

**INFLUENCE OF PASTORAL CARE IN COMBATING HIV/AIDS  
RELATED STIGMA AND DISCRIMINATION: A CASE OF METHODIST  
CHURCH KAAGA SYNOD IN THE MERU COUNTY //**

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**A RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL  
FULFILMENT FOR THE REQUIREMENTS OF THE AWARD OF  
MASTER OF ARTS DEGREE IN PROJECT PLANNING AND  
MANAGEMENT OF THE UNIVERSITY OF NAIROBI.**

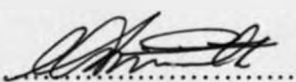
## DECLARATION

### Declaration by the student

I declare that this research project report is my original work and has never been presented for examination to any academic institution for any award.

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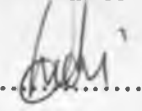
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## DEDICATION

I dedicate this study to my wife Rev. Doreen Murithi, my children Priestam Kinya and Prudence Kanana who kept on demanding to see what I had scored. Occasionally I could hear them say “Dad amekazwa na mitihani”.

## ACKNOWLEDGEMENT

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## ABBREVIATIONS AND ACRONYMS

<b>AIDS</b>	-	Acquired Immune Deficiency Syndrome
<b>ARV</b>	-	Antiretroviral
<b>GIPA</b>	-	Great Involvement of People Living with HIV/AIDS
<b>HIV</b>	-	Human Immuno Deficiency Virus
<b>ILO</b>	-	International Labour Organization
<b>MCK</b>	-	Methodist Church in Kenya
<b>PLHA</b>	-	People Living with HIV/AIDS
<b>TOT</b>	-	Training of Trainers
<b>UNAIDS</b>	-	Joint United Nation programme on HIV and AIDS
<b>USAID</b>	-	United States Agency for International Development
<b>VCT</b>	-	Voluntary Counseling and Testing
<b>WHO</b>	-	World Health Organization

## ABSTRACT

HIV-related stigma and discrimination exist worldwide. In Kenya, as elsewhere, stigma has been accompanied by discrimination affecting HIV transmission patterns and access to care and support. Stigma interferes with attempts to fight the AIDS epidemic. People fear discrimination and they refrain from seeking testing. Those who test positive may refuse to disclose their status, or change their behaviour to avoid negative reactions. This study was conducted to assess the influence of pastoral care in combating HIV stigma and discrimination. The aim of the study was to investigate the influence of pastoral support in combating HIV/AIDS related stigma and discrimination, to explore the influence of information in combating HIV/AIDS related stigma and discrimination, to determine the influence of pastoral counseling in combating HIV/AIDS related stigma and discrimination and to establish the influence of advocacy in combating HIV/AIDS related stigma and discrimination in MCK Kaaga Synod. Descriptive survey design was used. The target population included 265 members of which; 160 were church members, 75 HIV positive persons and 30 ministers. A sample size of 79 was selected through stratified random sampling. The study concluded that pastoral support helps in reducing HIV/AIDS stigma and discrimination in the sense that it demonstrates Gods love through prayers, encouragement and material support to the suffering, provision of accurate information does significantly reduce HIV stigma and discrimination in the sense that misconceptions about HIV transmission routes are addressed and corrected, pastoral counseling has positive influence in combating HIV related stigma and discrimination because it helps in cultivating a positive attitude and also guides the infected to live positively with the virus. Advocacy has a positive effect towards the reduction of HIV stigma and discrimination since people living with HIV/AIDS are encouraged to take a participatory role in policy formulation and program implementation. From the study the following recommendations were made that; the church should have zero tolerance for HIV/AIDS stigma and discrimination and do all that is necessary to eliminate rejection, fear and oppression of the infected and affected in the community. It should start home care programs to support orphans and other needy children with basic necessities, the church should provide accurate information about transmission risks and prevention of HIV/AIDS, about the economic and social pressures that make (especially women and girls) vulnerable to unsafe sex, about where to get care, support and medical treatment for those infected. The church should offer pastoral counseling to those infected with HIV/AIDS since it reduces the experience of stigma and discrimination, increases the number of those who seek voluntary testing for HIV treatment and helps them to live positively. The church should ensure active participation of the clergy, the laity and HIV positive persons in combating HIV stigma and discrimination.

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background to the study

HIV-related stigma and discrimination have been identified internationally as main barriers to HIV control and prevention in every country and region of the world, posing challenges to preventing further infections, alleviating the impact, and providing adequate care, support and treatment (Joint United Nations programme on HIV/AIDS {UNAIDS}, 2007).

Today, HIV/AIDS threatens the welfare and well being of people throughout the world. At the end of the 2010, 34 million people were living with HIV and 1.8 million had died from AIDS related illness that year (UNAIDS, 2011). Despite numerous efforts to change the negative attitudes and discrimination associated with HIV/AIDS, the disease continues to carry a significant stigma that impact many areas of society (Visser, Makin & Lahoby, 2006). Edwin Cameron, a high court judge in South Africa himself living and infected with HIV, commenting on the stigma and discrimination associated with HIV/AIDS said that HIV/AIDS is stigma, disgrace, discrimination, hatred, hardship, abandonment, isolation, exclusion, persecution, condemnation, punishment, a curse, rebuke and judgment (Edwin 2007). HIV/AIDS eats way at dignity and self respect. It causes fear, guilt, denial, stigma and discrimination (Igo Robert 2008). Attention needs to be focused on stigma, denial discrimination and mis-action as most of the negative behavioral patterns are associated with these elements. In the past, programs dealing with HIV and AIDS failed to have meaningful impact as they did not address issues of stigma, denial and discrimination.

According to UNAIDS, HIV-related stigma is “the process of devaluation” of people either living with or associated with HIV and AIDS. This stigma is derived from the historical and

contemporary association of HIV and AIDS with what society considers socially unacceptable behavior and the fact that it leads to an incurable, unalterable, severe, and degenerative condition that may result in physical disfigurement or death (UNAIDS, 2010). The Religions for Peace manual on Advocacy and Media Relations for Religious Leaders gives this definition: "Stigma is discrediting a person on the basis of his or her belonging to a particular group or on the basis of possessing certain characteristics such as color, the way the person talks, the way the person walks, etc. It is a mark and a token of disgrace." (Religions for peace, 2007). In previous years, and in the religious context, HIV was stigmatized because it was transmitted sexually and because of perceptions that those living with the virus were sinners and were thus paying the wages of sin or leading immoral lives. Stigma is also reinforced by fear driven by a perception of risk or the threat of infection with an incurable or potentially fatal disease. Fear of contagion is not reduced by general knowledge of how HIV is transmitted. As shown by studies in several countries and testimonials by people living with HIV and AIDS, even health workers who are quite knowledgeable about the modes of transmission routinely exhibit fear and irrational behavior and stigmatize people living with HIV and AIDS. Only in-depth knowledge and appreciation of how HIV is *not* transmitted and the vulnerability of the HIV virus in the open environment have been shown to reduce this fear.

According to UNAIDS, discrimination is different treatment of individuals who, within a particular culture or setting, have certain attributes that others define as discreditable and unworthy. It is thus the progression from stigma, which marks that person with an undesirable attribute, to giving them differential treatment. In relation to HIV and AIDS, discrimination is additionally spurred by the false notion that people living with HIV and AIDS are waiting to die and therefore have no need for education, jobs, skills upgrading, good medical care, property,

good clothes, entertainment, friends, marriage, or otherwise live normal lives. Several groups are at risk of being discriminated against since they have a lower social status due to historical or cultural practices. These vulnerable groups include women (especially widows), children, the physically or mentally challenged, and the poor. Children are especially at risk of discrimination by association when they are discriminated against because their parents are living with HIV (UNAIDS, 2010).

