions of the person in need. Their contribution to health and good lifestyle is great and, therefore, they fight both in material and spiritual ways against HIV/AIDS. In addition, Vitillo (2005) adds that the churches from South Africa have united to lobby for funds to support HIV programs offered by other organizations.

Development center and Activities of Population (2005) confirms a BBC 2004 survey that Nigerian people are very religious, it disclosed that an average Nigerian goes to a church, mosque, or other service that are religious regularly than other many nationalities. Thus, leaders of religion and those that have a relation with organizations based on faith have the difficult role of speaking out the truth and acting necessarily to reduce spreading and the hard times brought about by HIV in the most populous nation in Africa (www.worldatlas.com). By obtaining materials either locally or from ministries of health, NGOs, and other organizations, FBOs in Nigeria have been supporting the stoppage as well as care via the dispersion of information in local languages on HIV/AIDS (UNICEF, 2003). The church has also been giving a lot of love, care and a shoulder to lean on for people that are infected and also affected by the diseases that affect a large population. A good example of the actions been taken by the church is the action taken by the redeemed Christian church

of God which was Redeemed AIDS Program. Reduction in the spread and transmission of HIV/AIDS and sexually transmitted diseases is the vision that Nigeria was established with. They attain objectives via their religious discourse, writing books, acting, teaching, and giving advice. To add, institutions that belong to catholic are at the front line of care for PLWHA, as the Vatican approximates that they give 25% of all care provided to PLWHA in Nigeria. Whereas these are laudable efforts, Oluduro (2010) cites that they are also away from what is anticipated from the religious leaders in the face of the frightening a rise in the spread of the HIV in Nigeria.

Uganda, a nation which has experienced the most unbelievable decrease in infection rate of HIV has seen the main organizations that are religious (Catholic, Anglican and Muslim) become significant players in AIDs prevention. Working in together with the health ministry, WHO and other stakeholders, FBOs have been promoting “fidelity” and “abstinence” rather than condom use, an approach that is much sided with by President Museveni, who is credited with being the most activist African head of state in addressing the AIDS crisis. The Anglican Church of Uganda has also come up with special prevention programs aimed at young people, run in primary schools and Sunday schools. Green (2001) discusses that it is a fact that there are other groups other than FBOS that promote primary behavioral change, but them coming in between has actually helped advocate this approach in partnership with other groups, a lesson that Kenya can emulate.

Research of leaders of the church in Kenya by Campbell *et al.*, (2012) indicates that aids is now included in their teaching, affecting the attitudes of members of the church and coming up with chances for social spaces characterized with empathy and reflection. The church center, based in Kenya, and AIDS Global unites the community of religious people with the

main agenda declaring disgrace and disfavor the “enemy” and bring together people of faith to make a v program based on community that recognizes and also upholds persons that are HIV positive, accept them willingly into to the faith-based community as acting members and participants. Previous studies such as those of Kasomo (2012); Moswane (2013); Namukose (2010); Ochilloet *al.*, (2017) among others indicate the roles played by the religious communities in Kenya in the fight against AIDs. It is impossible to mention in this study all the theological directions and trends of different FBOs in Kenya towards the fight against AIDs. However, other than struggle to fight AIDs and the increasing consciousness of the disease by church, the widespread disease goes on to claim lives while putting heavy costs on the economy of Kenya. Campaigns for awareness creation have not grown the tempo required to turn back the spread and cushion the economy against the influence of the epidemic. Therefore, there should be a policy shift by FBOs to prevent early diagnosis, treatment, and social-economic support for those infected and affected from awareness campaigns. It is contrary to this background that this research sought to measure the effectiveness of pastoral care services on People that live with HIV/AIDs around Kenya, focusing specifically in PEFA churches in Kajiado County.

1.2 Statement of the Problem

In the fight against the AIDs scourge, there has been an increased participation by Faith Based Organizations (FBOs). Logically, the church participation on board in the struggle to do with HIV/AIDs needs no emphasis as the Church commands a strong following and influence in society. Thus, the Church should be considered to be the most stable and most widely dispersed stakeholder in the Country, with its own structures and systems which enable it to reach the common man in a persuasive way. While responding to the increase of

effects of HIV/AIDS on families and people, the Church has had HIV/AIDS initiatives in the country. With various outreach posts visited by HIV/AIDS specialists, the Church has in addition been using their church centers all over the county to discuss HIV/AIDS issues. Other FBOs focus on mobilization /sensitization on HIV/AIDS through mobilization and sensitization of the community and its leaders. The FBOs also coordinate HIV/AIDS-related training for community health workers and facilitate regular talks at outpatient care centers about Prevention of HIV/AIDS Transmission. Such interventions by the FBOs have raised awareness about the disease in Kajiado County. Despite the raised awareness, the prevalence trends and stigma index are worrying as statistics indicate that HIV/AIDS prevalence rates and stigma index have been on the rise. Therefore, this study tried to find out the pastoral care services effectiveness in promoting acceptance of people that live with HIV/AIDS in PEFA Churches in Kenya, Kajiado County.

1.3 Purpose of the Study

To assess the effectiveness of the pastoral care services in promoting acceptance for people living with HIV/AIDS in PEFA churches in Kajiado County, Kenya.

1.4 Objectives of the study

The study was guided by specific objectives to;

- i. Examine the biblical and theological foundations of pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya.
- ii. Evaluate the effectiveness of information dissemination in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya.
- iii. Examine the effectiveness of pastoral counseling in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya.

- iv. Assess the strategies by church leadership of implementing pastoral care services in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya.

1.5 Research Questions

The study was guided by the following research questions;

- i. What are the biblical and theological foundations of pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya?
- ii. What is the effectiveness of information dissemination in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya?
- iii. What is the effectiveness of pastoral counseling in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya?
- iv. What are the strategies used by church leadership in implementing pastoral care services to promote acceptance of PLWHA in PEFA churches in Kajiado County, Kenya?

1.6 Justification of the Study

Understanding the nature of pastoral care services and how they are informing society on the acceptance of PLWHA is essential for any society dimension. Moreover, the display of acceptance of PLWHA is perhaps the only measure of how much society has impacted on their wellness (Chaudhary & Madhuri, 2014). Through this study, the relationships between pastoral care services and acceptance of PLWHA will be exemplified regarding the perceived factors which include biblical foundations, dissemination of information and counselling services.

1.7 Significance of the Study

This research results will inform religious leaders and church administrators on ways of issues relating to the conduct of pastoral services that can positively influence the acceptance of PLWHA within society. The findings can also be of use to church programs developers, policy makers and researchers in religion with regard to the professional content that needs to include aspects that touch on the pastoral services and acceptance of the PLWHA. In addition, the PLWHA needs to learn about the willingness of the church to engage in programs and activities geared towards including them in societal undertakings.

In research areas, these research findings may account to the knowledge on pastoral care on people living with HIV/AIDS. The research is also going to be a source of reference materials for researchers who will be in future and students on topics that relate. Further, academicians will find these study findings useful in learning the role of pastoral counseling and caring for those people living with AIDS. Knowledge attained is, therefore, useful for purposes of professional teaching.

1.8 Scope of the Study

This research covered the concept with dimensions on pastoral care biblical and theological foundations, information dissemination, pastoral counseling and church strategies. The research's focal point was the three pastoral care aspects that influence acceptance of the PLWHA in Kajiado County. The study covered the PEFA churches in the County. The study also narrowed its target to the major stakeholders in the pastoral care services including pastors, youth leaders and church elders, The PLWHA sample was also included as they were the major focus of the acceptance problem in the church.

1.9 Delimitations of the Study

The research included only pastors, church leaders and PLWHA in PEFA Churches, Kajiado County, Kenya. This study's primary objective was to examine the function of pastoral care services in promoting acceptance of PLWHA in PEFA churches, Kajiado administrative region. AIDs risk reduction theory and planned behavior theory controlled this study. Although the people responding were chosen by the use of snowball method of taking samples, the study was confirmed only to the volunteered participants.

1.10 Limitations of the Study

Time period for data collection limited the study. This being academic work, data collection was scheduled to a period of two months. However, the effect of this on the study was reduced by setting aside full-time availability in data collection. Another significant study was the financial constraint throughout the research process. This effect was, however, minimized by narrowing down the scope to involve only the church leaders and the PLWHA. In some instances, there was a challenge of involving PLWHA due to stigma. The researcher minimized the effect of this limitation by assuring the participants of the importance of sharing their challenges as a way of informing strategies. Respondents were assured by the person conducting the study that the information they give would be confidential and that the results would be used for the purposes of studying only. And that in case they need results of the study, they would be availed to them on request.

1.11 Assumptions of the study

The research was found on the presumptions below:

- i. That partakers responded to the questions honestly and accurately. Otherwise, participants don't always answer questions honestly. Since partakers mostly answer what is desirable as per them.
- ii. That the information dissemination can promote acceptance of PLWHA in PEFA churches
- iii. That pastoral counseling promotes acceptance of PLWHA in PEFA churches.



1.12 Operational Definition of Terms

Acquired Immune Deficiency Syndrome (AIDs):

Many diseases brought about by virus that makes the body's ability to defend itself from infection weak, making the body to be prone to infections that are opportunistic (Anderson, De Mauro & Noonan, (2010).

Faith Based Organization:

A faith-based organization refers to an individual who come together because they have same belief and their efforts are pointed toward attaining the spiritual, social, physical and members psychological needs (community and Population Health, 1999).

Human Immunodeficiency Virus (HIV):

Human immunodeficiency virus that causes AIDs.

HIV stigma:

Disgrace aimed at HIV/AIDS victims in particular (Taylor, 2001).

Pastoral Care:

It's a task of caring related to individuals and communities for pastors, aiming at satisfying a need that has been brought about for instance healing need, sustaining need, need for guidance, reconciliation need, need to nurture, need to liberate, or empower (Dayringer, 2014).

Pastoral counseling:

Is a strategy in which individuals, couples, families, and groups are helped and led by the Bible and other pertinent information to make wise decisions about their circumstances in order to achieve wholeness and health (Mulinge, 2009).

Physical Needs: Physical needs include material, medical, and financial assistance (Joubert, 2011).

Psychological Support: This support assists to address behavioral and physical health concerns of eligible people living with HIV. Such services may include: counseling on bereavement; abuse of children and counseling on neglecting; groups supporting HIV; counseling on nutrition provided by a dietitian who is not registered; and/or pastoral care/counseling services (Silombe, 2013).

Social Needs: Need to be in relationship with others after the psychological needs and safety needs have been met (Maslow)



Mount Kenya University

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents the literature related to the study. It is pegged into the research objectives as well as the study problem. The chapter is presented in subsections starting with the biblical and theological foundations of pastoral care. The chapter then presents reviewed literature on effectiveness of information dissemination, influence of pastoral counseling and strategies for implanting pastoral care. Then it concludes with theoretical framework, and the conceptual framework. The research gaps and summary of literature ends the chapter.

2.1 Biblical and theological foundations of pastoral care

The roots of pastoral are deeply founded in biblical teachings. In addition, it is necessary to lay the foundation of theological care through the inspiration of the scripture, especially in today's post-Christian era where human life and the problems faced by humans rely heavily upon the language of the bible of sin, guilt and forgiveness. Thus, the bible has made sufficient and historical task in pastoral care field and counseling both in Old and New Testament.

2.1.1 Biblical and theological foundations of pastoral care in the Old Testament

While discussing the presence of pastoral care David (2000) states that there is no single theory in the Old Testament that tries to outline pastoral care. Generally, the goal of care in the Old Testament is that of restoration as well as relationship maintenance among people, between God and people as well as of people and universe. In addition, circumstances in which pastoral care may be given have been portrayed in countable essential views in scriptures. The Hebrews scriptures, for instance gives us God as our main character, a

thought from the bible that indicates existence of a active God in humanity matters in every aspect of life. The theocentric character defines humanity as acts of God, in the direction of people as well as whole of his creation, in love and kindness. God's biggest context of care for everyone and the whole universe comprises human care for one another. The biblical foundation of pastoral care is that of community and coming together but is not based on an individual. It is explicit in the bible that Israelites are related as persons not one person by God. It is also evident that Hebrews were told by God 'I was your God, and you were my people'. Thus, pastoral care even for individuals who are enduring sufferings is communal.

While defining care in the Old Testament, it is good to borrow from the ancient Hebrews who failed to draw difference, between the secular and religious, between physical and spiritual. According to them, they practiced care implying food for the hungry, gave comfort to the bereaved, justice to those that are oppressed, strangers and welcome among others. We are reminded not to make pastoral care spiritual, that is, taking care of their spirits while not considering needs that are physical. There should be affirmation and realization of what links freedom and justice search and pastoral care.

2.1.2 Biblical and theological foundations of pastoral care in the New Testament

Method of counselling provided by pastors manifested in New Testament as practiced by Jesus was that of holistic and inclusive pastoral care. In the gospels, images of Jesus are a clear manifestation of God's pastoral concern for someone and all that is made of him/her in terms of social, physical, and spiritual concern. Jesus is shown performing miracles such as curing the sick or impotence, relationship healing and declaring pardon of sins in the gospels. Jesus' ministry as evidenced in the New Testament was inclusive and treated everyone with dignity as well as with respect not leaving women and drew those rejected by

society such as sinners, those whose role was to collect tax and those that engaged in sex for payment. Mostly, evidence gives that Jesus' care other than reinstating a person to physical health, he also guided them to being accepted again in worship and social centers. Therefore, according to the New Testament, the aim of discipleship should be not to only deepen one's own relationship with God, even though this is key on its own, but it should also assist them in deepening their relationships within their community. Therefore, it is necessary to link the two aspects, one of making the relation with God to be deeper and also deepening individual relationship with other persons.

Mark 1:10, 12 highlights the story of the caring ministry. Jesus' ministry is portrayed as the Holy Spirit's work. Verse 11a portrays the ministry as messianic while 11b portrays it as servant hood. Jesus' teachings are said to be embodied in his healing work, where healing is depicted as a result of turning to God, via personal and social relationship. In the New Testament, emphasis in Mathew and Luke portrays pastoral motifs in many parables, for instance Luke 10: 25-37.

The understanding of pastoral care by Paul as a servant of Jesus Christ (Romans 1:1) is manifested through his pastoral counseling. He speaks of a father in Christ Jesus who admonishes and guides his beloved children. Galatians chapter 6 verse 2 says that to carry one another's burdens is to keep fully the law of Christ, clearly indicating that one is able to bear his own burden with the support from the community. The other new testament parts, Acts of the Apostles as well the letters in the bible, pastoral care is seen in two patterns. Experts existed to provide support socially and care while also ordinary care of Christians for others was there.

2.2 The effectiveness of information dissemination in promoting acceptance of PLWHA

Providing factual information regarding HIV transmission, according to Nyblade (2008), considerably lowers HIV stigma and disfavor. Complete understanding of how AIDS is not transferred results in a higher level of acceptance of those who live with HIV and the members of their families (Overt. Org, 2006). Research has shown that ignorance about HIV and misconceptions about transmission ways of HIV are basic elements adding to disgrace and disfavor. Even though the knowledge about HIV may be insufficient to decrease disgrace related to HIV, the wrong idea of getting affected with HIV infection through casual contact can lead to discrimination (Apinundecha, Cameron & Lim, 2007). In their assessment of HIV/AIDS stigma, Ogden and Nyblade (2005) looked at what factors were most likely to contribute to people's views of shame and identified four that were closely related to the development and presentation of stigmatizing notions, a preoccupation that has modes of transmission that are unlikely, and a relation of the disease that are as a result of immoral behaviors. Parker and Aggleton (2003) argues that responses to HIV/AIDS stigma need to have a number of ways not forgetting activities that are knowledge oriented for instance making information that is factual about HIV transmission as well as stigma available, strategies that are lawful and rights oriented, approaches of leadership and initiatives at the level of the community.

Ministers of the church need to employ training that are spiritual or sacred texts that are religious to stress care, healing as well giving a shoulder to those that live with AIDS. Working different leaders that are religious, coalitions based on faith and leaders of the community to look at or beliefs that are same, teachings that are spiritual and morally right,

legal and societal norms that support the defense of HIV and ease the suffering of AIDS patients. Working together can make it easier to develop common theological principles and emphasize ethics. Using AIDS barriers spiritual growth opportunity, have compassion for others, give a shoulder to lean on to those that are living as well as those dying, and to give thanks for the life gift.

It is important to teach young people about sexuality, reproductive health, and sexual health so they may understand how their bodies function and make informed decisions about their behavior. A lot of proofs show that the more informed the youth are concerning sexuality and sexual behavior that is responsible, chances are that they will take time to engage in sexual relations or they will take protection if at all they are involved in such relations. Therefore, it is important that guidance be given to young people as well as advice before they become active sexually on HIV/AIDS. They ought to know how HIV is transmitted, dangers and how to stop HIV, available choices for them, in addition to evacuation of the relations that sex based before marriage, social-economic pressures which lead girls exposed to sex that is not wanted or safe, on places to find counselling that is for self-will and HIV testing., how to prevent infections, compassion, support and treatment medically for infected people. To do with their HIV/AIDS rights as well as duties in such circumstances. Talking about HIV/AIDS as well as stress to parents so that they can be the first ones to give protection to their daughters and sons. It is good to advice and help them to speak about sex activities to sons and daughters belonging to them, values that are positive and responsibility individually. Youth organizations that are religious are necessary to speak to the youth themselves together with those living with HIV including those that are exposed to the virus – on their hope and concern, leading to values discussions that are open, sexual purity as

well as relationships that are healthy. Address groups that are interested with youth, for instance health and social workers and also teachers. (Chitando, Ezra 2009).

Lives can be saved by clear and accurate information about HIV/AIDS. Even though there will be reactions that are invariable specific phrases or words. The meaning can be understood without offending anyone. For example, while most people find the word "sex" offensive, phrases like "sexual relations" or "human sexuality" may be acceptable. Supposing leaders that are religious bring themselves to talk without any closures and telling the truth about a topic that is hard to speak about, others too can.

2.3 Influence of Pastoral Counseling on HIV/AIDS Stigma

For people affected by HIV or those that live with it, it is important that they are counseled and given other psychological support. This aids in developing a positive attitude, dealing effectively with the virus, or caring for the afflicted family. Anything done to aid the immune system get along with the HIV virus so as to have a good and productive life is positive living. One should not give up on lying when they are diagnosed to be HIV positive. Despite there being modifications to be made and matters that are practical to be worked on, there is a need to aid those people that are affected by HIV/AIDS on how to handle themselves in advance before they are not well to do so. Encouragement for them to keep on doing work as long as possible is necessary. They should keep and not cancel dreams and aspire to do all things they enjoy as they do and not to do away with their dreams and aspiration. There should never be a factor like loneliness; supportive partners may still be found. An ordained pastor or church minister is not the only one who can provide pastoral counseling. Any church member who is working to restore others to the welfare of their emotions, bodies, and spirits can carry out that function (Waruta & Hannah, 2000).

The church must address the issue of secrecy through pastoral counseling. In decreasing the experience of disgrace and disowner relating to AIDS, in order to increase the number of people seeking treatment for HIV/AIDS as well as voluntary testing, anonymity must be ensured (Star Smith, 2008). Confidentiality can be compromised by rumors, discussions among friends and family, and other means. It can also be compromised by seemingly unimportant requirements, such as the need that health service bills to be delivered to the place of employment of a person undergoing HIV/AIDS testing. Churches should support an environment where people can talk about HIV/AIDS openly and without fear, as well as share their personal experiences with the disease. Openness about HIV status not only cause increase in opportunities for support and care, accepting a HIV diagnosis which includes opening up to both members of the family as well as allies in regard to an individual's HIV status leads to personal growth (UNAIDS, 2011). It may be traumatic to disclose one's HIV status.

The church must assist HIV positive individuals in getting ready for it because it relies on how committed and courageous they are. According to statistics, HIV/AIDS positive individuals who are upfront about their status tend to live longer (UNAIDS, 2011). People with lower disease resistance who try to carry their own burdens and keep their status private are likely to pass away sooner.

2.4 Strategies by church leadership of implementing pastoral care services in promoting acceptance of PLWHA

People who have HIV/AIDS directly experience factors that expose individuals and communities to the virus, illnesses associated with it, and treatment options. So as for relevance to be improved, acceptability and the strategies effectiveness employed by church,

it would be necessary to include them in development of programs and policy implementation as well as making. Parry (2008) states that success is inevitable when communities are engaged in ensuring their health proactively. The need for people living with HIV/AIDS to be involved is becoming increasingly critical as nations gauge their progress toward the goal of prevention through universal access to care, treatment, and support services (USAID, 2010). At the personal level, self-esteem can be improved, and morale boosted, isolation as well as depression is reduced, and health is improved through availability of information that is better on care and prevention. In businesses, the people living with HIV/AIDS participation is able to alter change vision, as well as provide experiences that are valuable and knowledgeable. At social and community levels, people living with HIV/AIDS can be courageous if publicly involved, by displaying the faces of people living with HIV/AIDS and demonstrating that they are part of society who are useful and contribute to it. The church has to develop a seminar and workshop schedule where topics like HIV/AIDS, shame, and bigotry can be discussed. The PLHWA would have the chance to discuss their experiences, difficulties, and recommendations for the overall benefit of the body of Christ.

Gulaid (2010) asserts that in order to provide all of the requirements of people living with HIV/AIDS, many agencies must work together. For live engagement enabling those people living with AIDS, communities that are religious as well as other actors have made sure that those people that are living with HIV/AIDS are given space and practically supported for their rise and involvement with meaning. PLWHA are actually stigma objects and are thus very much exposed to the dread of being disgraced or being rejected. Such may be expressed via denial feelings, dread, guiltiness, depression, withdrawal, hopelessness, as well as

ineffectiveness, and can lead to suicidal thoughts and deeds. 'Felt' disgrace as well as rejection may not necessarily directly relate to initial levels of disgrace and rejection in the community that is broad. According to Malcolm, Aggleton, Bronfman, Galvao, Mane & Verral (1998), stigma fear among PLWHA prevents them from accessing HIV/AIDS support services such as voluntary counseling and testing (VCT) and other types of services. Disclosure phobia may be included, judgmental attitudes of health workers phobia, as well as confidentiality fears. Note should be taken that stigma phobia crosses with other processes that are psychological to do with infection of HIV. PLWHA as well subjected to the processes of identity which include constructions of 'the other's both negative and positive, and therefore PLWHA may stigmatize other people who live with the virus.

There is importance of involving HIV/AIDS positive persons how to prevent and care, theological debates as well as spiritual outreach as a means of accepting and improving their decency of theirs (Igo Robert, 2008). The main goal should be to instill optimism in people. Religious leaders can support those who are HIV/AIDS positive in living long, meaningful lives that are also dignified lives. They therefore can make people ready to face death – also give a shoulder for them to lean on for the family and friends surviving when it's the right time (Religions for Peace. 2007).

2.5 Theoretical Framework

2.5.1 AIDS risk reduction Theory

The development of reduction of risks of AID theory took place in 1990. Joseph Katania was the theory developer, Susan Kegeles together with Thomas Coates. The social cognitive theory and the diffusion of innovation theory, Health belief model are the constructs from the health belief model that are used in this AIDS risk reduction theory; for the purpose of

expounding the ways which people (or groups) go through as they change behavior pertaining risks of HIV. The model 3 stages are identified to be involved in reduction of HIV transmission risk, including: Behavior marking, change commitments and acting.

At stage one, HIV transmission knowledge, HIV susceptibility perceived, as well as unpleasant stimulus emotions affect how humans see AIDS. Four factors shape the stage of commitment: enjoyment perceptions, social norms, self-efficacy as well as emotions that are aversive. Catania *et al.*, (1990) lists emotions that are aversive, communication pertaining to sexuality, how to seek behavior as well as social elements alter the process of making decisions for people the last stages (Catania *et al.*, 1990).

To this study, the theory is relevant as church programs was assumed to be using the model of AIDS risk reduction focusing on: customers assessment risk, affecting the reduction of risk decision via enjoyment perceptions or self-efficacy and support from clients to enact the transition (condoms access, social help).

2.5.2 The Theory of Planned Behavior (TPB)

The planned behavior theory proposed by Ajzen (1991) adds perceived influence over behaviour (PBC) to the reasoned action theory, so as contribute for elements away from control volitional of a person which can alter their behavior or intention. The idea that performance is determined by behavior via motivation (intention) and ability was the base of the extension (behavioral control). According to Montano & Kasprzyk (2002), saw control of behavior is the same as Bandura's self-efficacy concept, which means belief of an individual in his/her performance ability to a particular behavior under many circumstances. As per planned behavior theory, behavioral control that is perceived is concluded by beliefs of control that has to do with facilitators and behavioral performance barriers availability or

non-availability, measured by the power perceived every factor input to create room for or behavior inhibiting. Thus, the highest perceived control is with that person who holds strong beliefs on control about elements facilitating behavior, meaning a rise in performance of the behavior intention (Ajzen, 1991; Montano & Kasprzyk, 2002). Planned behavior theory was considered for this study because it was discovered to be a good HIV/AIDS predictor on health behavior compared to other theories (Fishbein, 1993; Terry, Gallois & McCamish, 1993; Warwick *et al.*, 1993). The research used was mainly conducted in North America and Europe, thus the need to try the theories relevance to the context of South Africa. Wellbeing behavior- behavior of preventing AIDS in this study processing of the information available by an individual, a decision on action to be taken after consequences reflection of the behavior performance and his/her beliefs on what is expected of him or her by other people. The people under study have been familiar with enough information on HIV/AIDS and how to prevent it. It is important to change behavior. Since beliefs and attitudes are shown to be important in choice of action by people, the theory of organized behavior concerns change in behavior. For ease of application in this study it was assumed that it will be possible to change behavior if attitudes of people towards specific AIDS-preventive-behaviors are shaped in particular ways and their expectation beliefs of their significant others are reinforced. Jokonya (2015) criticizes TPB by arguing that it excludes habits and emotions as moderator variables of constructs and lack of knowledge of relationships between determinants predictors.

2.6 Conceptual Framework

The study assumed a conceptual framework that has pastoral care activities being taken as the independent variable and the effectiveness of the pastoral care activities in promoting acceptance of PLWHA as the dependent variable.



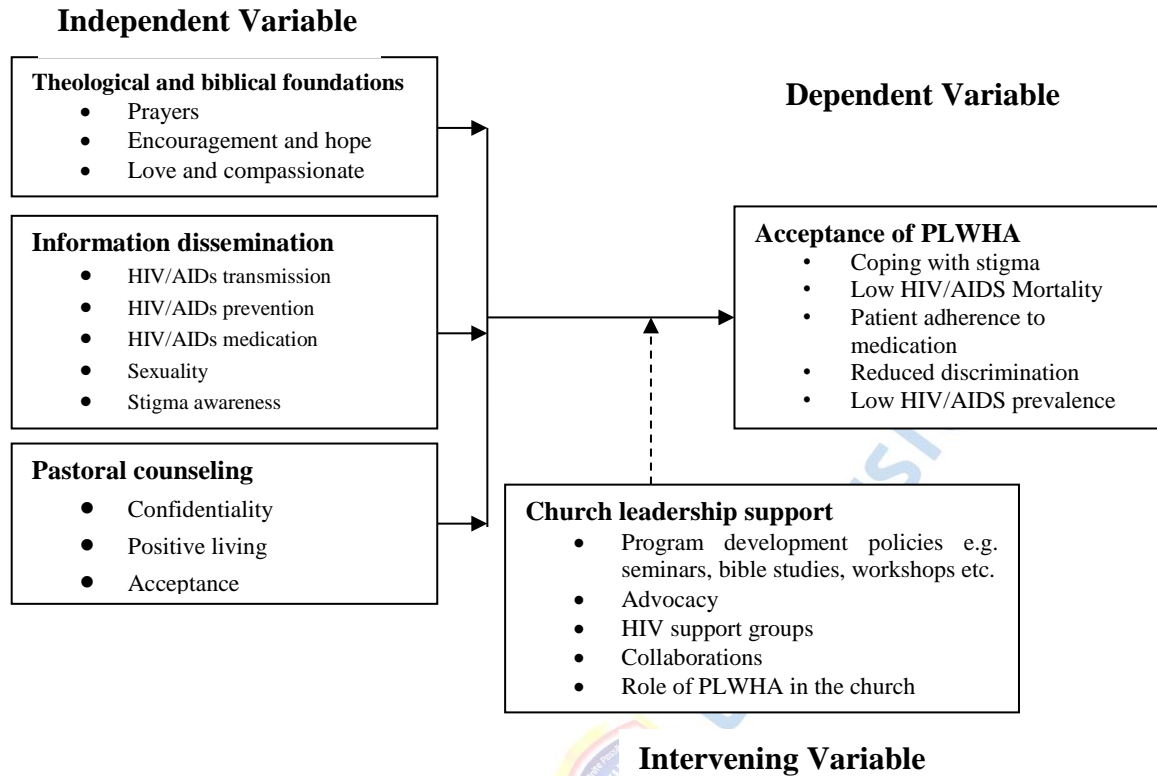


Figure 1: Conceptual Framework

The researcher looks at three variables that promote acceptance of PLWHA; biblical and theological foundations, information dissemination and pastoral counseling as the independent variable. When the church offers the right information about HIV/AIDs to the community, they are able practice safe sex, which in turn lowers prevalence rates. The involvement by the church in stigma awareness may result in reduced discrimination. On the other hand, the researcher assumes that pastoral counseling to HIV/AIDs patients and other affected members lowers HIV mortality and enables them to cope with stigma.

2.7 Research Gaps

While the reviewed literature provides a robust foundation for understanding the biblical and theological underpinnings of pastoral care, several gaps remain relevant to the study's focus

on promoting acceptance of people living with HIV/AIDS (PLWHA) in PEFA churches in Kajiado County, Kenya. First, there is limited research on how Old and New Testament teachings are contextualized in African Pentecostal settings, particularly among the Maasai-dominated communities in Kajiado, to address HIV/AIDS stigma. Second, the effectiveness of information dissemination strategies, such as sermons or workshops, lacks empirical evidence specific to PEFA churches, with most studies focusing on general populations rather than faith-based contexts. Third, while pastoral counseling is recognized as vital, there is insufficient data on its practical implementation and impact in reducing HIV/AIDS stigma within Kenyan Pentecostal churches. Finally, the literature does not adequately explore the specific strategies employed by PEFA church leadership to integrate PLWHA into community activities, nor their effectiveness in fostering acceptance in a culturally sensitive manner. These gaps highlight the need for localized, church-specific research to inform effective pastoral care interventions for PLWHA.

2.8 Summary of Literature

The literature review explores the biblical, theological, and practical dimensions of pastoral care in promoting acceptance of people living with HIV/AIDS (PLWHA), with a focus on its potential application in PEFA churches in Kajiado County, Kenya.

Pastoral care is deeply rooted in biblical teachings emphasizing restoration, community, and holistic care. In the Old Testament, care is theocentric, focusing on God's love for humanity and communal relationships, as seen in the Hebrews' view of God as their protector (David, 2000). It integrates physical and spiritual needs, advocating justice and support for the marginalized. The New Testament portrays Jesus' ministry as inclusive, healing the sick, and reintegrating outcasts, emphasizing dignity and community (Mark 1:10, 12; Luke 10:25-

37). Paul's teachings further highlight communal support, urging believers to bear each other's burdens (Galatians 6:2).

Effective dissemination of accurate HIV/AIDS information reduces stigma by addressing misconceptions about transmission (Nyblade, 2008; Ogden & Nyblade, 2005). Church leaders can leverage spiritual teachings to promote compassion and acceptance, while educating youth on sexual health is critical for prevention (Chitando, 2009). Culturally sensitive language, such as "sexual relations" instead of "sex," enhances communication without offense.

Counseling supports PLWHA in positive living and coping with stigma, fostering openness about HIV status, which correlates with longer life expectancy (UNAIDS, 2011). Churches must ensure confidentiality to encourage voluntary testing and reduce secrecy-related stigma (Star Smith, 2008). Counseling extends beyond ordained pastors to trained church members (Waruta & Hannah, 2000).

Involving PLWHA in program development enhances relevance and reduces isolation (Parry, 2008; USAID, 2010). Support groups, workshops, and income-generating activities, as exemplified by the Kaaga Synod, foster acceptance and dignity (Gulaid, 2010; Kaaga Annual Synod Minutes, 2011). However, stigma-related fears, including disclosure phobia, remain barriers (Malcolm et al., 1998). This literature underscores the potential of biblically grounded pastoral care to combat HIV/AIDS stigma, but localized strategies are needed for effective implementation in PEFA churches.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the methods used to conduct the study. The methods are presented systematically starting with the research design and location of the study. The section then shows the target population, sampling, instrumentation and data analysis. It ends with the ethical considerations observed in the research.

3.1 Research Design

The research employed descriptive design. Kothari (2007) has it that large numbers and describes population characteristics by the selection of unbiased sample are involved in Descriptive design (Kothari, 2007). According to Mugenda & Mugenda (2003), descriptive studies are more formalized and frequently have well-structured hypotheses or research questions. This design of research aimed at obtaining information that describing existing phenomena via individuals questioning their attitude, implementations, values or behavior.

3.2 Location of the Study

This study was conducted in Kajiado County, Kenya, specifically within the Pentecostal Evangelical Fellowship of Africa (PEFA) churches. Kajiado County, located in the southern part of Kenya, borders Nairobi and extends to the Tanzanian border. It is predominantly inhabited by the Maasai community, with a mix of other ethnic groups, and is characterized by a semi-arid climate and pastoralist livelihoods. The county's socio-cultural context, including traditional beliefs and practices, influences attitudes toward people living with HIV/AIDS (PLWHA). PEFA churches in Kajiado County were selected due to their active role in community welfare and spiritual guidance, making them suitable for assessing

pastoral care services. The study focused on multiple PEFA church congregations across urban and rural areas of the county to capture diverse perspectives on the effectiveness of pastoral care in promoting acceptance of PLWHA, ensuring a comprehensive understanding of the local context.

3.3 Target Population

According to Bryman (2012), target population is the entire study of a real or fictitious group of individuals, occasions, or items that the person doing the investigation hopes will yield a universally applicable conclusion. The study used 10 PEFA churches in Kajiado County, Kenya. In the 10 churches, the study focused on 1 pastor per church and 3 church leaders per church. The study also used PLWHA attending the 10 PEFA churches in Kajiado County which the researcher assumed to be about 4% of the total church population of 7800. The assumption follows national government of Kenya (GoK) (2009) statistics that states that 4% of Kajiado's total population are PLWHA. Thus, PLWHA are about 312 in in PEFA churches in Kajiado County. In addition, there are about 10 HIV/AIDS Affected Members of the Congregation (HAAMC) in each church, making up to approximately 100 persons. Therefore, the study's target population consisted of 312 PLWHA in PEFA churches in Kajiado County, 30 church leaders, and 10 pastors or priests. Table 1 below shows target population.

Table 1: Target Population

Sector (Strums)	Count	Percentage
Church pastors	10	2.21
Church leaders	30	6.64

PLWHA	312	69.03
HAAMC	100	22.12
Total	452	100.00

Source: Author (2018)

3.4 Sample size and Sampling Method

3.4.1 Sample size

As stated by Cooper & Schindler (2003) the sum of entities in a given subset of a chosen population for analysis is a sample size. Using Krejcie and Morgan (1987) sampling tables, a population of the PLWHA at 452 gave 255 sample size. Owing to the small size of the target pastors and church leaders, the study purposively included all of them in the sample. Thus, the sample consisted of 10 pastors, 30 church leaders, 150 PLWHA and 65 who were attending PEFA churches in Kajiado County. The sample size selected is as shown in Table 2.

Table 2: Sample Size

Sector (Strums)	Sample size	Percentage
Church pastors	10	3.92
Church leaders	30	11.76

PLWHA	150	58.82
HAAMC	65	25.49
Total	255	100.00

Source: Author (2018)

3.4.2 Sampling Method

Groves (2010) defines sampling as a technique for selecting a subset of individuals from a statistical population to infer characteristics of the entire group, enabling researchers to study large populations efficiently. Cooper and Schindler (2011) emphasize the practicality of sampling when examining an entire population is logistically or financially unfeasible, such as in studies requiring extensive resources or access to diverse groups. This study utilized snowball sampling to select its sample, a method suited to its research context.

Snowball sampling, a non-probability sampling technique, is particularly effective for accessing hidden or hard-to-reach populations, such as drug users, commercial sex workers, or people living with HIV/AIDS. These groups are often difficult to identify due to social stigma, privacy concerns, or lack of a clear sampling frame. The method begins with a few initial participants who meet the study criteria and relies on them to refer other eligible individuals, creating a chain of referrals that expands the sample. This approach leverages existing social networks to locate respondents who might otherwise be inaccessible. However, snowball sampling has limitations, as it does not use a predefined sampling frame, leading to potential biases. The sample may over-represent certain subgroups or exclude others, reducing its representativeness of the broader population and affecting the generalizability of findings. For instance, the most likely respondents to be recruited into the

sample are those who have many links (Katz, 2006). The study employed snowball sampling in order to reach out to 150 HIV/AIDS patients attending the 10 PEFA churches in Kajiado County. In addition, purposive sampling was used to reach out to 10 pastors and 30 church leaders working with HIV/AIDS patients and programmes in PEFA churches in Kajiado County.