Pastoral care involves all the action the church is called to undertake in relation to the physical, social, economic and even spiritual needs of a person. It includes partnership in discussion and reflection about the specific problems and challenges the individual and his or her family are facing. In that sense, pastoral care may be concerned with many different areas of the life of a person or a family, and may address physical, practical, psychological, social and spiritual needs. The goal of pastoral care would be to help infected persons come to terms with their situation; and to promote coping strategies for the infected and the affected, including preventing or reducing HIV-transmission (Stutterheim, et al, 2009).

By their very nature as communities of faith in Christ, churches are called to be healing communities. This call becomes the more insistent as the AIDS pandemic continues to grow. Within the churches we are increasingly confronted with persons affected by HIV/AIDS, seeking support and solidarity and asking: are you willing to be my brother and sister within the one body of Christ? (Douglas & Hannah, 2000). In this encounter our very credibility is at stake. Many churches, indeed, have found that their own lives have been enhanced by the witness of persons living with HIV/AIDS. These have reminded us that it is possible to affirm life even when faced with severe, incurable illness and serious physical limitation, that sickness and death are not the standard by which life is measured, that it is the quality of life - whatever its length -

that is most important. Such a witness invites the churches to respond with love and faithful caring. Despite the extent and complexity of the problems, the churches can make an effective healing witness towards those affected by HIV/AIDS. (Macmaster SA, Thompson & Sanders, 2006). The experience of love, acceptance and support within a community where God's love is made manifest can be a powerful healing force. Healing is fostered where churches relate to daily life and where people feel safe to share their stories and testimonies. Through sensitive worship, churches help persons enter the healing presence of God. The churches exercise a vital ministry through encouraging discussion and analysis of information, helping to identify problems and supporting participation towards constructive change in the community.

## **1.2 Statement of the Problem**

HIV stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is the chief reason why the AIDS epidemic continues to devastate societies around the world (Ban, Ki moon, 2008).

This is further supported by a study done by the World Council of Churches which reveals the churches being in agreement that the most powerful contribution they could make in combating HIV transmission is the eradication of stigma and discrimination (WCC, 2009). The words echoed by Archbishop Desmond Tutu challenges the Church to be more aggressive in addressing the problem of HIV-related stigma. He said that silence kills, stigma kills. The Church should not want those living with HIV to be the modern equivalent of the biblical leper who had to carry a bell and a sign saying I am unclean (Simbeyi, Cloetes & Maeket, 2007).

People infected with HIV/AIDS find themselves in terrible situations. They long for guidance as to where they can find meaning on how they can make sense of this destructive virus. Sometimes people are suffering from a far deeper pain due to a distorted Christian theology that is insensitively administered by ill equipped priests and religious brothers and sisters. This study is therefore borne of the desire to deal with HIV stigma from a pastoral point of view. The researcher seeks to investigate the influence of pastoral care in combating HIV-related stigma and discrimination in MCK Kaaga Synod in the Meru County. Pastoral care gives people the time and opportunity to share the deeper emotional and spiritual difficulties they experience as people living with HIV/AIDS (Igo Robert, 2008). MCK Kaaga synod runs a HIV/AIDS programme which started in 2003 and has initiated the formation of HIV/AIDS support groups in 10 circuits. The research was a result of the researcher's interaction with people living with HIV/AIDS within the synod having worked as a Church minister for the last seven years.

### **1.3 Purpose of the Study**

The purpose of the study was to investigate the influence of pastoral care in combating HIV/AIDS related stigma.

### **1.4 Objectives of the Study:**

The objectives of the study were:-

- (a) To investigate the influence of pastoral support in combating HIV/AIDS related stigma and discrimination in Kaaga synod.
- (b) To explore the influence of information in combating HIV/AIDS related stigma and discrimination in Kaaga synod.
- (c) To determine the influence of pastoral counseling in combating HIV/AIDS related stigma and discrimination in Kaaga synod.

- (d) To establish the influence of advocacy in combating HIV/AIDS related stigma and discrimination in Kaaga synod.

### **1.5 Research Question**

The study was guided by the following research questions;

- (a) How does pastoral support influence HIV/AIDS related stigma and discrimination?
- (b) How does information influence HIV/AIDS related stigma and discrimination?
- (c) What influence does pastoral counseling have on HIV/AIDS related stigma and discrimination?
- (d) To what extent does advocacy influence HIV/AIDS related stigma and discrimination?

### **1.6 Assumptions of the Study**

The major assumptions made on this study were;

- a) That the respondents would be free to respond to all the questions raised in the questionnaires correctly and faithfully.
- b) That the questionnaire return rate of over 75% would be realized to ensure good representation.

### **1.7 Limitations of the Study**

The researcher was only able to deal with HIV/AIDS support groups under Kaaga Synod due to the logistics and time. It would have been ideal to deal with the entire population within the synod.

### **1.8 Delimitations of study**

The study was done in Kaaga Synod of Meru County dealing with the Ministers and the members of Methodist church within the sampled circuits. The study was limited to the four research objectives which are pastoral support, provision of information, pastoral counseling and



advocacy, investigating their influence on HIV stigma and discrimination. The researcher has grown in this synod and served as a church minister for seven years and therefore had some advantage when collecting data from the people.

### **1.9 Significance of the Study**

This study is necessary so as to enable the church leaders, counselors and the community to come up with strategies to help in combating HIV-related stigma and discrimination. In addition, this will enable the policy makers to come up with policies meant to address the issues affecting people living with HIV/AIDS and ensure their rights are respected.

## **1.10 Definition of significant Terms**

**Advocacy** – Taking action to bring about the intended change by actively involving the stakeholders.

**Bishop** – A Methodist minister elected to be in-charge of a synod.

**Circuit** – A term used in Methodist Church referring to churches put together.

**HIV discrimination** – refers to any unfair and unjust treatment directed towards persons infected or affected by HIV/AIDS.

**HIV stigma** –refers to all unfavorable attitudes, beliefs and policies directed at those living with HIV/AIDS.

**Pastoral care** – It encompasses all the action the church is called to undertake in relation to the physical, spiritual, economic, social and even political needs of a person to ensure wholeness.

**Pastoral counseling** – Is an approach whereby individuals, couples, families and groups are empowered and guided through the word of God and relevant knowledge to enable them make informed decisions regarding their situations in order to achieve wholeness and health.

**Pastoral Support** – attending the physical, social, economic and spiritual needs of people living with HIV/AIDS

**Provision of Information** – refers to awareness creation on the importance of seeking VCT, modes of HIV transmission and prevention, available medical care and care giving, sexuality and reproductive health.

**Superintendent Minister** –A Methodist minister appointed to be in-charge of a circuit.

**Synod** – A term used in Methodist Church referring to circuits put together.

### **1.11 Organization of the Study**

The study is organized into five chapters. Chapter one has covered introduction consisting of background of the study, statement of the problem, purpose of the study, research objectives and questions, significance of the study, delimitation, limitations of the study, assumptions of the study, definition of significant terms and finally organization of the study. Chapter two has covered the literature review based on the research objective, the theoretical and conceptual framework. Chapter three explains the research methodology covering the introduction, research design, target population, sampling procedure, methods of data collection, validity and reliability, data analysis procedure and operational definition of variables. Chapter four has dealt with data analysis, presentation and interpretation while chapter five is the summing of the findings, discussion, conclusion, recommendation and suggestion for further studies.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

This chapter looks at the literature related to HIV/AIDS stigma and discrimination. It has discussed the following topics- the meaning and content of stigma, types of HIV-related stigma, causes of HIV-related stigma, effects of HIV-related stigma and the church and HIV-related stigma, theoretical framework, pastoral care and its functions, pastoral support, influence of information, influence of pastoral counseling and advocacy, in combating HIV/AIDS stigma and discrimination. Finally the chapter has discussed the appropriate conceptual framework followed by a summary.