3.5 Data Collection Instruments

3.5.1 Questionnaires for PLWHA

Questionnaires were used to collect the data for this study. The questionnaires were made to give answers to questions under research as well as objectives. They were meant for the collection of data from the PLWHA. The ideal instrument in survey studies for collection of data is questionnaires (Saunders, 2009). The questionnaires entailed both structured and semi-structured items. The structured items were meant to generate quantitative data where they were designed with mutually exclusive and exhaustive considerations. For the semi-structured items, the respondents were required to give further information that they felt was not captured in the former test items.

3.5.2 Interview schedules for Pastors and church leaders

In-depth interview schedules were constructed for the church pastors and leaders since they were small. The interview items were designed in as per objectives of the research to maintain themes of the study consistency. The interview schedules were intended at generating qualitative data from the pastors and church leaders.

3.5.3 Data Collection Procedure

The researcher requested permission from mainstream churches and organizations handling PLWHA in PEFA Churches, Kajiado County, in a letter after receiving an introduction from

the university and a research permit from the National Commission for Technology, Science, and Innovation. The questionnaires for the survey were self-administered by the researcher after obtaining authorization, with assistance from the individual conducting the research and helpers. Each questionnaire was accompanied by a cover letter that informed the respondent in question of the study's objectives.

3.6 Pilot Testing

The pilot test helps to determine whether there are flows, disadvantages or other parts that are not strong in the design of the interview and gives room for revisions that are necessary prior to the study implementations. Sekaran & Bougie (2009) shows that pilot test is required for examining the degree to which the instruments can be relied as well as study validity. 10 respondents, that is 1 respondent per church, was used for pilot study as suggested by Mugenda & Mugenda (2003). The people giving response were selected from a sample that has similar characteristics with those in research.

3.7 Validity and Reliability of Data Collection Instruments

3.7.1 Validity

Validity means the issue of either a devised indicator or one that is not devised (or set of indicators) to do concept gauging really weighs that concept Bryman & Bell, (2011). In this research, content validity was adopted. Through expert judgment an instrument Content validity is improved. For validity of content, there was subjection of questionnaires to supervisors so that assessment can be done to know if every question of measurement in the questionnaire is important, can be used or necessary. Evaluation of each response from each panelist was, and values that met statistical significance were retained. (Cooper & Schindler, 2011).

3.7.2 Reliability

Reliability is defined by Bryman (2012) as the continuity concept measure (Bryman, 2012). On the other hand, Kothari (2009) stated that if an instrument for measure provides results that are consisted of its reliability is good. Cronbach's alpha (α) extracted from internal technique of consistency was used to make sure that there is a good internal consistency that is reasonable of the items as well as weigh the same underlying construct consistently. Cronbach's alpha (α), outlined by Sushil and Verma (2010), is a statistical measure, varying from 0 to 1, that evaluates a test's internal consistency or homogeneity, indicating how effectively items assess the same concept. A higher alpha reflects stronger item correlations, ensuring dependable measurement. Bryman (2012) notes that a reliability coefficient of 0.7 is widely regarded as the standard for acceptable internal reliability, acting as a common guideline in research. This threshold confirms that test items are adequately interconnected, instilling confidence in the stability of results across multiple applications, which is essential for validating scales in social science research.

3.7.3 Questionnaire Reliability Analysis

To ensure the reliability of research instruments before collecting actual data, a pilot study was conducted. This preliminary testing phase involved administering the questionnaire to a small group of people living with HIV/AIDS (PLWHA) to evaluate its effectiveness. Following the pilot, the internal consistency of the questionnaire was assessed using Cronbach's alpha (α), a statistical coefficient ranging from 0 to 1, as described by Sushil and Verma (2010). This measure evaluates the homogeneity of a test by examining the correlation among its items, indicating how well they measure the same underlying construct. A higher alpha signifies stronger item interrelations, reflecting a reliable

instrument. The Cronbach's alpha value was calculated using the Statistical Package for the Social Sciences (SPSS), a widely used software for statistical analysis. This process ensured that the questionnaire was robust and consistent, minimizing errors and enhancing the validity of data collected from PLWHA respondents in the main study, thereby strengthening the overall research quality. Reliability coefficient of 0.7 was typically employed as the thumb rule to show the level of acceptance of internal reliability (Bryman, 2012). Results were tabulated and presented in Tables 3 and 4.

Table 3: Case Processing Summary

		N	%
Cases	Valid	10	100.0
	Excluded ^a	0	.0
	Total	10	100.0

a. Listwise deletion based on all variables in the procedure

Table 3 above gives the case processing short forms of the reliability test of the questionnaire. N shows that there were 10 valid data while the missing data is zero (0) with percentages 100.0 and .0 respectively. This implied that all the data collected during the pilot involving the 10 sampled respondents in the process was processed.

Table 4: Reliability Statistics

Cronbach's Alpha	Number of Items
0.785	10

Table 4 gives the obtained Cronbach's Alpha, $\alpha=0.785$. Compared to the threshold value of 0.7 for acceptable level of internal reliability, there was high reliability in the questionnaire. This allowed the use of the questionnaire in the actual study.

3.8 Data Analysis and Presentation

The field data collected for the study underwent meticulous processing to ensure accuracy and readiness for analysis. This involved cleaning the data to remove errors, coding it for systematic categorization, and entering it into a computer using SPSS 22.0, the Statistical Package for the Social Sciences. Martin and Acuna (2002) highlight SPSS's capability to handle large datasets efficiently while providing an extensive array of statistical tools designed specifically for social science research, making it ideal for this study's needs. The research generated both quantitative and qualitative data, reflecting a mixed-methods approach to capture diverse perspectives. Quantitative data was analyzed using descriptive statistics, which, according to Mugenda and Mugenda (2003), enable researchers to concisely summarize and characterize score distributions or measurements using a few key indices. In this study, descriptive statistics, specifically percentages and frequencies, were employed to present the findings in a clear and meaningful manner. This approach facilitated an accessible interpretation of the data, allowing patterns and trends to emerge, which were critical for addressing the study's objectives, such as evaluating pastoral care services' effectiveness in promoting acceptance of PLWHA in PEFA churches in Kajiado County.

Analysis, that is Qualitative, considered the conclusions that were made from the respondents' opinions. Information that qualitative was qualitatively resolved by use of content analysis based on meanings analysis as well as respondents implied' data and checking responses against data that is documented on pastoral care services influence on

PLWHA. Thematic staging of the qualitative data was done in accordance with the study's goals.

3.9 Ethical Considerations

The person conducting the study sought University permission, Science, Technology and Innovation National Commission for (NACOSTI) and PEFA church Administration so as for the study to be conducted. The researcher also sought the respondents' informed consent prior to distribution of the questions and conducting of the interviews. To uphold ethical research standards, questionnaires were administered solely to respondents who voluntarily gave their informed consent. Before participating, the researcher thoroughly explained the study's purpose, methods, and potential benefits, emphasizing its focus on assessing pastoral care services for PLWHA in PEFA churches in Kajiado County. Participants were explicitly informed of their right to refuse participation or withdraw at any point without facing any repercussions, ensuring their autonomy was respected. To protect confidentiality and prevent victimization, respondents were not required to provide their names on the surveys, a measure designed to foster trust and encourage honest responses. This commitment to anonymity was clearly articulated in the questionnaire's introductory section, ensuring all participants were fully aware of their rights and the protections in place.

Every respondent was treated with fairness, dignity, and respect, regardless of their background, status, or circumstances, aligning with ethical principles of non-discrimination. No form of coercion or pressure was used, allowing individuals to participate only if they felt comfortable and willing. This approach created a safe and inclusive environment, particularly important for sensitive topics like HIV/AIDS, ensuring participants' rights and well-being were prioritized throughout the research process.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter includes information analysis, presents the findings, and talks about how the findings from the field were translated. It presents the rate of response, reliability analysis, demographics of the PLWHA respondents, descriptive analysis, inferential statistics, and parametric tests. The part is organized logically according to the goals of the study. Data resolved as well as presented are findings from the administered questionnaires for the PLWHA, the interview schedules carried out with pastor and church leaders.

The study consisted of four objectives including. To investigate the foundations of pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado administrative region, Kenya biblically and theologically; ii. To evaluate information effectiveness when disseminated in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya; iii. To find out effectiveness of pastoral counseling in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya; and iv. Assess the ways by church leadership of implementing pastoral care services in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya. The objectives also generated research questions including; i. What are the foundations of pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya biblically and theologically? ii. What is the effectiveness of information dissemination in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya? iii. Exactly what effectiveness of pastoral counseling in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya? And iv.

What are the ways used by church leadership in implementing pastoral care services to promote acceptance of PLWHA in PEFA churches in Kajiado County, Kenya?

4.2 Response Rate

The total number of interviewees reached was all the sampled 40 consisting of 10 pastors and 30 other church leaders. The total number of questionnaires given to the PLWHA was 150. The number of questionnaires collected back was 145 while only 122 of them were complete. This meant that the 23 were not useful and thus discarded. Therefore, 122 questionnaires were considered for analysis as shown in figure 2.

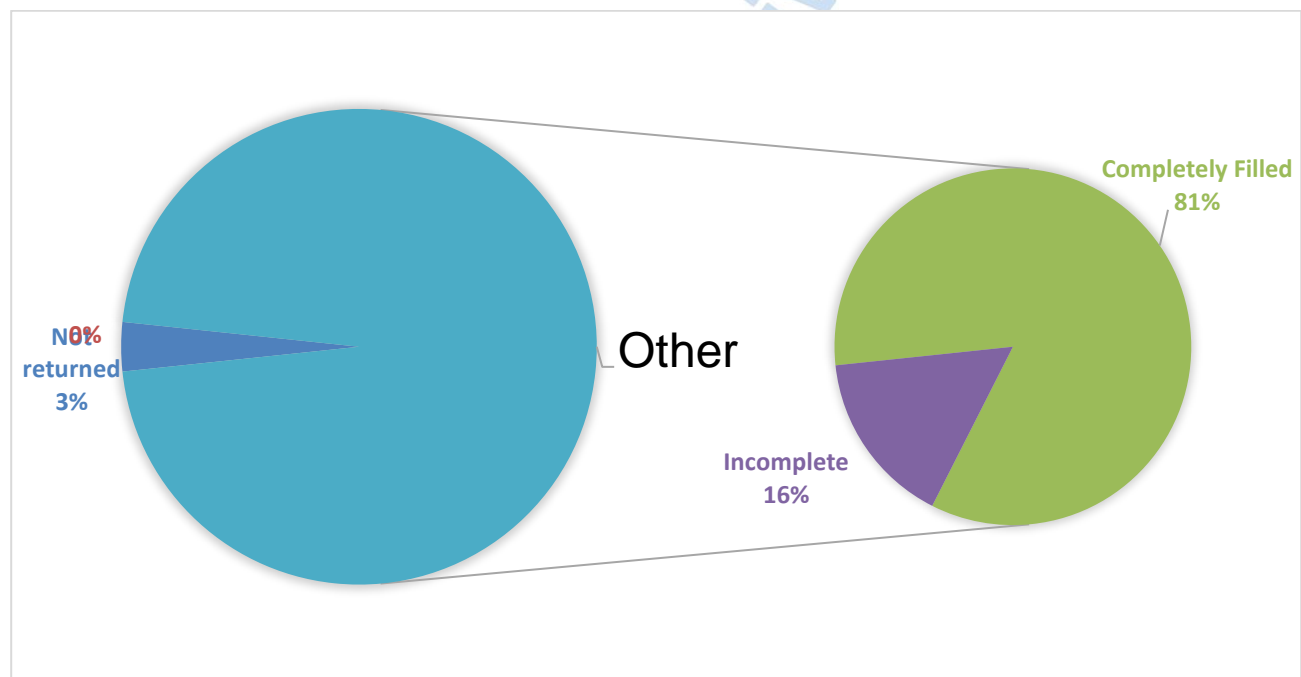


Figure 2: Response rate

Figure 2 highlights an impressive 97% questionnaire return rate, a result of persistent follow-up strategies, including in-person visits and phone calls, which ensured high respondent engagement. Furthermore, fostering trust and rapport through close collaboration with

participants significantly enhanced their willingness to participate, critical for a study likely focused on pastoral care services for people living with HIV/AIDS (PLWHA) in PEFA churches in Kajiado County. However, 16% of the returned questionnaires were incomplete and thus unusable, reducing the effective response rate to 81%. According to Draugalis, Coons, and Plaza (2008), in their article from Volume 72, Issue 1 of the American Journal of Pharmaceutical Education, a minimum response rate of 80% is typically expected for survey research intended for publication. The achieved 81% surpasses this threshold, demonstrating a robust level of participation and ensuring the data's reliability for analysis. This high response rate strengthens the credibility of the study's findings, providing a solid foundation for evaluating the effectiveness of pastoral care in promoting acceptance of PLWHA. The adequate response rate supports confident data scrutiny, enabling meaningful conclusions to be drawn about the role of PEFA churches in addressing HIV/AIDS stigma.

4.3 Demographic Information

4.3.1 Gender distribution

The gender of the PLWHA respondents must be indicated on the survey. The data was analysed and presented using figure 3.

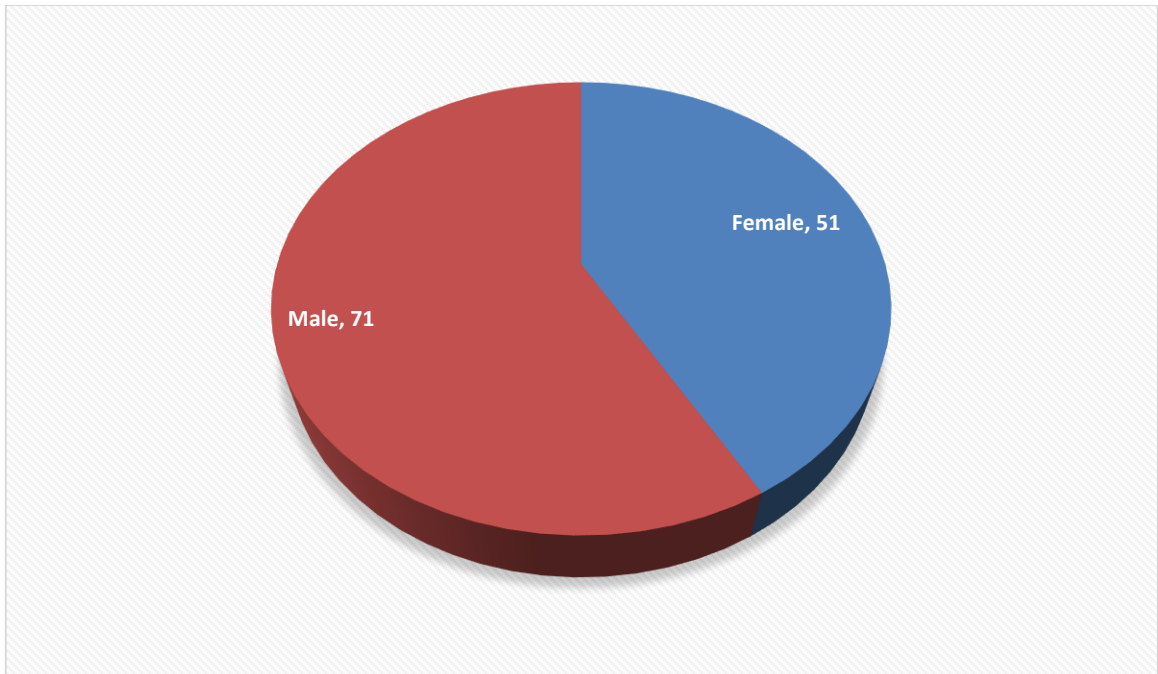


Figure 3: Gender distribution

Figure 3 shows that most (71) of the respondents were males while 51 being females.

This implies that there was fairness in engagement of both genders, the results of this study were therefore unaffected by gender bias.

4.3.2 Age of the Respondents

The PLWHA those responding to the questionnaire were requested to indicate their age (years) structured in a scale of ranges 18-24 years, 25-30 years, 30-36 years, 37-44 years and 45 years and above. The collected data on the demography was analysed and presented using a bar chart in figure 4.

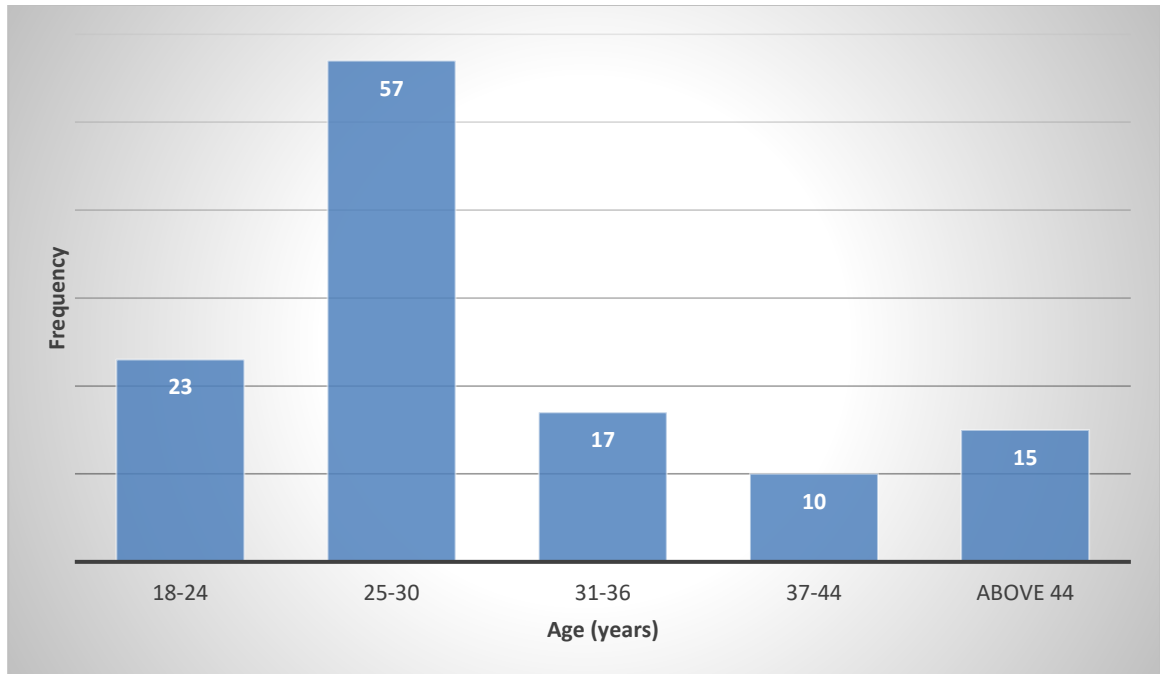


Figure 4: Age of the PLWHA Respondents

Figure 4 shows that the respondents had a representation across all the five structured ranges with the age bracket 25-30 having the majority (57), followed by the age 18-24 years olds at a frequency of 23, followed by 31-36 at 17, then above 44 years at 15 while the fewest were in the age bracket 37-44 years at a frequency of 10. According to this, the respondents' ages ranged from 18 to over 44, with the majority of them being young adults (18 to 36 years). This helps to describe the study findings with greater interest among the youths.

4.3.3 Education level

PLWHA members who were responding to the questions were also requested to indicate their highest education level acquired. The item was structured and drawn on a closed-ended form. The responses were analysed and presented using Table 5.

Table 5: Level of Education of PLWHA Respondents

Highest Level Attained	Frequency	Percentage
No formal Education	18	14.75
Primary School Certificate	13	10.66
Secondary School Certificate	47	38.52
Tertiary College Certificate/Diploma	27	22.13
Bachelor's degree	16	13.11
Master's degree and above	1	0.82
Total	122	100.00

Table 5 communicates that 47(38.52%) of the participants have a secondary level of education certificate as their highest education level achieved. This was come after by a 22.13% of the participants being tertiary College Certificate/Diplomaholders, 14.75% having no formal education, 13.11% having attained bachelor's degree, 10.66% having primary school certificate while only .82% have a master's degree and above as their highest education level. This implies that most of the people responding to the questionnaire were actually educated to a level of being exposed to the academic world that has an integration of HIV/AIDS related curriculums. This was important to know the level of understanding as well as awareness of the AIDS pandemic amongst the respondents.

4.3.4 Marital Status

According to the results of the pilot study, options were provided when asking respondents to the questionnaire about their marital status. The results are shown in Figure 5.

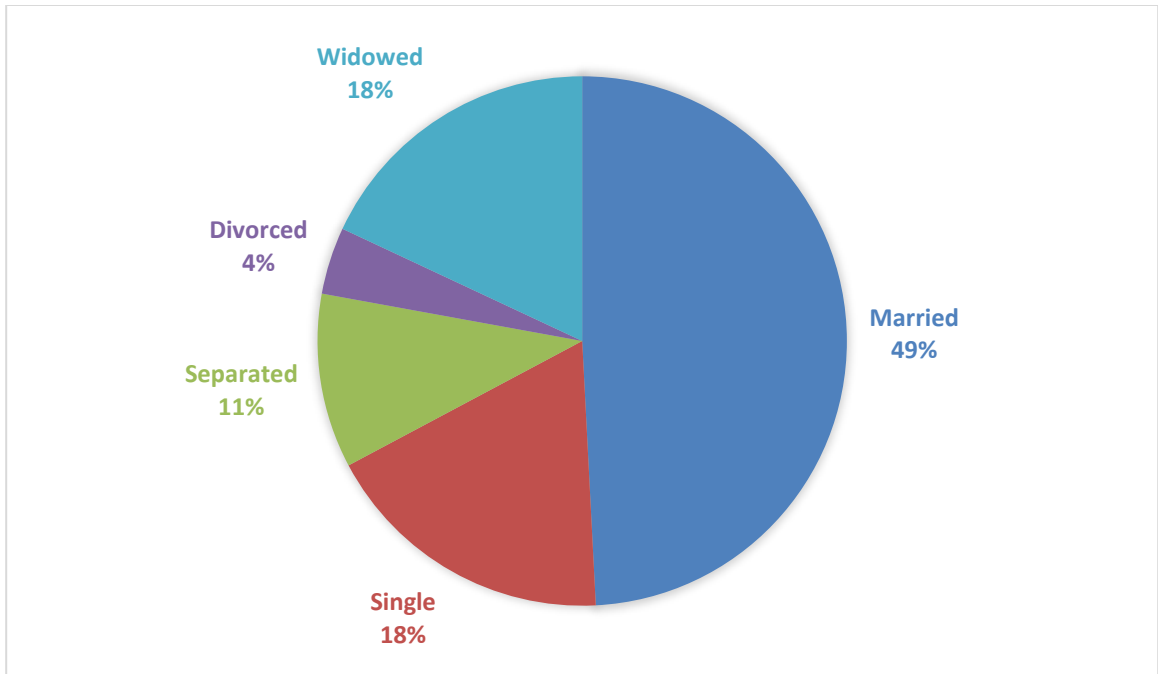


Figure 5: Marital Status of the Respondents

Figure 5 shows that most of the people responding (49%) were married, equal proportions of 18% each were single and widowed. On the other hand, 11% and 4% were separated and divorced respectively. This showed that the information inspection was carried out on the information gathered from a variety of respondents in terms of marital status.

4.4 Biblical and theological foundations of pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County

The study first objective was to examine the biblical and theological foundations of pastoral care biblically and theologically in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya.

4.4.1 Bible Testaments on occurrence and cure of diseases

The PLWHA respondents were asked to indicate which testament they were most familiar with in terms of the verses that explain the causes and treatments of diseases. The 122 respondents indicated their views and the data analyzed by use of percentages and frequencies and the results given using figure 6.

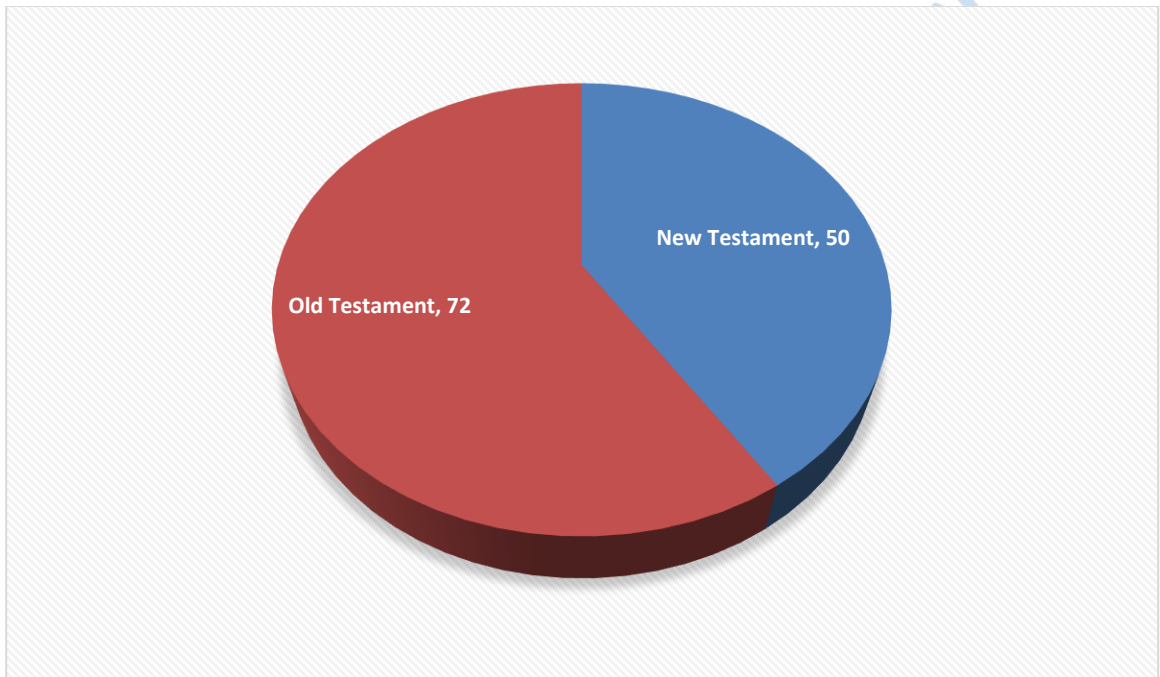


Figure 6: Bible Testaments on occurrence and cure of diseases

Figure 6 shows that minority (50) of the PLWHA respondents knew about bible verses explaining diseases in New Testament. Compared to the 72 of the respondents who indicated they knew more scriptures about diseases from the Old Testament, implied that the churches would be mostly read and preached on Old Testament. This is on contrary to what is expected of the church to focus more on the New Testament contains the four famously known Gospel books including Mathew, Luke, Acts and John. The biblical and theological foundations of

pastoral caring for the sick is illustrated in both old and new testaments. In the Old Testament, Israelites were not related by God as individuals but as persons while in the New Testament, Jesus' teachings are said to be embodied in his healing work, where healing is depicted as a result of turning to God, via personal and social relationship. This contrasts in the exiting values in church and the biblical and theological requirements points to some weaknesses in the church which may call for address of the needs as spelt out in the bible.

4.4.2 Godly Comfort provided by the church to PLWHA

The PLWA respondents were asked to indicate any Godly comfort provided by the church to the PLWHA. The responses were in a structured closed-ended test items with availed options as giving hopes, providing needs, protecting from stigma, preaching on trust in God, preaching on shouting for joy and mourning or rejoicing with them. An analysis and presentation of the responses using Table 6.

Table 6: Godly Comfort provided by the church to PLWHA

Services Offered	Frequency	Percentage
Giving hopes	33	66
Providing needs	41	82
Protecting from stigma	23	46

Preaching on trust in God	45	90
Preaching on shouting for joy	35	70
Mourning or rejoicing with them	36	72
Average	35.5	71

Table 6 shows that majority 45(90%) of the respondents whose churches offered PLWHA-related services indicated the Preaching on trust in God, Providing needs at 41(82%), Mourning or rejoicing with them at 36(72%), Preaching on shouting for joy at 35(70%). The second least services offered by the churches was Giving hopes at 33(66%) while protecting from stigma indicated the least at 23(46%). On average, 35.5(71%) of the respondents reported the availability of the highlighted PLWHA-related Godly comfort in their churches. This implied that the churches which have programs on PLWHA have put in place considerations for the need of these services at a 71% which is evidence of the concern about pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County. However, this representation was only for the 41% of the respondents (in Figure 5). This implied that there is a contrast in what exists in the pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County.

4.4.3 Rating of Bible Verses Known to discuss diseases

The interview schedules for the sampled 40 church leaders (both 10 pastors and 30 church leaders) required the respondents to indicate how many verses and scriptures related to diseases they knew. The responses were structured on test item Likert scale as Very many,

Many, Few Very Few and None. The analyzation of data collected was done using frequencies as well degrees, and the findings given by use of Figure 7.

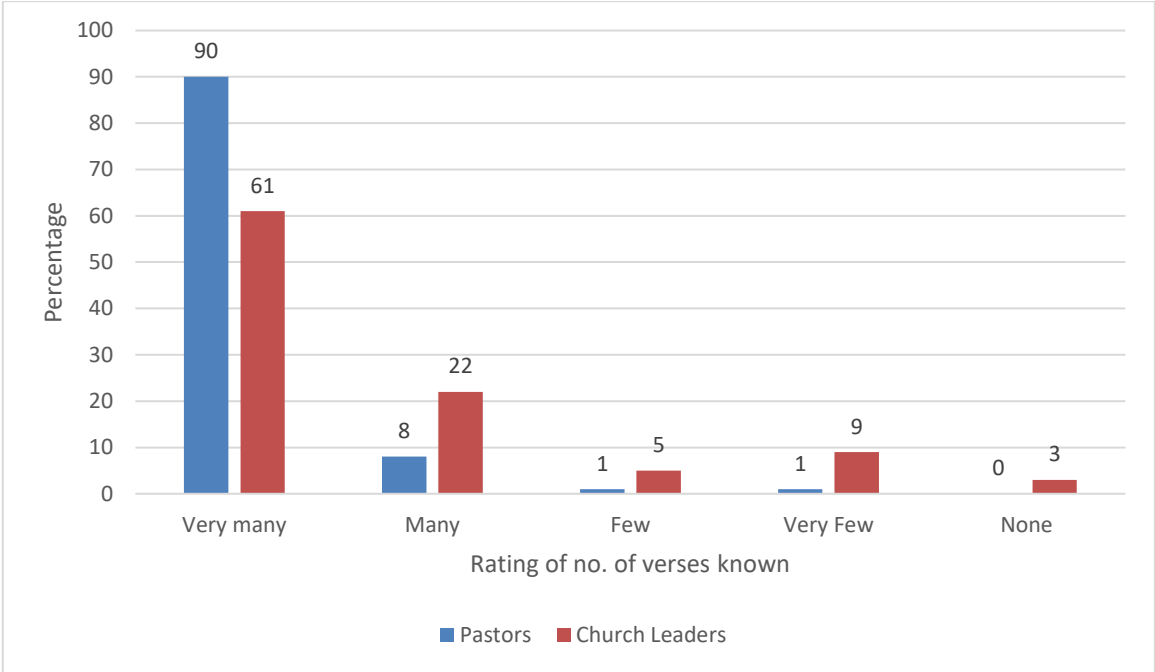


Figure 7: Availability of Formal training pertaining to HIV/AIDS in churches

Figure 7 shows that majority (90% and 61%) of the pastors and church indicated being aware of very may verses and scriptures from the bible discussion diseases. Only 8% of the pastors, 22% of the church leaders and indicated aware of many verses. Only 1% of the pastors indicated knowing bible verse discussing diseases as Few and Very Few. For the church leaders, this was 5% and 9% respectively. Moreover, the None rating indicated 0% for the pastors and 3% for the church leaders. This depicts recognition by the church of the foundation biblically and theologically of the church to diseases including HIV. This implies that there is willingness to incorporate the PLWHA programs consequently implying that

the PEFA churches in Kajiado County have foundations that are biblical and theological that call for counselling provided by pastors for the PLWHA.

4.4.4 Mistreatment and Treatment of PLWHA in church

In order to clarify on the issue of foundations of pastoral care biblically and theologically in promoting acceptance of PLWHA in PEFA churches in Kajiado County, the PLWD respondents were requested to show any form of mistreatment they might have seen or gone through in the church. On a closed-ended items, the options included Rejection and avoidance, Discrimination, Compulsory testing, Violence against HIV infected persons, and Quarantines for PLWHA. The collected data was analyzed and presented using Figure 8.

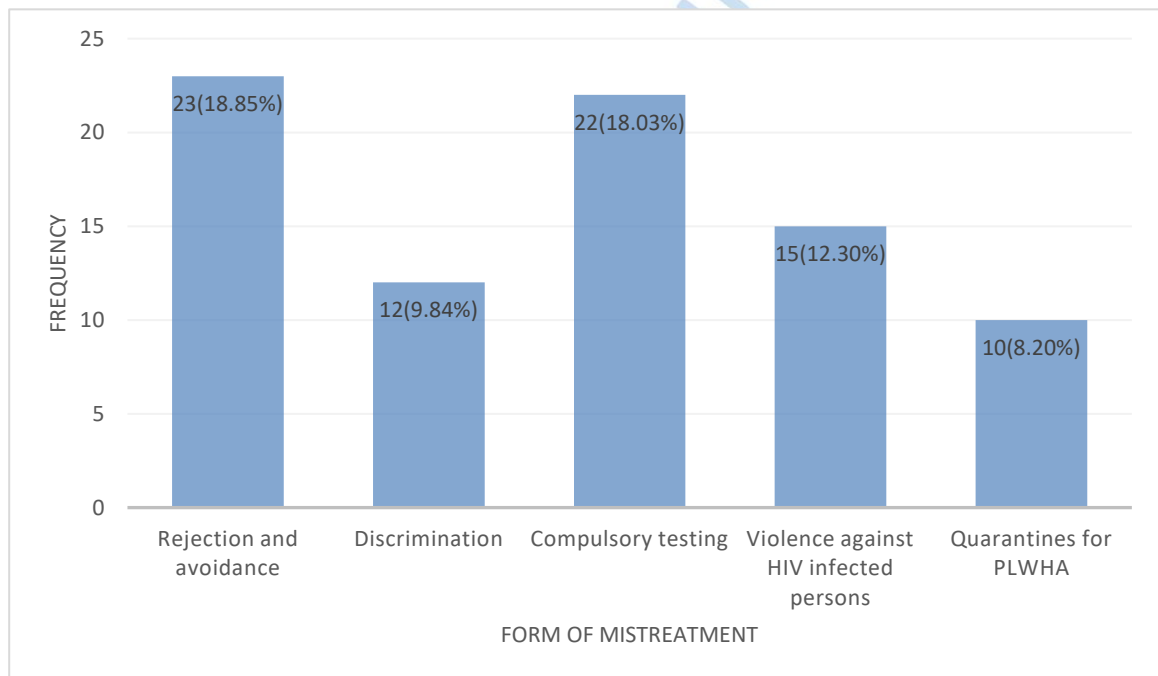


Figure 8: Forms of Mistreatment felt by PLWHA

Figure 8 shows that the majority 23(18.85%) only who much fewer than half are of people responding to the questions felt that they were mistreated through rejection and avoidance.

Similarly, only 22(18.03%) felt mistreatment by compulsory testing, 15(12.30%) by violence, 12(9.84%) by discrimination and 10(8.20%) by quarantines. This implied that the PLWHA respondents are much not mistreated possibly pegged on foundations of pastoral care the biblically and theologically in promoting acceptance of PLWHA in PEFA churches in Kajiado County. This conforms to the biblical where it spells out the love that God had for the world (John 3:16); and that there is need to show love to others as you love yourself (Mathew 22:34).

In a further analysis on the Biblical and theological foundations of counselling provided by pastors in promoting acceptance of PLWHA in PEFA churches in Kajiado administrative region, PLWHA pastors who respond to the questionnaire were asked to rank their agreement level with some identified sentences relating to pastoral care in churches. The levels were ranked on a Likert scale with options 5-strongly agree, 4-agree, 3-neutral, 2-disagree, 1-strongly disagree. The results were analyzed and presented using Table 7.

Table 7: Level of agreement with some identified statements relating to the pastoral care

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
Individuals living with HIV should be encouraged to acknowledge the behaviors or actions that may have contributed to their infection	0(0%)	2(1%)	2(1%)	10(8%)	108(98%)	122(100%)
People living with HIV occasionally experience harsh or unfriendly treatment from members of the church community	36(29%)	40(32%)	9(7%)	18(14%)	19(15%)	122(100%)
Individuals with HIV are at times stigmatized as sinful, unethical, and lacking moral values, despite the notion that living with HIV can be viewed positively	29(23%)	54(44%)	22(18%)	8(6%)	9(7%)	122(100%)
Creating a distinct worship service for those living with HIV is considered a commendable concept.	54(44%)	35(28%)	9(7%)	15(12%)	9(7%)	122(100%)
Voluntary Counseling and Testing (VCT) is intended for individuals who suspect they may have contracted HIV, as access to accurate HIV/AIDS information can help decrease stigma toward affected individuals	3(2%)	10(8%)	3(2%)	47(38%)	59(48%)	122(100%)
Access to the right information on HIV/AIDS would reduce stigma against people living with HIV.	34(27%)	48(39%)	19(15%)	13(10%)	8(6%)	122(100%)
Individuals who are HIV positive should not be assigned leadership roles within the church	37(30%)	59(48%)	16(13%)	8(6%)	2(1%)	122(100%)
Church leaders are expected to fulfill an essential role in supporting and guiding their congregations	23(18%)	69(56%)	15(12%)	12(9%)	3(2%)	122(100%)
Average	27(22%)	39(32%)	11(9%)	16(13%)	27(22%)	

Table 7 shows that most of the people who gave their response 108(98%) Strongly disagreed with the sentence, *in order to gain spiritual healing, HIV-positive people should be encouraged to confess the sins that caused their illness*. Being asked on views on whether *churchgoers occasionally treat HIV-positive people unfairly by whispering, slandering, and outright rejection*, only 40(32%) agreed with the statement. Similarly, a majority 54(44%) agreed that *HIV-positive people are commonly characterized as sinners, immoral, and uncontrollable*. In coincidence, 54(44%) of the respondents strongly agreed that *it is a good notion to provide a distinct service for people who are HIV positive*. Majority of respondents 59(48%) also strongly disagreed that *VCT is for people who might have contracted HIV*

because of their bad behavior. Access to accurate information on HIV/AIDS might lessen discrimination towards people living with the virus, only 48(39%) as majority agreed that it would. On a higher agreement level of 59(48%) felt that since an HIV positive individual does not set a good example for Christians, they should not be granted any leadership roles in the church. Finally, the majority (69(56%)) agreed that church leaders are expected to play a significant part in the fight against HI/AIDS-related discrimination and stigma.