#### 2.2 Meaning and content of stigma

The concept of “stigma” is derived from a Greek word referring to a tattoo mark .Generally it has two meaning one derived from Christianity and denotes bodily marks which are similar to those of crucifixion of Jesus Christ . They are associated with divine favour .The second meaning is secular, namely Marks of disgrace, discredit or infamy (Gulmore & Somerville, 1994) Today stigma is recognized as an attribute that is deeply discrediting , that reduces the bearer from a whole and usual person to a tainted, discounted one (A.Miller & D. Rubin, 2007). Stigma is also used to set the affected persons or groups apart from the normalized social order and this separation implies devaluation (Mawar, Saha & Muhafan 2005). HIV –related stigma is often compounded when affected individuals come from already stigmatized groups such as those who are homosexual, bisexual, promiscuous, use drugs, those who are sex workers, the poor or the disenfranchised (Theo, Smart 2008)

HIV stigma is a social construct, which has significant impact on the life experiences of individuals both infected and affected by HIV/AIDS (Taylor 2001). Stigma includes prejudice

and can lead to active discrimination directed towards persons either perceived to be or actually infected with HIV and the social groups and persons with whom they are associated (Http://.www.edc, 2011).

Campbell described discrimination as negative behaviour and stigmatization as any negative thoughts, feeling, or action towards PLHA, irrespective of whether people are discriminated because they know that they are devalued (Campbell & Nicholson, 2007)

### **2.3 Types of HIV-Related stigma**

Thomas (2008) in a study done in Namibia views stigma as multi-dimensional. According to him there are three broad types of HIV/AIDS –related stigma, first is self stigma which occurs through self blame and self deprecation of those living with HIV/AIDS. Second, is perceived stigma which is related to the fear that individuals have that if they disclose their HIV positive status, they may be stigmatized. Third is the enacted stigma, which occurs when individuals are actively discriminated against because of their HIV status –actual or perceived.

According to Makoae, Greeft and Phetihu stigma can be placed under two broad categories. Stigma can be external or internal. External stigma refers to the actual experiences of discrimination. Internal stigma (felt or imagined stigma) is the shame associated with HIV/AIDS and PLHAs fear of being discriminated against (L. Makoae, M.Greeft and Phetihu, 2008). Internal stigma is a survival mechanism aimed at protecting oneself from external stigma and often results in thoughts or behavior such as the refusal or reluctance to disclose a positive HIV status, denial of HIV/AIDS and unwillingness to accept help (L. Simbayi, Cloete & Maeketi, 2007). Stigma may be manifested through gossip, verbal abuse and distancing from individuals living with HIV and AIDS. It can cover subtle actions as well as extreme degradation, rejection and abandonment (Thomas, 2006).

## **2.4 Causes of HIV-Related stigma**

Alonzo and Raynolds (2005) and DeBruyn (2006) identified four factors that contribute to HIV-related stigma. First, HIV/AIDS is a life-threatening disease, perceived to be contagious and threatening to the community. Second, people living with HIV are often seen as responsible for having contracted the disease, which increases feelings of guilt. Third, HIV/AIDS is related to behavior sanctioned by religious and moral beliefs which results in the belief that HIV is the consequence of deviant behavior and deserves punishment. Fourth, HIV/AIDS is associated with pre-existing social prejudices such as sexual promiscuity, homosexuality, and drug use, behavior that is already considered less worthy by many societies. HIV then adds to the existing societal judgment (Alonzo & Raynolds, 2006). Often, ignorance, lack of accurate information about HIV/AIDS, and misunderstanding about HIV transmission are common sources of HIV/AIDS stigma (Apinundecha et al 2007). A survey done in China revealed factors contributing to stigmatizing and discrimination responses included lack of knowledge such as basic knowledge of HIV/AIDS and universal precautions, provider attitudes, and perceptions that caring for HIV persons is pointless because HIV/AIDS is incurable (Hevel G.2008).

## **2.5 Effects of HIV-related stigma**

HIV-related stigma and discrimination have been identified internationally as main barriers to HIV control and prevention in every country and region of the world, posing challenges to preventing further infection, alleviating the impact, and providing adequate care, support, and treatment (<http://Unaids>). Despite numerous efforts to change the negative attitudes and discrimination associated with HIV/AIDS, the disease continues to carry a significant stigma that impacts many areas of society (Visser, Makin & Lahoby 2006). HIV/AIDS-related stigma interferes with the well-being of people living with the disease. Stigma may increase new HIV infections because it can discourage people who are HIV-positive from discussing their status.

with their sexual partners or needle sharing partner (<http://lab.hsa.gov/publications>, 2009). They may choose not to protect themselves or others and they may not seek treatment if they are infected. In health care settings, HIV –related stigma discourages people with HIV/AIDS (PLHA) from seeking care if they previously experienced unwelcoming treatment or if their confidentiality was not respected (Foreman & Reinbwer & Washington 2003). On the other hand people living with HIV can experience stigma and discrimination such as being refused medicines or access to facilities, receiving HIV testing without consent and lack of confidentiality (Stutterheim Se et al, 2009). Lack of confidentiality has been repeatedly mentioned as a particular problem in healthcare settings.

Many people living with HIV/AIDS do not choose, how, when and to whom to disclose their HIV status. Studies by the WHO in India, Indonesia, Philippines and Thailand found that 34 percent of respondents reported breaches of confidentiality by health workers (WHO, 2008). In the workplaces, people living with HIV may suffer stigma from their co-workers and employees such as isolation and ridicule, or experience discriminatory practices such as termination or refusal of employment. In December 2010, the international labour organization (ILO) and China’s centre for disease control and prevention (CDE) issued a joint report entitled “HIV and AIDS related employment discrimination in China. It noted that the national policy for recruiting civil servant specifies that “those who suffer gonorrhoea, syphilis, chancroid, genital Herpes or HIV will be disqualified” (ILO, 2010). Rulian will from the ILO commented that if the government discriminated against people with HIV, then other sectors will follow (Talha Khan Burki, 2011).

Some countries have laws that restricted the entry, stay and residence of people living with HIV. As of September 2011, people living with HIV were subject to some sort of restriction on their travel and, or stay in 47 countries, territories and areas (UNAIDS, 2011). Restrictions could

include the need to disclose HIV status or to be subjected to a mandatory HIV test, the need for discretionary approval to stay, and the deportation of individuals once their HIV-Positive status is discovered (UNAIDS, 2011). Until the 4<sup>th</sup> January 2010, the United States restricted all HIV positive people from entering the country whether they were on holiday or visiting on a longer term basis (Goosby E, 2010).

Community level stigma and discrimination can manifest as ostracism, rejection, verbal and physical abuse .It has even extended to murder. AIDS –related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, South Africa and Thailand (ATLIS 2010).

A Dutch survey of people living with HIV found that stigma in family settings in particular avoidance, exaggerated kindness and being told to conceal one's status was a significant predictor of psychological distress. This was believed to be due to the absence of unconditional love and support, which families are expected to provide (Stutterheim SE et al 2009).

## **2.6 The Church and HIV –Related stigma**

Since the time of slavery, Churches have served as the foundation for spiritual growth and development, political and civil activity and social cohesion and organization in the African American community (Coytne & Schoenbach, 2000). The Church has remained the focal point of life for many African Americans (Tylor, Thonthon & Chatters 2001). In recent years the Church has also been seen as a centre for health promotion and disease prevention, as the issue of health equality became the next phase of the civil rights movement (Kaplan, Calmens Building, 2006). Although African American Churches have provided a number of health promotion and disease prevention programs focusing on a variety health related issues, HIV /AIDS prevention programs have received much less attention (Macmaster, Thompson & sanders, 2007). In January 2006, the South Carolina HIV/AIDS Council (SCHAC) established project F.A.I.H (Fostering AIDS Initiatives that Heal) whose purpose was to reduce HIV –



related stigma among African American Churches and faith-based organizations in South Carolina (<http://www.cde>, 2009). Religious institutions have been documented as playing both supportive and detrimental roles towards PLHA (Hartwing & Kissioki, 2006).