The findings conform to the requirements of the bible where all people have same opportunity before God. The bible in both new and old testaments emphasize that anyone who prays for anything, will indeed get it. Moreover, the biblical foundation for this would be the New Testament where Jesus states that he came for the sinners (Luke 5:32). Regardless of the form of the HIV/AIDS transmission, the church won't look at the victims as more "sinners" than the rest of the congregation. Jesus uses a story of the prostitute bought before him and asked the people who wanted to stone her because of laws of Moses stated that such would be stoned. Jesus asks the public that whoever has never sinned be the first one to throw a stone to the prostitute. None attempt to throw, as they leave one by one (John 8:7).

4.4.5 Discrimination against the PLWHA and Bible teaching about incurable diseases

The study used 60 HIV/AIDS Affected Members of the Congregation (HAAMC) sampled from the 10 churches with 6 from each church. The HAAMC were put into discussion groups. The data gathered showed various aspects of the bible teachings about the incurable diseases. The sampled participants also indicated that other members had attitudes that depict both the infected and the affected were discriminated against. One participant in group 2 said;

The bible shows us that some incurable diseases are brought to humanity as punishment by God. *In the book of Deut 28:38, God says that if the Israelites do not honor Him, He would punish them with incurable boils for defiance. The bible also acknowledges that it is God who brings the diseases as well heals the diseases (Exodus 15:26)*

This means that the believers in the church have the knowledge that every living thing under the sun is under God's own control irrespective of the health status. That God has power of all diseases. That God understands the cause of the disease and has powers to heal it or even stop its occurrence. Another participant in group 6 said;

The bible teaches that God is the Forgiver of human iniquities and heals all diseases (Psalms 103:3). In relation to this, no one should discriminate against another person because God is the Creator and the Healer. He created man in His own image and has power to heal him. If God was able to create man, there is no way He can lack abilities to heal him of any disease.

From the noting, the participants showed that the bible teaches on knowing that God is the Mighty with abilities over the creatures of the earth. This implies that nothing is impossible with him. As much as HIV/AIDs is termed as incurable among humanity across the globe, before God, it is indeed a curable one. Another participant emphasized the point with the writing in the book of Luke chapter 5 verse 12. The Bible tells us that Jesus healed a leprosy man. This disease had been perceived among men that it was incurable. But when Jesus healed the man, the followers understood that God has power over diseases.

One participant noted that God has no intention or meaning in discrimination among human races. The participant stated that from Genesis, man was created in Gods image, and likeness. It implies that irrespective of the nature or status of human beings, they remain the

same – in the image and likeness of God. Thus no one should discriminate against them. In job 2:7, when God allow Satan to try Job with any diseases except touching his life, the Satan caused him incurable boils from the toes to the head. However, God had preserved his soul against the Satan power.

4.5 Influence of information dissemination in promoting acceptance of PLWHA

The second study objective was to evaluate effectiveness of data dissemination in promoting acceptance of PLWHA in PEFA churches in Kajiado County. Guided with a question of research. What is information dissemination in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya effectiveness? the study asked the PLWHA respondents for some information in regard to the goal. The respondents had to say how frequently they went to church. The collected data was analyzed and presented using Table 8.

Table 8: Level of agreement with some identified statements relating to the pastoral care

Attendance	Frequency	Percentage
Frequently	78	63.93
Less frequently	33	27.05
Never	11	9.02
Total	122	100.00

Table 8 shows that majority 78(63.93%) of the PLWHA respondents frequently attend church, 33(27.05%) attended church less frequently while 11(9.02%) never attended church. This depicted the church as one of the most preferred social gatherings for the PLWHA. The

church has a mission to accommodate everyone with the guidance laid in the bible which calls for everyone to belief in the Living Lord with hope to live in eternity (1Timothy 4:10). The results are in line with Chitando's (2009) recommendations, which contend that religious youth organizations can be used to reach out to young people directly, including those who are HIV positive or at risk for infection. It is through church attendance that the religious youth organizations can effectively engage their target groups.

4.5.1 Church and Biblical Information about Incurable Diseases (HIV/AIDS)

The PLWHA pastors who were responding to the questions were asked if they ever received information concerning HIV/AIDS from church. Those who had received it before were also required to briefly describe the information they received and what they learned from it. The collected data was analyzed and presented using Figure 9.

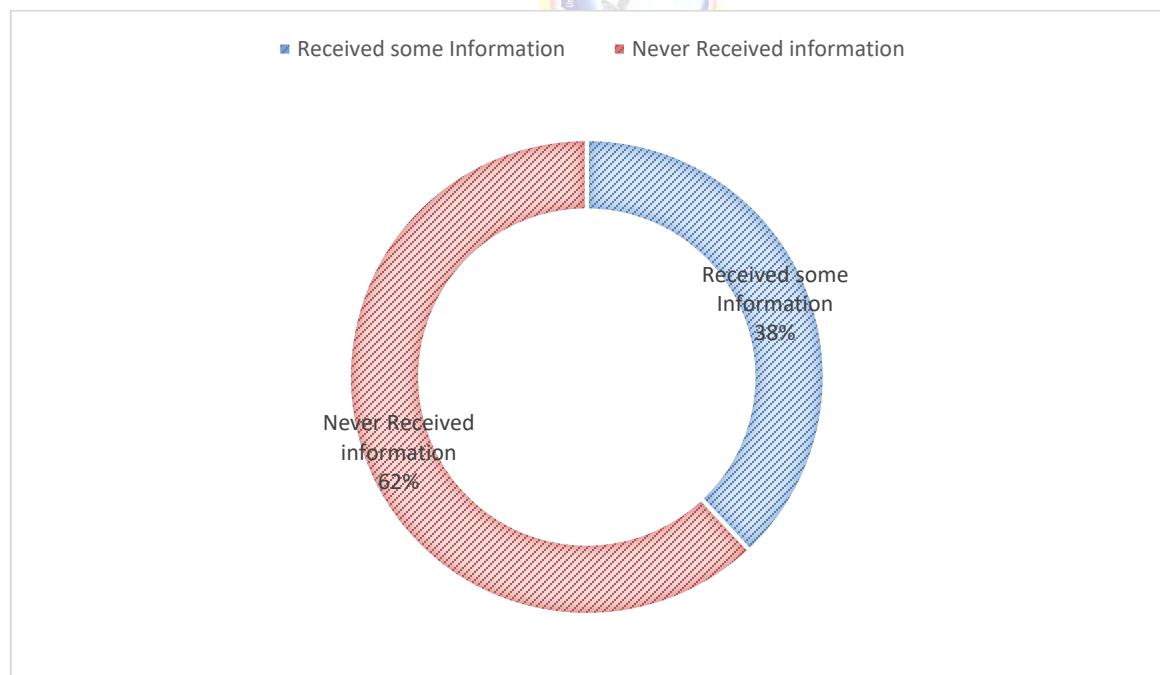


Figure 9: Church provision of information on HIV/AIDS

Figure 9 demonstrates that most (62%) of those who responded had never received any information relating to HIV/AIDS from the church. This left only 38% of those who responded indicating that they had ever come across such information from the church. This meant that the PLWHA might be lacking information on HIV/AIDS especially with sourcing from church. These findings showed that the recommendations by Overt. Org (2006) on importance of providing information to the PLWHA is necessary, the church lacks this noble requirement. While there may be other sources of information, the church plays a “home” role for some of the victims where they may only trust and belief in what the church provides. Some of the respondents described some source of information on HIV/AIDS not literally mentioning the disease but the relation to God’ divine punishment of the world due to its sins. One respondent illustrated that the disease is medically incurable which implies that it is God’s punishment to humans. This is related to what Olaore and Olaore (2014) describes that God would have already shown the medical cure for the disease were it not for a judgment divine. The authors cite God’s message through Isaih13:11 that he would punish the world for its evil and wickedness.

4.5.2 Sources of Information on HIV/AIDS in church

Those giving response were also requested to show the source of the information they got on HIV/AIDS from various selected sources including Books and magazines, Peer group discussions, Teachings by church leaders, Lectures and teaching from church leaders/pastors and Others. The collected data was analyzed and presented using Figure 10.

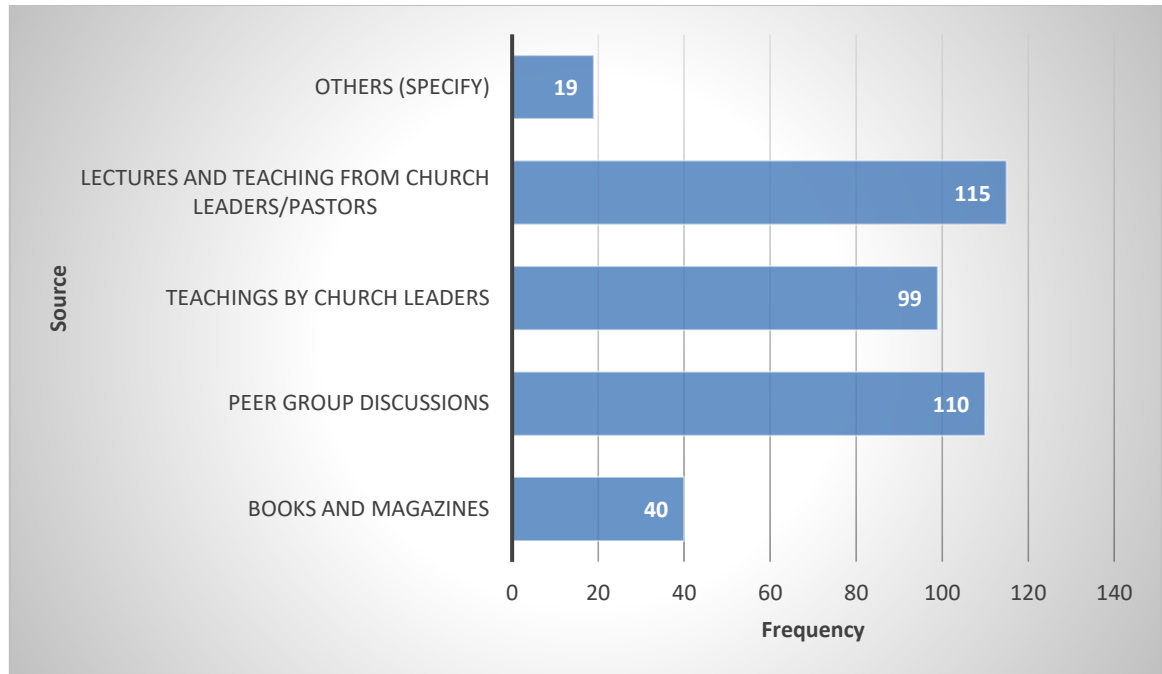


Figure 10: Sources of Information on HIV/AIDS in church

Figure 10 shows that the sources of information for the PLWHA from the church varied from the highest frequency of 115 for the lectures and teaching from church leaders. Peer group discussions are the second highest frequency source of the information at 110, followed by teachings by church leaders, then books and magazines and others at 99, 40 and 19 respectively. The lecturers and teachings from the church leaders is possibly associated with the research (Olaore & Olaore, 2014; Nyblade, 2008) recommendations that ignorance about HIV/AIDS as well wrong ideas about transfer of HIV/AIDS from one person to another are crucial elements adding to disgrace and discrimination as well.

4.5.3 Church Leaders' packaging of HIV/AIDs information

In relation to sources of information, the church leaders were asked in the interview on how they packaged HIV/AIDS information that they teach to the church members. An analysis and presentation of the responses was done using Table 9.

Table 9: Church Leaders' packaging of HIV/AIDs information

Packaging	Frequency	Percentage
Books	32	80
Magazines	30	75
Discussions	29	72.5
Bible study	35	87.5
Preaching	39	97.5

Table 9 shows that of the 40 interviewed church leaders, the majority 39(97.5%) employed preaching in passing the information related to HIV/AIDs to the PLWHA. Bible study was the second highly used packaging of the information on HIV/AIDs among the PLWHA at 35(87.5%). This was followed by the use of books, magazines and discussions at 80%, 75% and 72.5% respectively. This showed that the leaders were informed of the importance of providing the message to the PLHWA with packaging of the information in various forms.

4.5.4 Description of the information provided to PLWHA

The PLWHA persons giving response were requested to also explain the kind of information they get from sources indicated. The test item was a closed-ended question with options of

Curing, Supporting, Mentoring, Conforming, Providing for, setting free and Empowering. The responses were analyzed and presented using Figure 11.

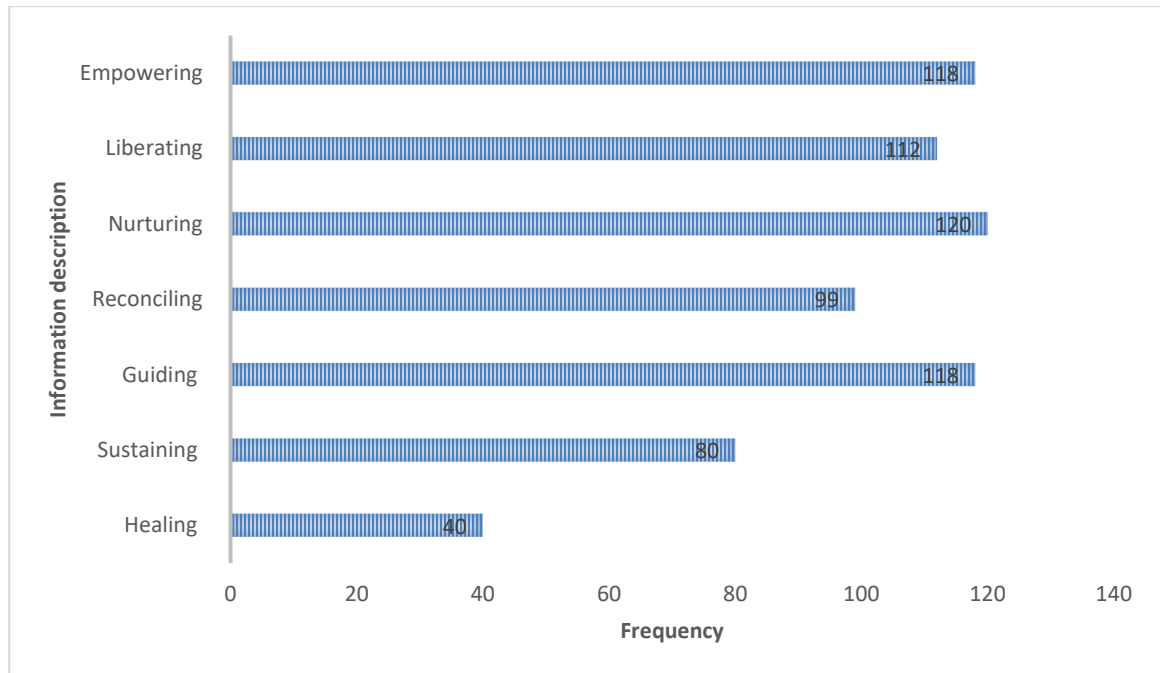


Figure 11: Description of the information provided to PLWHA

Figure 11 indicates that most of the respondents indicated finding the provided information nurturing at a frequency of 120. At time, the information was described as empowering and guiding at 118. In the same order, liberating, reconciling, sustaining and healing followed at 112, 99, 80 and 40 respectively. These results also conformed to the importance pegged in HIV/AIDs related information provision by researchers (Apinundecha, Cameron & Lim, 2007).

4.5.5 Bible interpretation on HIV/AIDS and behavior change

The PLWHA persons giving response were required to show to the satisfaction level they felt with how the bible is interpreted on HIV/AIDS and behavior change among the members

in their church. On a Likert-scale of Very satisfied, moderately satisfied, Low satisfaction, Unsatisfied, and I don't know, the data was collected. The data analysis was performed, and the results presented using Table 10.

Table 10: Bible interpretation on HIV/AIDS and behaviour change

Satisfaction	Frequency	Percentage
Very satisfied	26	21.31
Moderately satisfied	34	27.87
Low satisfaction	46	37.70
Unsatisfied	12	9.84
I don't know	4	3.28
Total	122	100.00

Table 10 shows that majority 46(37.7%) of the respondents indicated low satisfaction with the way the biblical interpretation on HIV/AIDSs and behavior change was being carried out in their churches. The moderately satisfied was at 34(27.87% with very satisfied at 26(21.31%). The unsatisfied and I don't know were the least at 12(9.84%) and 4(3.28%) respectively. This depicted a need in interpretation the bible in regard to HIV/AIDSs within the population.

4.6 Influence of Pastoral Counseling in promoting acceptance of PLWHA

The study third objective was to examine effectiveness of pastoral counseling in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya. To achieve this

objective several test items were raised both in the questionnaires for the PLWHA and the interviews for the church leaders.

4.6.1 Nature of counseling services provided for in the church

The PLWHA persons responding were requested to show by ticking on nature of services about counselling given for in the holy place of prayer. Test item was designed in a closed-ended form as either Acceptance, Positive living, or Confidentiality. The answers given by respondents were analyzed and the results shown using Figure 12.

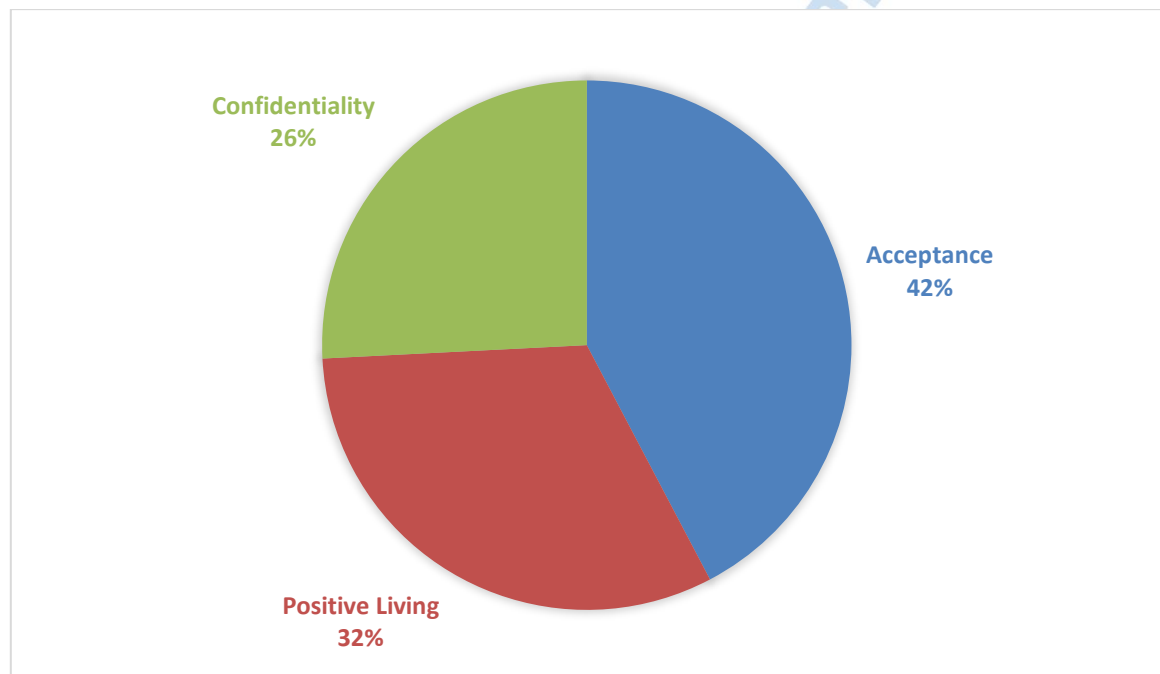


Figure 12: Nature of counselling services provided for in the church

Figure 12 shows that most of the people who responded described counseling services provided in church as acceptance (42%). The respondents also responded with acknowledgment of the positive living nature of the counseling services offered at 32%. Lastly, the nature of the services offered were least described as confidential at 26%. This

implied that the PLWHA respondents are not free with the services provided possibly through the view of the services as not as confidential. This would demean the service's intake. This conforms to the positing of psychologists Malcolm et al., (1998) who reported that disclosure and judgement fears among the counseling clients may affect their intake of the services. Despite the association that may exist between pastoral counselling and acceptance of the PLWHA, the nature of the counseling services may be an impediment in the process.

4.6.2 Effectiveness of the Pastoral counseling in Church

The PLWHA members giving response were requested to classify their feelings about the effectiveness of the counseling given by pastors provided in the church. Analysis was done to the information gathered and presented using Table 11.

Table 11: Rating of effectiveness of the Pastoral counselling in Church

Reason	Frequency	Per cent
Poor	56	46%
Fair	35	29%
Good	26	21%
Very good	5	4%
Excellent	0	0%
Total	122	100%

Table 11 indicates majority of those who responded 56(46%) felt the pastoral counseling services offered to the PLWHA are poor. Only 35(29%) felt that the services were fair while 26(21%) indicated that the services were good. None of the respondents indicated the services as being excellent while only 5(4%) indicated the services as very good. This implied that there was a gap in making the pastoral services more effective. These findings

conform to Feiruz and Mirgissa (2000) work as they associated poor counseling services to PLWHA with low intake and thus lower impact.

4.6.3 Challenges facing the pastoral counseling services in Church

During the interviews with the church leaders, the respondents were requested to give some of difficulties that they came across with pastoral counseling in the church. The collected data was analyzed and presented using Table 12.

Table 12: Challenges facing the pastoral counselling services in Church

Challenge	Frequency	Per cent
Lack of support/recognition by church administration	12	29%
Limited time allocation	8	21%
Inadequate resources	7	18%
Lack of goodwill from PLWHA	4	11%
Avoidance by PLWHA	4	11%
Unclear roles	3	7%
Others	2	4%
Total	122	100%

Table 12 displays that most of the people that gave their response 12(29%) felt that failure of the church administration to give support was the major challenge facing pastoral counseling. Closely rated to that, 8(21%) of the respondents indicated the challenge of limited time allocated for the services. While only 7% indicated the challenge as unclear roles in the services, the least 2(4%) indicated others as the major challenge facing administration of the pastoral counseling services to the PLWHA in churches. This implies that impediments to the offering of the services were significant and impacted on the effectiveness of the service in acceptance of the PLWHA. This conforms to what is stated in Stahl's (2008) survey that

reported that in 2008, Catholic Charities in USA had to close about 1,600 agencies that gave services to those suffering from HIV/AIDS, in addition of housing and mental health services due to various challenges ranging from lack of political will.

4.6.4 Preparedness to address challenges facing pastoral counseling

The church leaders' interviewees were also asked on whether there is any will for them as leaders of the church to address the reported challenges. The interviewees were also required to indicate how they were prepared to address the challenges arising. The collected data was analyzed and presented using Figure 13.

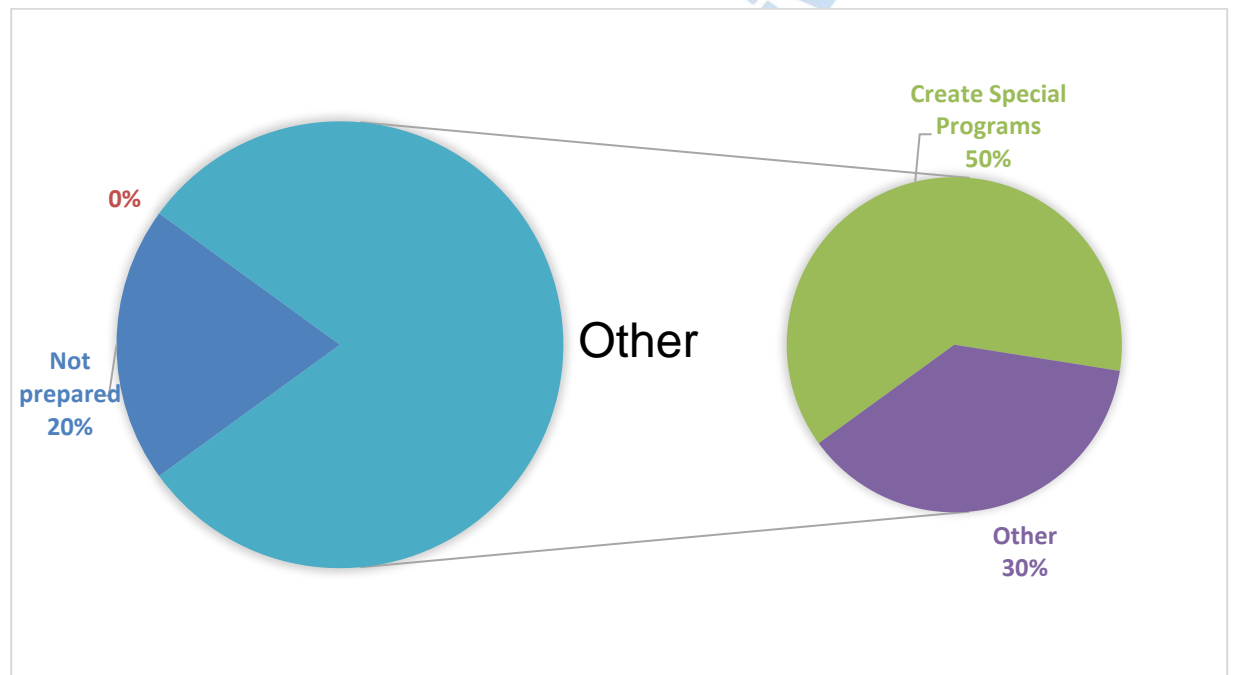


Figure 13: Preparedness to address challenges facing pastoral counselling

Figure 13 shows that only 20% of the interviewees were not prepared to handle the challenges facing the pastoral counseling among the PLWHA. On the other hand, the majority 80% were prepared to address the challenges of which 50% wished to address the

challenges through creating special programs for counseling the PLWHA. Of the 80%, 30% were prepared to address the challenges using other means. This meant that the challenges facing the pastoral counselling services were issues that could be addressed to enhance the effectiveness of the services in acceptance of the PHWHA.

4.7 Inferential Statistics

The research entailed questions of the research; what is the relationship between information dissemination and acceptance of PLWHA? And ii. What is the relationship between pastoral counselling and acceptance of PLWHA? The item on the extent of agree with the designed statements were provided with a Likert scale ranges from 5-strongly agree, 4-agree, 3-neutral, 2-disagree, to 1-strongly disagree. The data was analyzed and presented in Table 13.

Table 13: Information dissemination and PLWHA acceptance

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
The church provides information on ARVs and other medication for HIV/AIDs patients	20(16%)	12(9%)	14(11%)	44(36%)	32(26%)	122(100%)
The forum for networking with other HIV/AIDs patients lessens feelings of isolation and being neglected	24(19%)	13(10%)	12(10%)	32(26%)	41(33%)	122(100%)
Stigma awareness reduces discrimination of HIV patients and the members of their families	15(12%)	16(13%)	32(26%)	34(28%)	25(20%)	122(100%)
Information on HIV/AIDs medication reduces HIV mortality rates	13(10%)	18(14%)	23(19%)	33(27%)	35(28%)	122(100%)
Information on HIV/AIDs medication ensures adherence to medication	24(19%)	16(13%)	23(19%)	44(36%)	15(12%)	122(100%)
Information on sexuality reduces HIV/AIDs prevalence rates	18(14%)	17(14%)	20(16%)	37(30%)	30(24%)	122(100%)
Average	19(15%)	15(12%)	20(17%)	37(30%)	29(24%)	

Scale reliability coefficient: 0.8820

Table 13 presents the results of a Likert-scale assessment of information dissemination strategies and their impact on promoting acceptance of people living with HIV/AIDS (PLWHA) in PEFA churches in Kajiado County, Kenya. The data indicates that a significant portion of respondents, averaging 37 (30%), agree that these strategies—such as sermons, workshops, or educational programs—positively influence acceptance of PLWHA within the church community. Additionally, 29 respondents (24%) strongly agree, reflecting a strong positive perception of these efforts. Conversely, the lowest average, 15 (12%), disagree, suggesting some skepticism or perceived inefficacy among a minority. The scale's reliability coefficient of .882, calculated using Cronbach's alpha, indicates high internal consistency, ensuring the reliability of the responses. These findings highlight the potential of effective information dissemination in reducing stigma and fostering acceptance of PLWHA in faith-based settings, though further exploration of dissenting views may be necessary.

The findings are in tender with UNICEF (2003) which showed that FBOs has been supporting prevention and care of PLWHA in Nigeria through the distribution of information in local languages on HIV/AIDSs. The research used the information collected from the PLWHA questionnaires to answer the research questions by determining the correlation between the variables, regression analysis, and Analysis of Variance (ANOVA).

4.7.1 Correlation matrix

An analysis on correlation to ascertain the association between information dissemination, pastoral counseling and acceptance of PLWHA used the data collected on satisfaction level among respondents. The findings of the correlation analysis were presented using Table 14.

Table 14: Correlation Matrix

Variables	Statistics	Information dissemination	Pastoral counseling	Acceptance of PLWHA
Information dissemination	Pearson correlation	1	.731**	.600**
	Sig (2-tailed)		.000	.000
	N	99	99	99
Pastoral counseling	Pearson correlation	.731**	1	.784**
	Sig (2-tailed)	.000		.000
	N	99	99	99
Acceptance of PLWHA	Pearson correlation	.600**	.784**	1
	Sig (2-tailed)	.000	.000	
	N	99	99	99

Table 14 highlights a statistically significant positive correlation between information dissemination and the acceptance of people living with HIV/AIDS (PLWHA) in PEFA churches in Kajiado County, Kenya, at a 99% confidence level ($r = 0.600$, $P < 0.01$). This implies that as church members receive more accurate information about HIV/AIDS—through sermons, workshops, or community programs—acceptance of PLWHA increases, reducing stigma. This finding is consistent with Olaore and Olaore (2014), who demonstrated a strong statistical link between providing information and fostering acceptance of PLWHA, underscoring the role of education in combating discrimination. Furthermore, the data reveals a robust positive correlation between pastoral counseling and acceptance of PLWHA ($r = 0.784$, $P < 0.01$), indicating that counseling initiatives, such as one-on-one support or group sessions, significantly enhance acceptance. However, these results diverge from Waruta and Hannah (2000), who found a 70% negative correlation between pastoral counseling and acceptance, yet still concluded that counseling positively influences attitudes toward PLWHA. This discrepancy may reflect contextual differences in church practices or cultural attitudes in Kajiado County, suggesting the need for tailored

counseling approaches to maximize acceptance and support for PLWHA in faith-based settings.

4.7.2 Regression Results

The collected data was analyzed by regression to ascertain what percentage change in the acceptance of PLWHA could be decided by the two variables that are independent in the research. This analysis used the Durbin Watson value to assess any autocorrelation problem on the regression model. The outcomes are as given in Table 15.

Table 15: Model Summary for combined variables

Model	R	R squared	Adjusted R square	Std error of the estimate	Change Statistics		df 1	df 2	df 3	Sig. F change	Durbin Watson
					R square change	F change					
1	.785 ^a	.616	.598	.395	.616	33.69	3	40	39	.000	2.572

a. Predictors (Constant), Information dissemination, pastoral counseling

b. Dependent variable: Acceptance of PLWHA

As presented in Table 15, the R-squared value of 0.616 demonstrates that 61.6% of the variation in the acceptance of people living with HIV/AIDS (PLWHA) within PEFA churches in Kajiado County, Kenya, can be explained by the independent variables: information dissemination and pastoral counseling. This suggests that strategies like sharing accurate HIV/AIDS information and providing counseling significantly influence acceptance, reducing stigma in these faith-based settings. However, the remaining 38.4% of the variance in acceptance is attributed to other factors not explored in this study, such as cultural beliefs, community attitudes, or socioeconomic conditions, which could also play a

role. Additionally, the Durbin-Watson statistic of 1.892, which falls within the acceptable range (1.5–2.5), confirms the absence of autocorrelation in the regression model, ensuring the reliability of the results and the independence of the observations in the analysis.

4.7.3 Analysis of Variance

All the two predictors (Information dissemination and Pastoral counseling) were combined, and analysis of variance (ANOVA) carried out to explain the effect on the acceptance of PLWHA. The ANOVA results are shown in Table 16.

Table 16: ANOVAa on combined variables

Model		Sum of squares	df	Mean of squares	F	Sig.
	Regression	10.517	2	5.258	33.6991	.000 ^b
1	Residual	6.553	40	.156		
	Total	17.072				

a. *Dependent variable: Acceptance of PLWHA*

b. *Predictors (Constant), Information dissemination, pastoral counseling*

Table 16 shows that the regression model can be used to explain effectiveness of pastoral care services in promoting acceptance of PLWHA. The F-calculated = 33.6991 is less than the as P-Value = 0.000 which means that effectiveness of pastoral care services is significantly explaining promoting acceptance of PLWHA at 99% confidence level.

The coefficients on combined variables were generated and the results presented using Table 17.

Table 17: Coefficients on combined variables

Model		Unstandardized coefficients		Standardized coefficients	t	Sig.	Collinearity Statistics Tolerance	VIF
		B	Std. error	Beta				
1	Constant	.280	.742		.378	.707		
	Information dissemination	0.101	.242	-.058	.416	.679	.465	2.149
	Pastoral counseling	0.825	.156	-.741	5.288	.000	.465	2.149

a. Dependent variable: Acceptance of PLWHA

Table 17's regression analysis yields the equation $Y = 0.280 + 0.101X_1 + 0.825X_2$, where Y represents the acceptance of people living with HIV/AIDS (PLWHA) in PEFA churches in Kajiado County, Kenya. When other independent variables are zero, the baseline acceptance level is 0.280. A one-unit increase in information dissemination (X_1) results in a modest 0.101 increase in acceptance, while a one-unit rise in pastoral counseling (X_2) significantly boosts acceptance by 0.825, highlighting counseling's stronger influence. The absence of multicollinearity is confirmed, with Variance Inflation Factor (VIF) values below 10, as noted by Cooper and Schindler (2003), ensuring the model's reliability. The findings from Table 15 were used to address the study's research questions, focusing on factors influencing acceptance of PLWHA. Despite a positive correlation, the relationship between information dissemination and acceptance is statistically insignificant ($P = 0.679 > 0.05$), indicating a weak effect in this context. This contrasts with Ogden and Nyblade (2005), who reported a significant positive association between information dissemination and

acceptance of PLWHA, suggesting that cultural or contextual factors in Kajiado County may diminish the impact of information-sharing strategies in reducing stigma within PEFA churches.

About the relationship between pastoral counselling and acceptance of PLWHA, the research revealed a persistent link between the two factors at 0.01 significant level, $P(0.000) < 0.01$. These results were consistent with Parker and Aggleton's (2003) who studied factors affecting HIV/AIDS disgrace responses. The authors found that including a number of ways including activities that are knowledge oriented is key in effectiveness of acceptance of PLWHA.

4.8 Strategies by church leadership of implementing pastoral care services in promoting acceptance of PLWHA

The objective number four of the research was To assess ways by church leadership of implementing pastoral care services in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya. The study used both the PLWHA questionnaire and the church leaders' interviews to collect data on the possible strategies. The PLWHA respondents were asked to suggest general recommendations on HIV/AIDS behavior change communication on best messages on HIV/AIDS that the church should communicate to its members. The PLWHAs were also asked to suggest the methods of communication that should the church use to build awareness on HIV/AIDS and behavior change among its members. The data collected was analyzed and presented using Figure 14.