One of the strategies used by some churches to regain their lost moral authority is vigorously linking sexual transgressions and AIDS with sin and immorality (Thomas F. 2008). Some religious approach warrants stigmatizing people as “saved” or “sinner” “pure” or “impure”, “us” or “them” and it strengthens the broader social stratifications within which stigma flourishes (E. Glolok, Ateryambe & Wor denhanna, 2007). A study done by Campell, Nair and Nicholson reveals that some Churches impose mandatory HIV testing before allowing marriage and individual with HIV have either been excommunicated from Churches because they were deemed “sinners” or have been forced to confess their sins (Campell, Y, Nair & J, Nicholson, 2007 ).

However, in the year 2001 there was a strong ecumenical response to HIV/AIDS in Africa. The Churches felt that the most powerful contribution they could make to combating HIV transmission was the eradication of stigma and discrimination (WCC, 2001). In November 2001, the World Council of Churches convened a meeting of African Church leaders, in Nairobi to draw up an ecumenical plan of action for responding to the AIDS epidemic. It was unanimously agreed that for Churches the eradication of HIV and AIDS –related stigma must be a priority, a resolution that has since then been endorsed, regionally and internationally by individual denominations (Alison, 2002). The move is also reflected in the statement of African primates on AIDS:

“We raise our voices to call for an end to silence about this disease, the silence of stigma, the silence of denial, the silence of fear .We confess that the Church herself has been compliant in this silence .We have raised our voices in the past, It has been too often a voice of

condemnation. We now wish to make it clear that HIV/AIDS is not a punishment from God. Our Christian Faith compels us to accept that all persons, including those who are living with HIV/AIDS, are made in the images of God and are children of God” (Bevans and Schroeder, 2004).

## **2.7 Theoretical Framework**

The individual identity theory states that individual identity is the product of how we think of ourselves and of others. This includes our attitudes, beliefs and values about our commonalities and differences in relation to others (Woodward, 2002).

Identity gives us a location in the world and presents the link between us and the society in which we live. It gives us an idea of who we are and how we relate to others and to the world in which we live. It spells out the need for harmonious living and respect for human dignity regardless of whether one is HIV positive or not. Our sense of identity is intertwined with social and cultural ideas that allow us to understand ourselves in relation to others, including social differences linked to gender, age, class, religion, race, ethnicity, nationality, sexual orientation and physical attributes.

Stigma is that part of identity that has to do with prejudice – the setting apart of individuals or groups through the attachment of heightened negative perceptions and values. Stigma is a process that may occur at the individual level, but it is also influenced by social processes related to assumptions, stereotypes, generalizations and labeling of people as belonging to a particular category on the basis of association. Stigma involves the social expression of negative attitudes beliefs and policies that contribute to processes of rejection, isolation, marginalization and harm of others (Link, 2001).

It is useful to distinguish between stigma and discrimination. Stigma is largely related to ideas about others, whilst discrimination involves some form of direct enactment of stigma which may

be verbal or physical, and which is likely to be hurtful and/or harmful to the person to whom it is addressed. Many authors, however, refer to stigma as encompassing both ideas and action. Most countries and societies have recognized that forms of stigma and discrimination are antagonistic to concepts of human rights and equality. Constitutions, bills of rights and various pieces of legislation have been enacted with a view to addressing and limiting such practices. Many inequalities are perpetuated in social practices that are well established and embedded such as in the use of language. In the case of HIV/AIDS, for example, the naming of people as 'victims' and 'sufferers' contributes to their stigmatization, and therefore there is need to create avenues where such constructions can be addressed.

## **2.8 Pastoral Care and its Functions**

Pastoral care is like an umbrella that encompasses all the action that the church is called to undertake in relation to the physical, spiritual, economic, social and even political needs of those who are affected by the virus. Pastoral care has application to the broadest range of pastoral and communal practices in the life of the church (Mulenga, 2009).

It is not limited to person to person encounters only, but is also applicable to caring for the church family and its community and the environment of the community of faith. Pastoral care to the community of faith entails the fulfillment of the church's evangelistic task to the world at large (Gerkin, 2004). In relation to this study pastoral care will focus on pastoral support (spiritual, physical and economic help), provision of information, pastoral counseling and advocacy.

Magezi (2006) looks at pastoral care as having seven functions namely, healing, sustaining, guiding, reconciling, nurturing, liberating and empowering. Pastoral care is thus a composite process of caring for individuals and communities with the aim of meeting a need which has

emanated such as the need for healing, sustaining, guiding, reconciling, nurturing, liberating or empowering. Pastoral care involves undertaking a person's many social, personal, physical, cultural and spiritual needs and responding to them in an integrated way (Gennrich, 2004). In HIV and AIDS care where death might be imminent and the individual experiences anger, guilt and despair, a carer should stress God's acceptance and unconditional love of the person (Mulenga, 2009). People caring for people living with HIV/AIDS whose condition has deteriorated are therefore to be sensitive to spiritual needs which are only met in sharing and accepting the message of grace in the gospel.

## **2.9 Influence of Pastoral Support on HIV/AIDS Stigma**

The prime duty of a pastor is to feed or care for the well being of those who are in need. Jesus Christ declares himself the good shepherd who gives his life for his sheep (John. 10:11) and expects Christians to feed and take care of his needy flock as a way of demonstrating that they love him (John. 21:15). The church should be actively involved in dealing with human suffering and the conditions that propagate the suffering. In his address the Presiding Bishop of the Methodist Church urged the church to provide pastoral care to individuals, families and relatives of those infected with HIV/AIDS (Kaaga Annual Synod minutes, 2010). The Christian community should have the heart to empathize with those who are suffering. Christians are charged with the responsibility of carrying each other's burdens (Galatians 6:2). Every Christian has an obligation and role to play as an individual in the fight against HIV/AIDS stigma and discrimination. Christians are called to remember, proclaim and act on the fact that their God is a compassionate God, who calls upon every individual to be compassionate, to suffer with those who suffer and seek lasting changes of their suffering (Luke 6:36; Mathew 25:31-46).

HIV/AIDS is a disease with moral, psychological, social, economic and political repercussions. It is a highly stigmatizing disease and patients with it fear discovery, discrimination, rejection

and abandonment. Patients are likely to develop feelings of hopelessness, uselessness, guilt, shame, loneliness, pain and fear of losing ones mental and physical faculties during the progression of the infection and finally death. Those employed are afraid of losing their jobs. The families of the infected person also suffer economic hardships if the affected person was the bread winner (Douglas & Hannah, 2000). It is for this reason that the church need to come in very strongly with the message of love, hope and encouragement to the affected. The church should have zero tolerance for HIV/AIDS stigma and discrimination and do all that is necessary to eliminate the isolation, rejection, fear and oppression of the infected and affected in our communities. The pastoral approach should be to reach out with God's love, prayers and assistance, both medical and material to the suffering. Jesus expects Christians to respond positively to those in need by offering them a compassionate hand. He says " I was hungry and you gave me food, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me" (Mathew. 25:35 & 36). The HIV/AIDS programme under Methodist church, Kaaga Synod has for the last six years engaged the church into pastoral care by praying together, reading from the word of God, awareness creation and giving material assistance to the affected through various HIV/AIDS support groups (Annual Synod report, 2011).

The church should develop home care programmes to support orphans and other needy children with food, school fees and school uniforms (Sonja, W. & Christoph, B. 2004). Kaaga Synod through HIV/AIDS programme is currently supporting over 200 children in primary schools, secondary schools also in colleges (Annual Synod report, 2011).

### **2.10 Influence of Information on HIV/AIDS Stigma**

Pastoral care which integrates the provision of accurate information about HIV transmission can significantly reduce HIV stigma and discrimination (Nyblade 2008). Complete knowledge of

how HIV is not transmitted translates into a greater degree of acceptance of people living with HIV and their family members (Overt. Org 2006). Previous studies have demonstrated that lack of information about HIV/AIDS and misconceptions about HIV transmission routes are important factors contributing to stigma and discrimination. Although HIV knowledge may not be sufficient to reduce HIV-related stigma, as misconceptions about acquiring HIV infection through casual contact may lead to an avoidance of social situations (Apinundecha, Cameron & Lim, 2007). In a review of HIV /AIDS stigma, Ogden and Nyblade (2005) explored the root causes of individual perceptions of stigma. They found fundamental similarities in the development and expression of stigmatizing ideas which included fear of contagion through everyday contact, a preoccupation with unlikely modes of transmission, and an association of the disease with immorality, Parker and Aggleton (2003) argued that responses to HIV/AIDS stigma should involve a range of strategies including knowledge oriented activities such as providing factual information about HIV transmission as well as stigma, legal and rights oriented strategies, leadership approaches and community level initiatives .

Church ministers should use spiritual teachings or religious scriptures to emphasize compassion, healing and support for people living with HIV/ AIDS. Working with other religious leaders, faith based coalitions and community leaders to find common beliefs, spiritual teachings and moral, legal and social standards that can help prevent HIV and alleviate the suffering of those affected by AIDS. Working together can help to decide what common theological and ethical standards can be more strongly emphasized. Using the challenge of AIDS as an opportunity for spiritual growth, to care for one another, to support the living and the dying, and to appreciate the gift of life.

Young people should be taught about sexuality, sexual and reproductive health, in order that they can understand how their body functions and make informed choices about their behavior.

There is overwhelming evidence showing that the more educated young people are about sexuality and responsible sexual behaviour, the better the chances that they will delay having sexual relations or will protect themselves if they do. It is therefore critical that young people receive guidance and advice about HIV/AIDS before they become sexually active. They ought to know about transmission, risks and prevention of HIV, about the choices available to them, including the avoidance of sexual relations before marriage, about the economic and social pressures that make girls particularly vulnerable to unwanted or unsafe sex, about where to get voluntary and confidential counseling and testing for HIV, information on preventing infection, as well as care, support and medical treatment for those infected. About their rights and responsibilities in the context of HIV/AIDS.

Talking to parents about HIV/AIDS and stress that they are the first line of defence in protecting their children. It is good to encourage and support them to talk to their children about sexuality, positive values and personal responsibility, and about what they can do to protect themselves. Religious youth organizations can be used to talk to young people themselves – including those living with HIV or AIDS or at high-risk of infection – about their concerns and hopes, encouraging open discussion of values, sexual integrity and healthy relationships. Address groups concerned with young people, such as teachers and health and social workers. (Chitando, Ezra 2009).

Clear and accurate information about HIV/AIDS can save lives. However, there will invariably be reactions to certain words or phrases. Try to get the meaning across in ways that will not offend. For example, people in many societies may be uncomfortable with the word ‘sex’ but may accept terms such as ‘sexual relations’ or ‘human sexuality’. If religious leaders can bring themselves to communicate openly and honestly about a subject that is difficult to talk about, others will too.

## **2.11 Influence of Pastoral Counseling on HIV/AIDS Stigma**

Counseling and other psychosocial support is critical for the person living with or affected by HIV. It assists in developing a positive attitude, living positively with the infection, or taking care of those within the immediate family who are infected.

Positive living is doing everything to help the immune system cope with the HIV virus in order to live well and have a more productive life. Being HIV-positive should not mean giving up on life. Although there are adjustments to be made and practical matters to be dealt with, people living with HIV and AIDS should be helped to deal with them as soon as possible while they are still well enough to do so. They should be encouraged to keep on working as long as possible. They should not give up things they enjoy doing or cancel dreams and aspirations. Loneliness should not be a factor; it is still possible to meet a loving and supportive partner. Pastoral counseling is not exclusively the work of an ordained pastor or church minister. That role can be fulfilled by any person within the church who is engaged in the tasks of restoring fellow human being to physical, emotional and spiritual well being (Waruta & Hannah, 2000).

The church through pastoral counseling needs to address the issue of confidentiality. Guaranteeing confidentiality is critical in reducing the experience of stigma and discrimination related to HIV status, and in increasing the number of people who seek voluntary testing for HIV/AIDS and treatment (Star Smith, 2008).

Confidentiality can be breached through gossip, rumors, discussion between friends, family and others or through the effects of seemingly innocuous policies for example, bills for health services being sent to the places of employment of a person being tested for HIV/AIDS. Churches should encourage a supportive friendly environment in which individuals can discuss HIV/AIDS openly including their own experiences living with HIV/AIDS. Not only can openness about HIV status lead to increased opportunities for care and support, personal growth



comes from accepting a HIV diagnosis which includes being open with family and friends about one's HIV status (UNAIDS, 2011). Disclosing one's HIV status can be traumatic. An HIV diagnosis for many people is already a life changing event causing shock, grief and a sense of loss of control over one's life.

It depends on the commitment and courage of HIV positive individuals hence the church needs to help them prepare for it. Statistics have shown that HIV/AIDS positive people who are open about their status live longer and better, for it is a shared burden made lighter (UNAIDS, 2011). Those who keep their status secret and try to carry their burden alone have less resistance to disease and die much faster.

### **2.12 Influence of Advocacy on HIV/AIDS Stigma**

People living with HIV have directly experienced the factors that make individuals and communities vulnerable to HIV infection, HIV/AIDS related illnesses and strategies for managing them. Their involvement in program development and implementation and policy making will improve the relevance, acceptability, and effectiveness of programs. Experiences have shown that when communities are proactively involved in ensuring their own well-being, success is more likely (Dr. Sue Parry, 2008). GIPA seeks to ensure that people living with HIV are equal partners and breaks down simplistic (and false) assumptions of service providers (those living without HIV) and service receivers (those living with HIV). The engagement of people living with HIV/AIDS is all the more urgent as countries scale up their national AIDS responses to achieve the goal of universal access to prevention, treatment, care, and support services (USAID 2010). The benefits of GIPA are wide-ranging. At the individual level, involvement can improve self-esteem and boost morale, decrease isolation and depression, and improve health through access to better information about care and prevention. Within organizations, the participation of people living with HIV/AIDS can change perceptions, as well as provide

valuable experiences and knowledge. At the community and social levels, public involvement of people living with HIV/AIDS can break down fear and prejudice by showing the faces of those living with HIV/AIDS and demonstrating that they are productive members of, and contributors to society.

The church needs to come up with a program for seminars and workshops whereby issues of HIV/AIDS, stigma and discrimination can be addressed. This would provide the PLHA's with an opportunity to share their experiences, challenges and suggestions for the common good of the body of Christ.