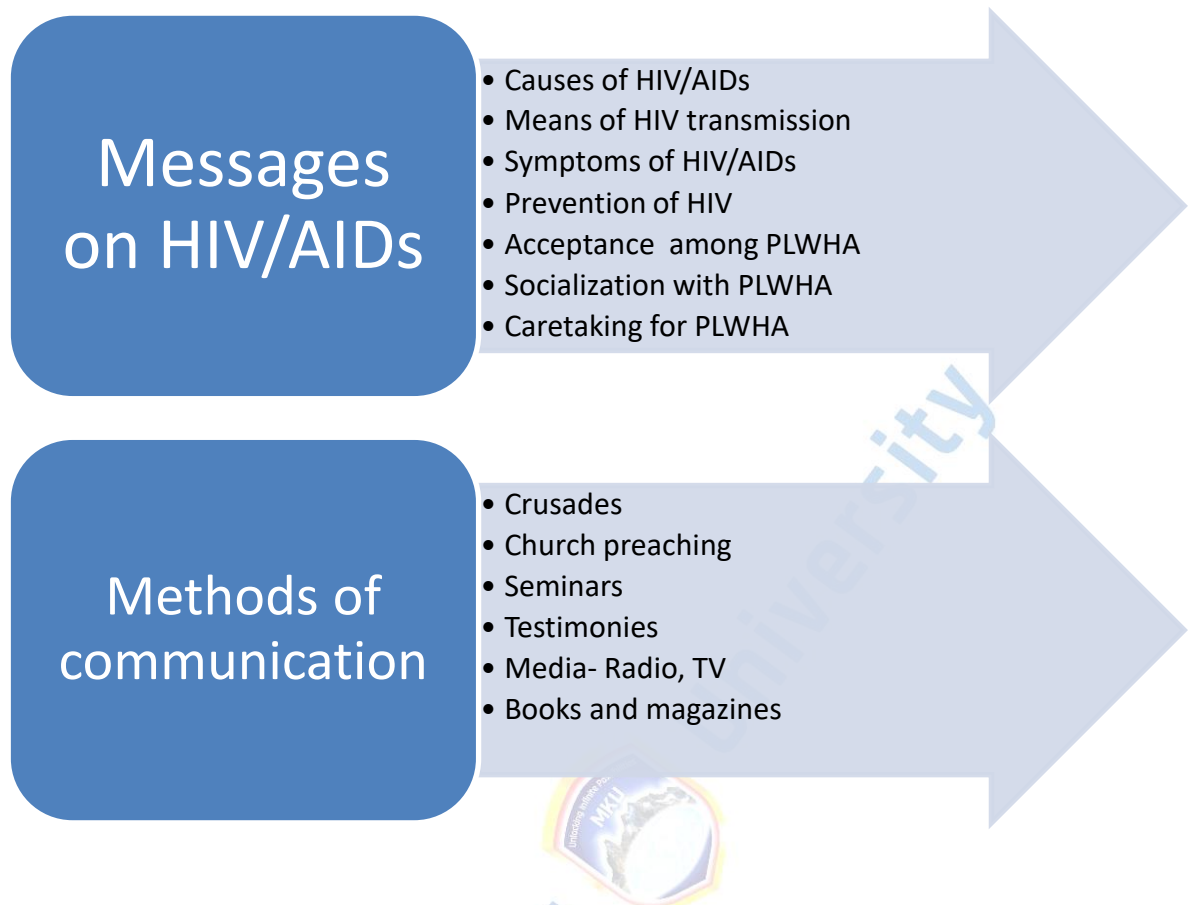


Figure 14: PLWHA suggestions HIV/AIDS behaviour change communication

Figure 14 shows that the PLWHA suggested both the nature of messages that the church should use in HIV/AIDS behavior change communication including causes of HIV/AIDS, means of HIV/AIDS transmission, symptoms, prevention, acceptance among the PLWHA, socialization with the PLWHA and caretaking of the PLWHA. Among the suggestions on the methods of communicating the message included crusades, church preaching, seminars, testimonies, media and books and magazines. These suggestions are the ones covered by Kejela (2002) and Burke (2013) in their advocacy for the enhancing acceptance of PLWHA.

4.8.1 Church Leadership strategies for pastoral care

A concern on the pastoral counseling strategies for shaping implementation of pastoral care services in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya was raised among the church leaders during the interviews. The specific research's primary question in particular was; What are the pastoral care strategies for shaping implementation of pastoral care services in promoting acceptance of PLWHA in your church? The question was designed in a closed-ended test item on a five (5) point Likert scale (where 1= strongly disagree 2= Disagree, 3= Neutral, 4= Agree and 5= strongly agree). The descriptive statistics of the results are shown in Table 18.

Table 18: Descriptive Statistics on Pastoral care Strategies

Statement	Valid N	Minimum	Maximum	Mean	Std Deviation
Talking to church administrator, counselor and other leaders	40	3.00	5.00	4.55	.623
Encouraging the PLWHA to be assertive.	40	1.00	5.00	4.53	.967
Preaching to the church members to leave the take care of the PLWHA	40	4.00	5.00	4.71	.458
Taking time to practice assertiveness approaches with the PLWHA	40	3.00	5.00	4.33	.603
Role-play with PLWHAs so that they are prepared with what to say and how to behave	40	2.00	5.00	4.33	.797
Encouraging the PLWHA to be in social groups, and avoid the loneliness	40	4.00	5.00	4.26	.447
Encouraging the PLWHAs to form support network	40	3.00	5.00	4.32	.701
Listening and talking to the PLWHA	40	3.00	5.00	4.31	.45

Table 18 indicates that the most of the people responding were in agreement with statements that there is talking to church administrator, counselor and other leaders (mean 4.5), encouraging the PLWHA to be assertive (mean 4.5), preaching to the church members to take care of the PLWHA (mean 4.7), Role-play with PLWHAs so that they are prepared with what to say and how to behave (mean 4.3), Taking time to practice assertiveness approaches with the PLWHA (mean 4.3), Encouraging the PLWHA to join groups, and avoid the loneliness (mean 4.2), Encouraging the PLWHAs to form support network (mean 4.3), and Listening and talking to the PLWHAs (mean 4.3).

While these strategies are match Parry's (2008) recommendations of the care takers being proactive like the church leaders, the strategies do not stretch to include some of the strategies including partnerships as called for by Gulaid (2010). Gulaid states that all needs of people with aids cannot be given by one agent, so association with partners among actors are in the caretaking of the PLWHA. This would be necessary as the PLWHA go beyond the church environment in their other social gatherings where they may meet the non-believers, other religions, or even the members who never attend church.

4.8.2 Behavior change strategy in implementing Pastoral care

In order to assess this strategy among the church leaders' interviewees, they were asked to suggest how different they thought the members in the church were from those outside the church. The test item aimed at identifying possible differences in behavior. The responses were analyzed and presented using Figure 15.



Figure 15: Characteristics differentiating church members from non-members

Figure 15 shows the two divisions differentiating the characteristics depicted by church members and non-church members. These behavioral characteristics that differentiate between the church members and non-members are well spelt out in Romans 12:1-21. In verse 1, says that we should offer ourselves to God as a living sacrifice dedicated to his service and pleasing to him. This is true worship that we should offer. This calls for church members to respect their bodies as whole temple of God. In verse 2 we are told to let God transform us inwardly by a complete change of our minds and not to conform ourselves to the world standards, therefore, we will be able to know Gods will –what is good and is pleasing to him and is perfect This verse intends to differentiate the church members and the non-members. Verse 4 calls for fellowship character among the church members, for in one body we have many members each with different function, 5 so we one body in Christ despite

of us being many, and members of one another individually. Verse 9 calls for loving one another ...*love should not be hypocritical. Whatever is evil abhor. To what is good cling to it.* 10 with brotherly love, be kindly affectionate to each other in honor giving preference to one another.

The interviewees were also asked how the church tailored its programs and communication on HIV/AIDS and behavior change that may lead to significant alterations in knowledge and attitudes that influence sexual behavior of youth. In relation to this, the interviewees were required to suggest why the members of their church continue to be infected despite receiving information about how to keep themselves from getting infected. The data collected was analyzed and presented using Figure 16.

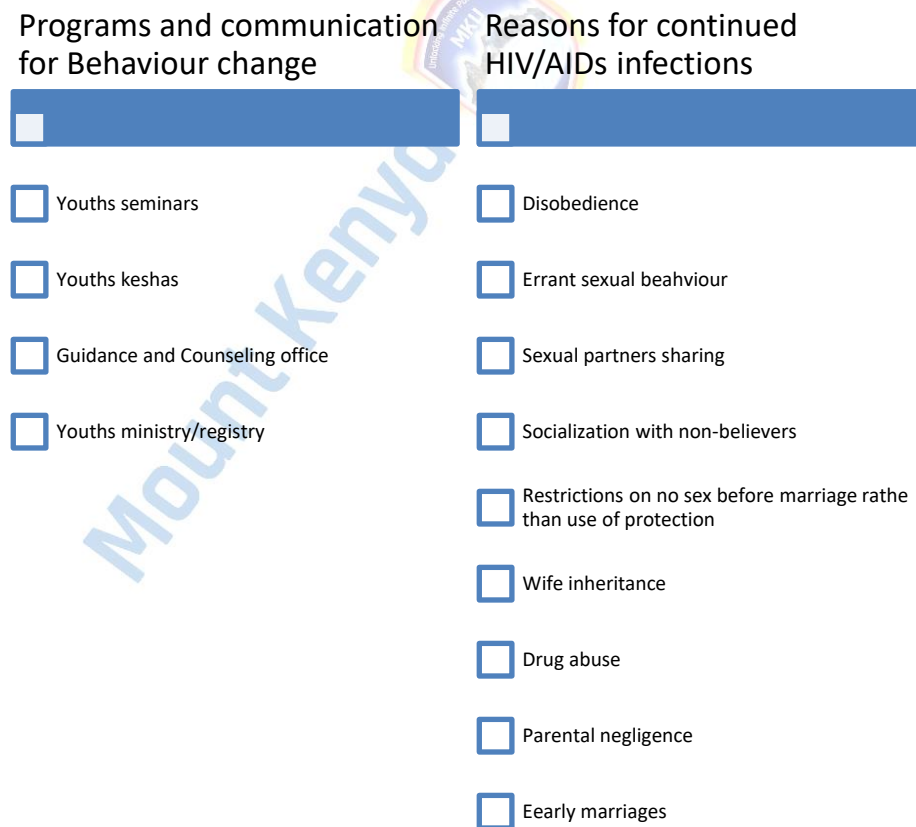


Figure 16: Behavior change programmes and hindrances

Figure 16 shows the programmes designed and installed by church leaders and specifically targeting youths. The programmes include youths' seminars, keshas, guidance and counseling office and youths' ministry/registry. On the other hand, the interviewees suggested some of the hindrances to the implementation of the pastoral care programmes installed to address behavior change as one of the means of preventing further HIV/AIDS infections. HIV/AIDS transmissions increase because of disobedience, errant sexual behavior, early marriages, wife inheritance, parental negligence and drug abuse.

The set-up programmes and communication strategies for behavior change conform to the recommendations of Igo (2008) who highlights the necessity for theological and spiritual outreach as a means of upholding and improving their dignity. The AIDS reduction theory that models 3 stages that are involved in risk reduction for HIV transmission, as well as: labeling of behavior, change commitment and action taking correspond to reasons suggested as impediments in effectiveness of pastoral care in behavior change in regard to further spread of HIV/AIDS.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the study findings, deduced conclusion as well as recommendations drawn from the findings. The chapter is based on the research questions in chapter one; i. What are the biblical and theological foundations of pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya? ii. What is the effectiveness of information dissemination in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya? iii. What is the effectiveness of pastoral counseling in promoting acceptance of PLWHA in PEFA churches in Kajiado County, Kenya? iv. What are the strategies used by church leadership in implementing pastoral care services to promote acceptance of PLWHA in PEFA churches in Kajiado County, Kenya?

5.2 Summary of Findings

5.2.1 Biblical and theological foundations of pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County

Minority (41%) of the PLWHA respondents indicated receiving support from their respective churches compared to the 59% of the respondents who indicated not receiving any support. This implied that the churches either didn't have such programmes or had less capacity to provide support. This contrasts in the exiting values in church and the biblical and theological requirements that the needy should be helped. However, the majority of the PLWHA respondents whose churches offered PLWHA-related services indicated the

assistance on HIV/AIDS transmission awareness, stigma awareness, HIV/AIDS treatment consciousness, and HIV/AIDS anticipation awareness.

The churches which have programmes on PLWHA have put in place considerations for the need of these services which is evidence of the concern about pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County. The majority of the church leaders (pastors and others) respondents agreed to have at least formal training pertaining to HIV/AIDS in their churches. Regardless, the majority of the PLWHA respondents felt that they were mistreated through rejection and avoidance. This contravenes the biblical and theological foundations of counselling given by doctors in promoting acceptance of PLWHA in PEFA churches in Kajiado County. This disregards the biblical requirements of love for all like spelt out in John 3:16. Even if the PLWHA are seen as sinners, the bible, in the New Testament says that Jesus came for the sinners (Luke 5:32).

5.2.2 Influence of information dissemination in promoting acceptance of PLWHA

In regard to the first research questions; what relationship between information dissemination and acceptance of PLWHA is, the analysis found that information dissemination has a positive relation with acceptance of PLWHA. However, the dissemination was insignificant at a significant level .05. Therefore, the study affirmed that there is not much serious relationship between dissemination of information as well as acceptance of PLWHA in PEFA churches in Kajiado County, Kenya, $P(0.679) > 0.05$. These findings differ with those of Ogden & Nyblade (2005) who found a positive but significant association between information dissemination and acceptance of PLWHA. However, information dissemination is positively correlated to acceptance of PLWHA at 99%

confidence level ($r = 0.600$, $P < 0.01$) which implies that as information dissemination among the PLWHA increases, acceptance of the PLWHA increases.

A further analysis showed that the majority of the PLWHA respondents frequently attend church. They also appreciated the church mission to accommodate everyone with the guidance laid in the bible which calls for everyone to believe in the Living Lord with hope to live in eternity (1 Timothy 4:10). Majority of the respondents had never received any information concerning HIV/AIDS from Christian house of worship. This shows that the church lacks the recommendations by Overt. Org (2006) on the importance of providing information to the PLWHA. The sources of information for the PLWHA from the church varied from the highest frequency for the lectures and teaching from church leaders. Peer group discussions is also a frequent source of the information. The majority of the church leaders employed preaching in passing the information related to HIV/AIDS to the PLWHA. Bible study was also highly a used packaging of the information on HIV/AIDS among the PLWHA.

Most of those who responded indicated finding the provided information nurturing. This conformed to the importance pegged in HIV/AIDS related information provision (Apinundecha, Cameron & Lim, 2007). Majority of the respondents indicated low satisfaction with the way the biblical interpretation on HIV/AIDS and behavior change was being carried out in their churches.

5.2.3 Influence of Pastoral Counseling in promoting acceptance of PLWHA

The relationship between pastoral counseling and promotion of acceptance of PLWHA is positively strong with a rise in unit in pastoral counseling leading to 0.825 rise in acceptance of PLWHA. The question under research, what is the relation between pastoral counselling

and acceptance of PLWHA was tested using ANOVA and thus, this research affirmed that a good relationship between pastoral counselling and acceptance of PLWHA in PEFA churches in Kajiado County, Kenya exists. These results were consistent with Parker and Aggleton's (2003) who studied factors affecting responses to HIV/AIDS stigma.

A further analysis revealed that the majority of respondents described the counseling services provided in the church as geared towards acceptance. This conforms to the positing of psychologists Malcolm et al., (1998) who reported that disclosure and judgement fears among the counseling clients may affect their intake of the services. The vast majority of responders thought the pastoral counseling services provided to the PLWHA were subpar. None of the respondents indicated the services as being excellent while only 4% indicated the services as very good. This implied that there was a gap in making the pastoral services more effective.

On challenges facing the pastoral services, most respondents believed that the church administration's failure to give support was a key impediment. In addition, an outstanding number of the participants indicated the challenge of limited time allocated for the services. This implied that impediments to the offering of the services were significant and impacted on the effectiveness of the service in acceptance of the PLWHA. In relation to this, the majority of the church leaders were prepared to address the challenges of which half of them wished to address the challenges through creating special programmes for counseling the PLWHA.

5.2.4 Strategies by church leadership of implementing pastoral care services in promoting acceptance of PLWHA

The study found that the PLWHA were keen with the nature of messages that the church uses in HIV/AIDS behavior change communication including causes of HIV/AIDS, means of HIV/AIDS transmission, symptoms, prevention, acceptance among the PLWHA, socialization with the PLWHA and caretaking of the PLWHA. Among the suggestions on the methods of communicating the message included crusades, church preaching, seminars, testimonies, media and books and magazines. These suggestions are the ones covered by Kejela (2002) and Burke (2013) in their advocacy for the enhancing acceptance of PLWHA. Most of those who gave response concurred that talking to church administrator, counselor and other leaders, encouraging the PLWHA to be assertive and preaching to the church members to take care of the PLWHA were key strategies. While these strategies match Parry's (2008) recommendations of the care takers being proactive like the church leaders, the strategies do not stretch to include some of the strategies including partnerships. The behavioral characteristics that differentiate between the church members and non-members such as selflessness, honesty, loving are conform to those spelt out in Romans 12:1-21. The church members express respect to their bodies as whole temple of God and observes the biblical call for fellowship character among the church members.

The pastoral care strategies for youths have programmes including youths' seminars, keshas, guidance and counseling office and youths' ministry/registry. The set-up programmes and communication strategies for behavior change conform to the recommendations of Igo (2008) who emphasizes need of spiritual outreach and theological debates. However, some

hindrances to the implementation of the pastoral care programmes include lack of support from the church administration and limited time allocated for the services.

5.3 Conclusion

Only fewer of PLWHA received support from their respective churches which contrast the biblical and theological requirements that the needy should be helped. PEFA churches offered PLWHA-related services on HIV/AIDS transmission awareness, stigma awareness, HIV/AIDS treatment consciousness, and HIV/AIDS anticipated awareness. The churches which had programmes on PLWHA have concerns about pastoral care in promoting acceptance of PLWHA in PEFA churches in Kajiado County. The PLWHA felt mistreated through rejection and avoidance which contravenes the pastoral care biblically and theologically foundations in promoting acceptance of PLWHA in PEFA churches in Kajiado County.

A significant relationship between information dissemination as well as acceptance of PLWHA in PEFA churches in Kajiado County, Kenya, $P (0.679) > 0.05$ can be seen. However, information dissemination is positively correlated to acceptance of PLWHA. Majority of the respondents had never received any information relating to HIV/AIDS from the church despite frequently attend church. Most of the church leaders employed preaching in passing the information related to HIV/AIDS of which the PLWHA found the information nurturing.

There is significant relationship between pastoral counselling and acceptance of PLWHA in PEFA churches in Kajiado County, Kenya. Pastoral counselling services majorly addressed acceptance of the PLWHA. However, the PLWHA felt that the counseling services were not

being excellent implying a gap in making the pastoral services more effective. Challenge in pastoral counselling services was lack of support from the church administration.

The key strategies used in pastoral care services included talking to church administrator, counselors and other leaders, encouraging the PLWHA to be assertive and preaching to the church members to take care of the PLWHA. There were behavioral characteristics that differentiate between the church members and non-members such as selflessness, honesty, loving is conform to those spelt out in Romans 12:1-21. The pastoral care strategies for youths have programmes including youths' seminars, keshas, guidance and counseling office and youths' ministry/registry.

5.4 Recommendations

5.4.1 Recommendations for Practice

The study makes the following recommendations;

1. The results could be useful to the PEFA church leadership for guiding intervention programs related to pastoral care, in particular with the dissemination of information, and addressing impediments in pastoral counseling towards acceptance of the PLWHA. This is important as some related challenges including time allocation and full support of the church administration may be raised.
2. Church leaders and other interested stakeholders can also use the research findings to ascertain acceptance classes of the PLWHA. The results that depict association of significant influence of pastoral counselling on acceptance of PLWHA can be used to enhance the counselling services. The church member scan utilizes the study findings through acknowledging that the PLWHA feel rejection and mistreatment and thus work on ways of making them change the feeling.