According to Gulaid (2010), no single agency can provide for all the needs of people living with HIV/AIDS, so partnerships among actors are needed. To enable the active engagement of those living with HIV/AIDS, religious communities and other actors need to ensure that people living with HIV/AIDS have the space and the practical support for their increased and meaningful involvement. PLHA are the objects of stigma and are thus vulnerable to fear of being stigmatized or discriminated against. Such 'felt' stigma/discrimination may be expressed through feelings of denial, fear, guilt, depression, withdrawal, loss of hope, and worthlessness, and sometimes extend to suicidal thoughts and actions. 'Felt' stigma and discrimination is not necessarily directly related to actual or pervasive levels of stigma and discrimination in the broader community. Fear of stigma amongst PLHA, or people who believe they are HIV positive, has been found to be a barrier to accessing Voluntary Counseling and Testing (VCT) and other HIV/AIDS-related support services (Malcolm, A., Aggleton, P., Bronfman, M., Galvao, J., Mane, P. & Verral, J. (1998). This may include fears of disclosure, fears of judgmental attitudes of health workers, and fears of confidentiality. It should also be noted that fear of stigma intersects with other psychological processes to do with HIV infection, including guilt at potentially having infected others, fear of illness and death, feelings of inadequacy, and

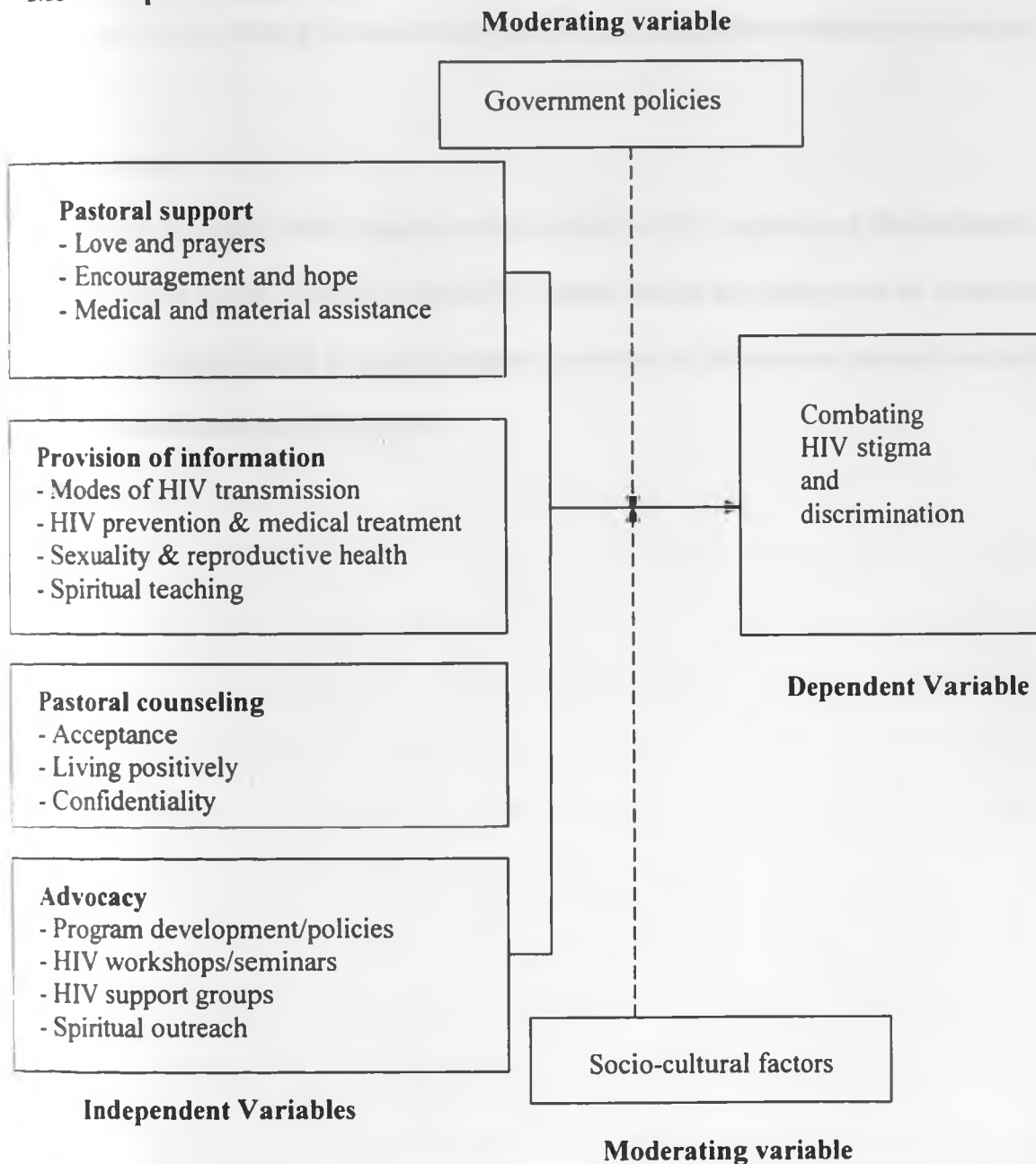
denial. PLHA are also subject to identity processes that include negative and positive constructions of 'the other', and therefore PLHA may themselves stigmatize others living with the virus.

It is important to include people with HIV and AIDS in prevention and care, spiritual outreach and theological debates as a way of affirming and enhancing their dignity (Igo Robert, 2008).

Engaging in religious reflections on HIV/AIDS that lead to reconciliation among individuals and within communities and holding public events together with people living with HIV and AIDS promotes reconciliation and healing in the community. The church should initiate the formation of HIV/AIDS support group and encourage people living with HIV/AIDS to register into such groups. This opens an opportunity for the people living with HIV/AIDS to be equipped with livelihood skills after which they are encouraged and assisted to start income generating projects.

The Methodist church, Kaaga Synod has since 2003 been able to initiate the formation of such support groups in the 10 circuits (Kaaga Annual Synod Minutes, 2011). Above all, people should be given hope. Religious leaders can help people with HIV and AIDS live longer, more meaningful and dignified lives. When the time comes, they can prepare people to meet death – and provide comfort and support to surviving family and friends (Religions for Peace. 2007)

## 2.13 Conceptual Framework



**Figure 1: Conceptual Framework**

The conceptual framework looks at four main factors as independent variables that possibly influence in combating HIV related stigma and discrimination. These factors include pastoral support, provision of information, pastoral counseling and advocacy. According to Mugenda and Mugenda (1999) conceptual framework shows how the researcher has conceptualized the

relationship between the variables in the. The purpose of the conceptual model is to help the reader see the relationship between the dependent and independent variables to be studied.

#### **2.14 Summary**

The chapter has dealt with literature review related to HIV stigma and discrimination. These include; stigma and its content, types of HIV stigma, causes and effects and the church and HIV stigma, it has also looked at pastoral support, provision of information, pastoral counseling and advocacy and conceptual framework.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.0 Introduction**

The aim of research methodology is to produce reliable and valid data that is free from personal biases (Cooper and Schindler, 2003). This chapter therefore describes the methodology that was used to carry out the study. It outlines the research design, location of the study, target population, sampling, instrumentation, data collection procedures, data analysis methods and finally the summary of the whole chapter.

#### **3.1 Research Design**

The study used descriptive survey design to determine the influence of pastoral care in combating HIV/AIDS related stigma and discrimination in Kaaga synod. Descriptive survey design gives the characteristics of a phenomenon or an object in its most natural form without the environment being altered in any way.

Descriptive survey is a method of collecting information by use of interviews or administration of questionnaires to a sample of individuals (Orodho, 2009)

#### **3.2 Target Population**

Target population is the group of individuals, objects or items from which a sample is drawn and thus which the sample will represent (Mutai, 2000). The target population comprised of Church ministers, Church members and the HIV positive persons from existing HIV /AIDS support groups in Kaaga Synod. They included 265 members of which; 160 were church members, 75 HIV positive from five support groups having been tested and registered and 30 ministers.

### 3.3 Sampling procedure

A sample size of 79 was selected and it represented 30 percent of the target population as recommended by Mugenda & Mugenda (1999). Stratified random sampling was adopted to give the appropriate and representative sample for each stratum.