3. The study findings can also be harnessed by the Cabinet secretaries of Health and the counterpart in social services to support the provision of HIV/AIDS related materials and resources to the victims through the church. The PLWHA church members who are lacking such information may play a key pointer to the gap in provision of such important information to build their hope and care and thus acceptance through pastoral care.

5.4.2 Recommendations for Future Studies

Further study may be carried out to determine causal relationships between pastoral care services and acceptance of PLWHA. While the study independent variables (information dissemination, pastoral care) explain a fraction of the acceptance of PLWHA, other variables can be investigated to exhaust the influence of the acceptance among the PLWHA. The scope can be expanded to include the partnerships between the church and the organs such as the government, and NGOs; and even increase the sample size to improve significance of the results.

Future studies may also explore some of study limitations including experienced to improve on the response rate from the currently attained 81%. Moreover, using other data collection instruments such as observation, improving the reliability level, and transferring the study to another church setting may ascertain the consistency of the influence of pastoral care on acceptance of the PLWHA in Christianity.

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APPENDICES

APPENDIX I: LETTER OF INTRODUCTION

EZEKIEL PASHA,

Date.....

MOUNT KENYA UNIVERSITY,

MAIN CAMPUS - THIKA

Dear Respondent (s)

**RE: DATA COLLECTION FOR MASTER OF ARTS IN RELIGIOUS
STUDIES THESIS PROJECT**

I am a postgraduate student pursuing a Master of Arts in Religious Studies at Mount Kenya University. For my academic requirements, I am conducting a research project titled “Assessment of the Effectiveness of Pastoral Care Services in Promoting Acceptance of People Living with HIV/AIDS in PEFA Churches in Kajiado County, Kenya.” I kindly invite you to participate in this study by completing the attached questionnaire. All the information you provide will be used exclusively for research purposes, and I assure you of complete confidentiality. Please refrain from writing your name on the questionnaire to ensure anonymity. Kindly fill out the questionnaire and return it as per our agreed timeline. Your participation is greatly appreciated.

Thank you for agreeing to participate in the study.

Yours sincerely,

Ezekiel Pasha

APPENDIX II: CONSENT FORM

Dear respondent,

I am Ezekiel Pasha, a student at Mount Kenya University, currently pursuing a Master of Arts in Religious Studies. As part of my degree requirements, I am conducting research titled: “Assessment of the Effectiveness of Pastoral Care Services in Promoting Acceptance of People Living with HIV/AIDS in PEFA Churches in Kajiado County, Kenya.” You have been chosen to participate in this study, and I have attached a questionnaire for your kind response. I encourage you to participate and answer all questions to support the study’s success. Feel free to ask any questions about the research. You may withdraw from the study at any time, and your decision will be fully respected. I will adhere to research ethics during data collection, analysis, and usage. All information you provide will remain strictly confidential and will be used solely for academic purposes. While the data will be included in my final report, papers, and articles, no names will be associated with it. A copy of the thesis will be submitted to Mount Kenya University as part of my degree requirements. I greatly appreciate your cooperation.

Acknowledgement: Please sign this form to show agreement and your willingness to take part in the study.

Name

Signature

Date

APPENDIX III: QUESTIONNAIRE FOR PLWHA

SECTION A: Demographic Information

1. Gender

Male Female

2. Age bracket (tick as appropriate)

18-24 years	
25-30 years	
30-36 years	
37-44 years	
45 years and above	

3. Highest level of education (tick as appropriate)

Primary	
Secondary	
College	
University	
Postgraduate	
Any other (please explain)	

OBJECTIVE I: Biblical and Theological Foundations of pastoral care

1. To what extent do you agree with the following statements? Please tick (5-strongly agree, 4-agree, 3-neutral, 2-disagree, 1-strongly disagree)

Statement	1	2	3	4	5
Individuals living with HIV should be encouraged to acknowledge the behaviors or actions that may have contributed to their infection					
People living with HIV occasionally experience harsh or unfriendly treatment from members of the church community.					
Individuals with HIV are at times stigmatized as sinful, unethical, and lacking moral values, despite the notion that living with HIV can be viewed positively					
Creating a distinct worship service for those living with HIV is considered a commendable concept.					
Voluntary Counseling and Testing (VCT) is intended for individuals who suspect they may have contracted HIV, as access to accurate HIV/AIDS information can help decrease stigma toward affected individuals					
Access to the right information on HIV/AIDS would reduce stigma against people living with HIV.					
Individuals who are HIV positive should not be assigned leadership roles within the church					
Church leaders are expected to fulfill an essential role in supporting and guiding their congregations					

OBJECTIVE II: Information dissemination in promoting acceptance of PLWHA

1. How frequently do you attend church? (tick as appropriate)

Frequently	
Less frequently	
Never	

2. Are you satisfied with how the bible is interpreted on HIV/AIDS and behavior change among the members in your church? (tick as appropriate)

Very satisfied	
Moderately satisfied	
Low satisfaction	
Unsatisfied	
I don't know	

3. To what extent do you agree with the following statements? Please tick (5-strongly agree, 4-agree, 3-neutral, 2-disagree, 1-strongly disagree)

Statement	1	2	3	4	5
The church provides information on ARVs and other medication for HIV/AIDS patients					
The forum for networking with other HIV/AIDS patients lessens feelings of isolation and being neglected					

Stigma awareness reduces discrimination of HIV patients and the members of their families					
Information on HIV/AIDS medication reduces HIV mortality rates					
Information on HIV/AIDS medication ensures adherence to medication					
Information on sexuality reduces HIV/AIDS prevalence rates					

SECTION D: Pastoral Counseling in promoting acceptance of PLWHA

1. Indicate by ticking on the nature of counseling services provided for in the church

- Acceptance
- Positive living
- Confidentiality

2. To what extent do you agree with the following statements? Please tick (5-strongly disagree, 4-disagree, 3-neutral, 2-agree, 1-strongly agree)

Statement	1	2	3	4	5
Guidance and counseling reduces suicide rates among HIV patients					
Guidance and counseling ensures safe sex practices hence reduces HIV prevalence rates					

SECTION E: Strategies by church leadership in promoting acceptance of PLWHA

1. To what extent do you agree with the following statements? Please tick (5-strongly agree, 4-agree, 3-neutral, 2-disagree, 1-strongly disagree)

Statement	1	2	3	4	5
Engaging individuals living with HIV/AIDS in the creation, execution, and policy formulation of programs could help decrease HIV-related stigma.					
Including people living with HIV/AIDS in seminars and workshops could be highly effective in combating HIV-related stigma.					
The church incorporates HIV/AIDS patients on social services such as music/drama festivals etc..					
The church sets aside a budget for HIV/AIDS pastoral care					
The church collaborates with other actors in the fight against HIV/AIDS					
The church organizes seminars and workshops to educate people on HIV/AIDS					

APPENDIX IV: INTERVIEW GUIDE FOR PASTORS

1. Biblical and theological foundations of pastoral care in promoting acceptance of PLWHA

- 1.1. What does the bible teach about the incurable diseases?
- 1.2. Explain the teaching of the bible on our attitudes towards those with incurable diseases
- 1.3. How can we use the bible to reduce discrimination against PLWHA

2. Effectiveness of information dissemination in promoting acceptance of PLWHA

- 2.1. How do you relay information about nature of HIV/AIDs?
- 2.2. How do you disseminate information about HIV/AIDs spread?
- 2.3. Explain the methods do you use to sensitize church members on prevention of HIV/AIDs.

3. Effectiveness of pastoral counseling in promoting acceptance

- 3.1. What information do the members of your church need to have concerning HIV/AIDs?
- 3.2. How do you package HIV/AIDs information that you teach to the church members?
- 3.3. How has the church tailored its programs and communication on HIV/AIDs and behavior change that can result in significant changes in knowledge and attitudes that affect sexual behavior of young people?

4. Strategies by church leadership of implementing pastoral care services

- 4.1. Why, in your opinion, do the members of your church continue to be infected despite receiving information about how to keep themselves from getting infected?

4.2. Why, in your opinion, do the members of your church continue to be infected despite receiving information about how to keep themselves from getting infected?



APPENDIX V: INTERVIEW GUIDE FOR CHURCH LEADERS

1. Biblical and theological foundations of pastoral care

- 1.1. Do you have any scriptures pertaining to HIV/AIDS counseling or any other training related to HIV/AIDS?
- 1.2. What are some of the youth prayer programmes that strengthen their relationship with God?
- 1.3. In your opinion, what are the benefits of the pastoral care programmes to the church members and the especially the ones affected and infected with HIV/AIDSs?

2. Effectiveness of information dissemination in promoting acceptance of PLWHA

- 2.1. What are any 3 ways by which the society has changed today that influences HIV/AIDS trends in the community?
- 2.2. What 3 challenges do you experience as church leaders in administering the pastoral care services?
- 2.3. How are you as a leader of the church prepared to address these challenges?
- 2.4. How different do you think the members in the church are from those outside the church?

3. Effectiveness of pastoral counseling in promoting acceptance

- 3.1. What type of counseling do the members of your church need to have concerning HIV/AIDS?
- 3.2. How do you package HIV/AIDS information that you teach to the church members?
- 3.3. Do you discuss matters related to HIV/AIDSs in your leaders' meetings?

4. Strategies by church leadership of implementing pastoral care services

- 4.1. Do you organize for seminars/workshops to educate people on HIV/AIDSs?

4.2. Are there initiatives by the church for HIV/AIDS care such as setting up of hospitals, VCT centers etc.?

4.3. Do you allocate funds from your budget for HIV/AIDS programs?



**APPENDIX VI: FOCUSED GROUP DISCUSSION FOR THE HIV/AIDS
AFFECTED MEMBERS OF THE CONGREGATION**

1. Biblical and theological foundations of pastoral care

- 1.1. Explain types of formal training offered in your church related to HIV/AIDS?
- 1.2. Are you aware youths are engaged in risky sexual behaviors that would predispose them to HIV/AIDS infections?
- 1.3. What are some of the factors increase the vulnerability of the youth to HIV/AIDS?

2. Effectiveness of information dissemination in promoting acceptance of PLWHA

- 2.1. What changes are there in the society today that influences HIV/AIDS trends in the community?
- 2.2. How are you as a leader of the church prepared to address these challenges?
- 2.3. How different do you think the members in the church are from those outside the church?

3. Effectiveness of pastoral counseling in promoting acceptance

- 3.1. What type of counseling do the members of your church need to have concerning HIV/AIDS?
- 3.2. How do you package HIV/AIDS information that you teach to the church members?
- 3.3. Do you discuss matters related to HIV/AIDS in your leaders' meetings?

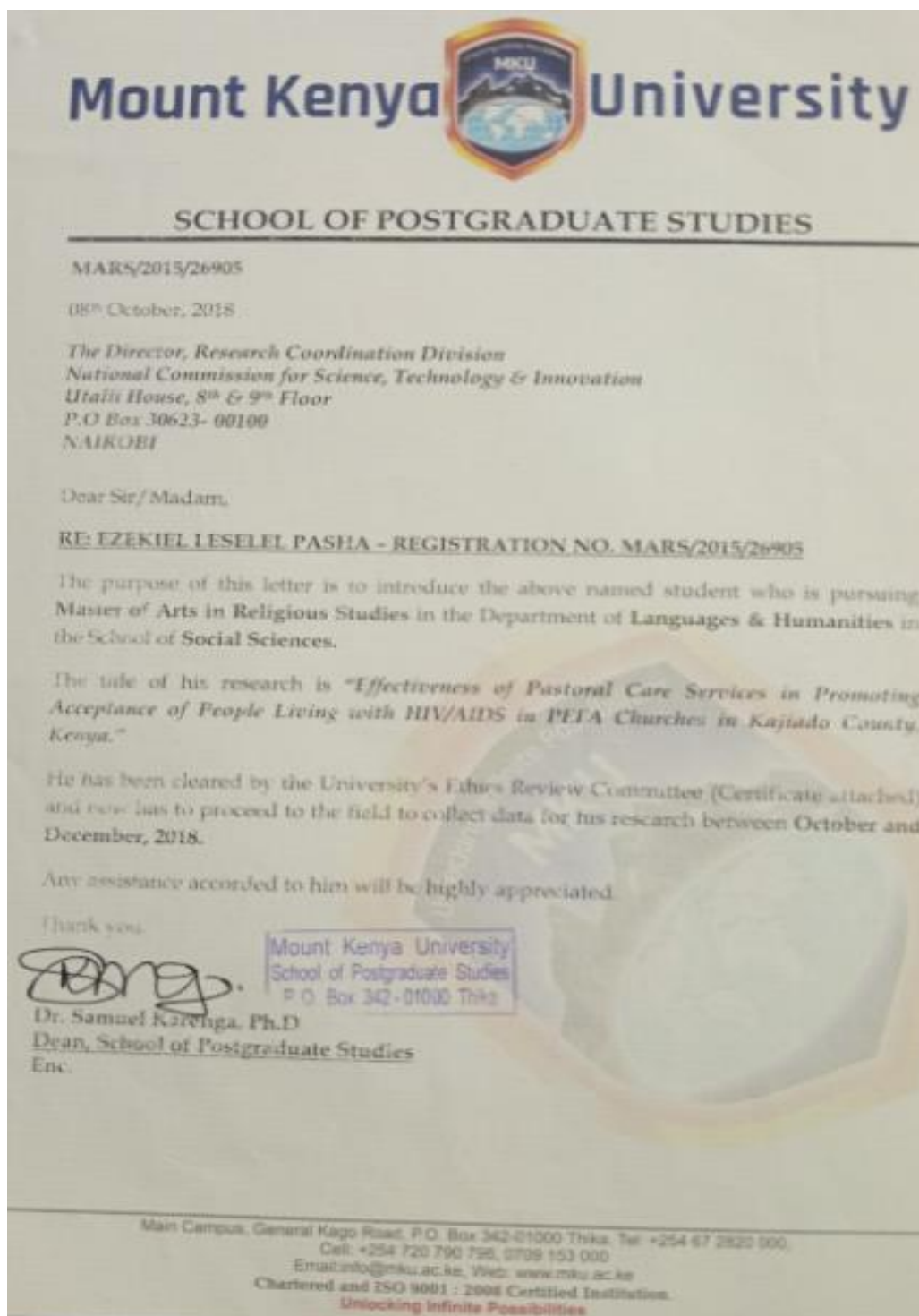
4. Strategies by church leadership of implementing pastoral care services

- 4.1. Do you organize for seminars/workshops to educate people on HIV/AIDS?
- 4.2. Are there initiatives by the church for HIV/AIDS care such as setting up of hospitals, VCT centers etc.?


4.3. Do you allocate funds from your budget for HIV/AIDs programs?



**APPENDIX VII: INTRODUCTICION LETTER FROM POSTGRADUATE
DIRECTORATE**



APPENDIX VIII: ETHICAL REVIEW COMMITTEE CLEARANCE



Mount Kenya University

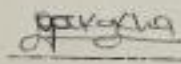
OCTOBER 1, 2018

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CERTIFICATE OF ETHICAL CLEARANCE

This is to certify that the proposal titled “EFFECTIVENESS OF PASTORAL CARE SERVICES IN PROMOTING ACCEPTANCE OF PEOPLE LIVING WITH HIV/AIDS IN PEFA CHURCHES IN KAJIADO COUNTY, KENYA” Whose Principal Investigator is Mr Ezekiel Leselel Pasha (MARS/2015/26905) has been reviewed by Mount Kenya University Ethics Review Committee (ERC), and found to adequately address all ethical concerns.

Dr. Francis W. Makokha
Secretary, Mount Kenya University ERC


Sign:  Date: 01.10.2018

Prof. Francis W. Muregi
Chairman, Mount Kenya University ERC

Sign:  Date: 01.10.2018

Main Campus, General Kago Road, P.O. Box 342-01000 Thika. Tel: +254 67 2820 000,
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APPENDIX IX: NACOSTI RESEARCH PERMIT



**NATIONAL COMMISSION FOR SCIENCE,
TECHNOLOGY AND INNOVATION**

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2241388,3310571,2219429
Fax: +254 20-318245,318249
Email: dg@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

NACOSTI Upper Kabete
Off. Wayaki Way
P.O. Box 50623-00100
NAIROBI-KENYA

Ref. No: **NACOSTI/P/18/72806/26796** Date: **16th November, 2018**

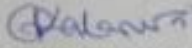
Ezekiel Leselel Pasha
Mount Kenya University
P.O. Box 342-01000
THIKA.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on *“Effectiveness of pastoral care services in promoting acceptance of people living with HIV/AIDS in PEFA Churches in Kajiado County, Kenya,”* I am pleased to inform you that you have been authorized to undertake research in **Kajiado County** for the period ending **15th November, 2019.**

You are advised to report to **the County Commissioner and the County Director of Education, Kajiado County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit a **copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

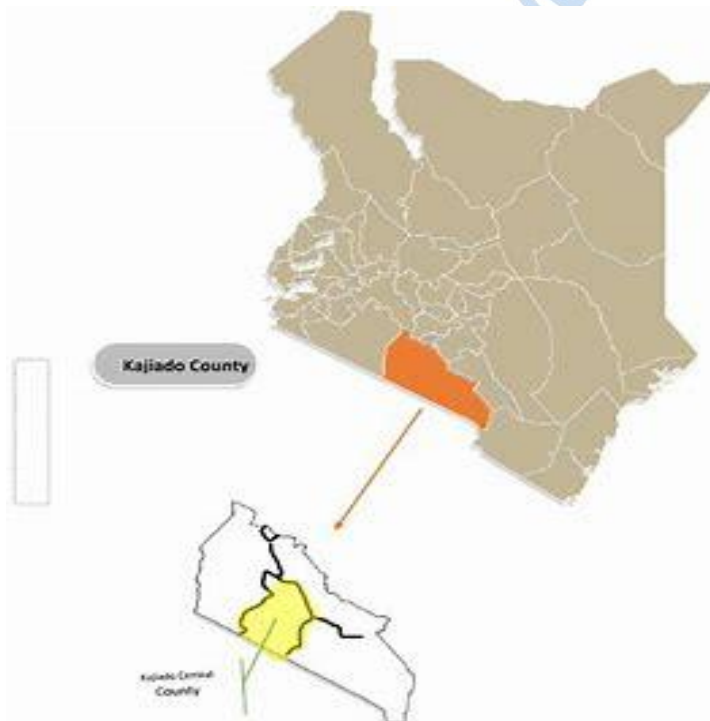

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Kajiado County.

The County Director of Education
Kajiado County.

APPENDIX X: MAP OF STUDY LOCATION, KAJIADO COUNTY



APPENDIX VIII: SIMILARITY INDEX REPORT

Ezekiel Pasha

EFFECTIVENESS OF PASTORAL CARE SERVICES IN PROMOTING ACCEPTANCE OF PEOPLE LIVING WITH HIV/AI...

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