The three categories of members were used as strata for sampling. Stratified random sampling was used as it gives each sampling element an equal chance of being included in the sample and it also avoids clustering of selected elements in one point. The selected number in each stratum was arrived at depending on the stratum's population in relation to the target population and sample size. Table 3.1 gives the various sub samples in relation to the various subpopulations/strata.

**Table 3.1 Sample Size**

<b>Category</b>	<b>Target Population</b>	<b>Percentage in Relation</b>	<b>Sample Size</b>
	<b>Population</b>	<b>to Target Population</b>	
Ministers	30	30%	9
Church members	160	30%	48
HIV Positive	75	30%	22
<b>Total</b>	<b>265</b>	<b>30%</b>	<b>79</b>

### 3.4 Methods of Data collection

Methods of data collection refer to the research instruments the researcher intends to use in gathering data in the field. A questionnaire was the data gathering instrument for this study. The instrument was developed by the researcher to collect data from the respondents in Kaaga Synod. The instrument contained both open and closed ended items. The questionnaire had two parts: Part A to collect data on personal information. Part B: to collect data according to the

research objectives. Questionnaires are data collection tools or instruments that are used to gather information from a larger sample. It is a written collection of self report questions to be answered by a selected group of research participants (Gray, 2003). It is a carefully designed instrument which is supposed to be self explanatory to the respondent. Open ended questions enabled the respondent to describe issues without their responses being confined. Closed questions included an array of choices /options from which the respondents choose. All the questionnaire items were based on set objectives. Data collection began upon getting university authority. The researcher further got authorization from the Bishop Kaaga synod to be allowed to carry out the research in the synod. The questionnaires were administered through the Superintendent Ministers, Church department leaders, and leaders of the support groups.

### **3.5 Validity and Reliability**

Validity refers to the extent to which an instrument measures what the researcher purports to measure (Kombo and Tromp 2006). Face validity refers to the likelihood that the question would be misunderstood or misinterpreted. Content validity refers to whether an instrument provides adequate coverage of a topic. The instrument was validated by my supervisor before piloting. Reliability is the degree to which an instrument yields consistent results after repeated trails (Mugenda & Mugenda, 2003). Reliability was tested using Cronbach's formula. Fouteen items from the questionnaire were correlated among themselves and Cronbach's coefficient Alpha was 0.782 showing a good level of internal consistency since it was above 0.75 as recommended by experts.

### **3.6 Data Analysis Procedure**

Once the data was collected it was coded and categorized according to the items in the questionnaire using frequency distribution table prepared by the researcher. The data was analyzed using descriptive statistics. The results of the study were presented in frequency tables



and percentages. The data generated from open-ended items was analyzed by comparing and combining the responses from the questionnaire.

## 3.7

## OPERATIONALIZATION TABLE

Table 3.2

Research Objective	Type the variable	Indicators	Measurements	Data Collection	Level of Scale	Approaches of analysis	Level of analysis
To investigate the influence of pastoral support in combating HIV-related stigma and discrimination	Independent Dependent	<ul style="list-style-type: none"> <li>- Visiting &amp; praying with PLHA</li> <li>- Giving medical and material assistance</li> <li>- Assisting orphans</li> </ul>	<ul style="list-style-type: none"> <li>- No. of times they are visited</li> <li>- No. of families assisted.</li> <li>- No. of orphans assisted.</li> </ul>	<ul style="list-style-type: none"> <li>- Questionnaire</li> <li>- Interviews</li> </ul>	Nominal	Quantitative and qualitative	Descriptive
To explore the influence of information in combating HIV stigma and discrimination	Independent Dependent	<ul style="list-style-type: none"> <li>- Accuracy in answering questions on modes of HIV transmission.</li> <li>- Going for VCT</li> <li>- PLHA accessing treatment</li> <li>- Living positively</li> </ul>	<ul style="list-style-type: none"> <li>- Assess levels of understanding</li> <li>- Number of people going for VCT</li> <li>- Number of PLHAs taking ARVs regularly.</li> <li>- Number of task force formed (TOT)</li> </ul>	<ul style="list-style-type: none"> <li>- Questionnaire</li> <li>- Interviews</li> </ul>	Nominal Ratio	Quantitative and qualitative	Descriptive
To determine the influence of pastoral counseling in combating HIV stigma and discrimination.	Independent Dependent	<ul style="list-style-type: none"> <li>- Pastoral visit to PLHA</li> <li>- Church giving support to PLHAs</li> <li>- Involving PLHA in church activities</li> <li>- People willing to disclose their HIV status freely</li> </ul>	<ul style="list-style-type: none"> <li>- Number of times they are visited.</li> <li>- Availability of programmes addressing HIV issues</li> <li>- Number of PLHAs who disclose their status.</li> </ul>	<ul style="list-style-type: none"> <li>- Questionnaire</li> <li>- Observations</li> </ul>	Interval Nominal	Quantitative and qualitative	Descriptive
To establish the influence of advocacy in combating HIV stigma and discrimination	Independent Dependent	<ul style="list-style-type: none"> <li>- PLHA participation in policy/programme making.</li> <li>- PLHA willingness to join support groups.</li> <li>- PLHA participation in HIV workshops</li> <li>- PLHA participation in income generating projects.</li> </ul>	<ul style="list-style-type: none"> <li>- Evidence of policies made.</li> <li>- Number of meetings.</li> <li>- Number of PLHA joining (list)</li> <li>- Number of seminars</li> <li>- Number of projects</li> <li>- Number of PLHAs in those projects.</li> </ul>	<ul style="list-style-type: none"> <li>- Questionnaire</li> <li>- Observations</li> </ul>	Nominal	Quantitative and qualitative	Descriptive

### 3.8 Summary

In this chapter, the researcher has discussed the research methodology that was used in the study. Different research methodology items are explained according to their application. The methodology items discussed appear in the following order; research design, target population sampling procedure, methods of data collection, validity and reliability, methods of data analysis and finally the operationalization table.

## **CHAPTER FOUR**

### **DATA ANALYSIS, PRESENTATION AND INTERPRETATION**

#### **4.1 Introduction**

This chapter presents data analysis, presentation and interpretation of the findings. The study was designed to assess the influence of pastoral care in combating HIV/AIDS related stigma and discrimination in Kaaga Synod. The responses were obtained from church ministers, church members and HIV positive persons from HIV/AIDS support groups in MCK Kaaga Synod.

#### **4.2 Questionnaire Return Rate**

A total of 79 questionnaires were distributed to various categories as shown in sample size table 3.1. Out of the questionnaires 9 were distributed to church ministers, 48 to church members and 22 to HIV positive persons. All the questionnaires administered were returned by the respondents indicating 100% return rate.

#### **4.3 General Information**

The general information provides the population structure and helps create a mental picture of the subgroups that exist in the overall population. Researchers obtain general information from the study subjects to understand sample characteristics and to determine if samples are representative of the population of interest. In this study, the researcher investigated gender, age, marital status and level of education of the respondents.

### 4.3.1 Distribution according to gender

**Table 4.1 Gender of the Respondents**

Distribution of the respondents according to gender was as shown in table 4.1

<b>Gender</b>	<b>Frequency</b>	<b>Percentage</b>
Female	48	61%
Male	31	39%
Total	79	100%

The respondents were requested to indicate their gender. The results are shown in table 4.1 and according to the findings, 61% of the respondents were female, while male respondents were 39%. This shows that most of the respondents were female. However, there was a reasonable representation from each gender.

### 4.3.2 Distribution by age

**Table 4.2 Distribution by to age**

Distribution according to age was as shown in table 4.2

<b>Age</b>	<b>Frequency</b>	<b>Percentage</b>
Less than 25 years	13	16%
26 – 35 years	34	43%
36 – 45 years	22	28%
46 years and above	10	13%
Total	79	100%

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NAIROBI

The researcher wanted to know the age limit of the respondents and according to the findings of this study as shown in Table 4.2 below, 43% of those that responded were between 26 to 35 years, 28% of the respondents were between 36 and 45 years, 16% were less than 25 years of age while 13% were 46 years and above. These figures indicate that 84% of the respondents were 26 years and above while 16% were youth. The figures also indicate that at least every age group had a chance to give their views. The figures further revealed that out of the 22 HIV positive respondents only 2 were men suggesting a very low enrollment of men into HIV/AIDS support groups.

#### **Table 4.3 Marital status**

Distribution according to marital status was as shown in table 4.3

<b>Status</b>	<b>Frequency</b>	<b>Percentage</b>
Single	19	24%
Married	41	52%
Divorced	10	13%
Widowed	9	11%
Total	79	100%

#### **4.3.3 Marital status**

The respondents were asked to indicate their marital status and according to the findings of this study, 52% of the responds were married, 24% were single, 13% had divorced and 11% were widowed. The study further revealed that the 10 respondents who had been divorced were HIV positive indicating that divorce could have been as a result of their HIV status.

### 4.3.4 Level of Education

**Table 4.4 Level of Education**

Distribution according to level of education was as shown in table 4.4

Level	Frequency	Percentage
Primary	13	16%
Secondary	40	51%
College	18	23
University	8	10%
Total	79	100%

According to the findings of this study majority of the respondents 51% were educated up to secondary level, 23% had gone to college level, 16% had up to primary school level 10% had gone up to the university level. This is an indication that most of the respondents had an average level of education hence most could understand when taught and teach and train others on issues relating to HIV/AIDS stigma and discrimination.

### 4.4 Response from HIV Positive Persons

The researcher wanted to get some information from the HIV positive persons and according to the findings the response was as indicated below.

#### 4.4.1 Attending the Church Regularly

**Table 4.5 Attending the church regularly**

Distribution according to church attendance was as shown in table 4.5

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<b>Level</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	14	64%
No	8	36%
Total	22	100%

According to the findings of this study, on whether they attend the church regularly, 64% of the respondents said yes while 36% indicated no. This is an indication that the church needs to intensify its pastoral care by ensuring that the needs of those who are not regular attendants are addressed.

#### 4.4.2 Having Leadership responsibility in the Church

**Table 4.6**

##### **Leadership responsibility in the church**

Distribution according to responsibility in the church was as shown in table 4.6

---

<b>Level</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	15	68%
No	7	32%
Total	22	100%

According to the findings of this study on whether they have any leadership responsibility in the church, 68% of the respondents indicated yes while 32% indicated no.



This is an indication that HIV positive persons have not been excluded from the church leadership which is a major achievement in the fight against stigma and discrimination.

#### **4.4.3 Response on problems experienced by HIV positive Persons**

All the 22 respondents indicated that they experience problems in relation to their HIV status. Among the listed problems were rejection 8, condemnation 9, lack of financial and material support 7, lack of livelihood skills 6 and hopelessness 10. The figures show that hopelessness had highest 10 followed by condemnation 9, rejection with 8 while lack of material support and lack of livelihood skills had 7 and 6 respectively.

#### **4.4.4 Respondents on usefulness of HIV/AIDS support groups**

The findings of the study revealed that 100% HIV/AIDS support groups are very useful to them.. They indicated that the group does receive assistance from the church and that they were formed through the church. They said that the groups help them to meet together and also serve as a channel through which they encourage and recruit others. Through the groups they indicated that they have started projects such as making soap for sale, table cloths, baskets, rearing goats for milk, rabbits and chicken. They also have kitchen gardens. These activities have helped them to earn some income enabling them to be self supporting. The respondents said that the services of ministers are very essential especially in providing guidance and counseling, moral and spiritual support.

#### 4.5 Response in Relation to People Living with HIV/AIDS

**Table 4.7 Response in Relation to People Living with HIV/AIDS**

<b>Statement</b>	<b>Yes</b>	<b>No</b>
	<b>%</b>	<b>%</b>
Do people fear eating food prepared by HIV positive persons?	76	24
Are people afraid to share plates, cups and other household utensils with HIV positive persons?	63	37
Do people fear sharing toilet and bathroom facilities with HIV positive persons?	13	87
Do people fear sleeping in the same room with an infected person?	12	88
Are HIV positive persons sometimes denied inheritance?	53	47
Are HIV positive persons sometimes denied education by their parents/spouses?	53	47
Are HIV positive persons sometimes neglected by family members?	61	39
Are HIV positive persons denied treatment?	53	47
Do you think pastoral counseling can help in reducing HIV related stigma and discrimination?	84	16

n=79. % = Percentage

The researcher wanted to know peoples attitude in relation to people living with HIV/AIDS.

According to the findings of the study 76% of the respondents indicated that people fear eating food prepared by HIV positive persons while 24% indicated no. On sharing plates, cups, other household utensils, toilet and bathroom facilities the findings of the study showed that 63% of

the respondents indicated that there was fear while 37% indicated there was no fear. Such fear would lead to discrimination whereby people are afraid of being infected through sharing of such items. People living with HIV can experience stigma and discrimination such as being refused medical treatment, inheritance and good education. According to the study 53% of the respondents indicated it was true while 47% of the respondents indicated it was false. According to the findings of the study majority of the respondents 84% felt that pastoral counseling can help in reducing HIV related stigma and discrimination. As to whether AIDS is a punishment from God for people to amend their ways 76% of the respondents disagreed while 24% agreed. On whether it is wise to spend money educating a child who is HIV positive, 82% of the respondents agreed while 18% disagreed. According to the findings, 51% of the respondents agreed that the church should make it compulsory for people intending to marry to be HIV tested while 49% disagreed. According to the findings 63% of the respondents disagreed that condoms encourage immorality and therefore should not be talked about while 37% agreed. This is an indication that there is a need for information on the importance of being HIV tested, safe sex methods and the place of condoms and HIV/AIDS transmission modes.

## **CHAPTER FIVE**

### **SUMMARY OF THE FINDINGS, DISCUSSION, CONCLUSION AND RECOMMEDATIONS**

#### **5.1 Introduction**

This chapter gives the summary, conclusions, recommendations and suggestions for further study drawn from the findings of the study. People living with HIV/AIDS suffer stigma and discrimination. The aim of this study was to investigate the influence of pastoral care in combating HIV/AIDS a case of Methodist Church Kaaga Synod in Meru County, Kenya.

#### **5.2 Summary of the Findings**

The purpose of the study was to investigate the influence of pastoral care in combating HIV/AIDS related stigma and discrimination. In order to achieve the purpose of the study, the following objectives were addressed; to investigate the effect of pastoral support in combating HIV/AIDS related stigma and discrimination, to explore the influence of information in combating HIV/AIDS related stigma and discrimination, to determine the effect of pastoral counseling in combating HIV/AIDS related stigma and discrimination and to establish the influence of advocacy in combating HIV/AIDS related stigma and discrimination.

**Table 5.1 Summary of the four key findings according to the four research objectives**

<p>Influence of pastoral support on HIV/AIDS stigma and discrimination</p>	<p>The findings of the study have revealed that the church has been very supportive to the people living with HIV/AIDS. It has initiated the formation of HIV support groups, has assisted them to start income generating projects as well as giving them moral and spiritual support. The respondents identified projects such as making soap, table cloths, baskets, rearing goats for milk, rearing chicken and rabbits and growing vegetables for sale and domestic use. All the respondents commented that the services of a minister are very useful to the group.</p>
<p>Influence of information on HIV/AIDS stigma and discrimination</p>	<p>Lack of information about AIDS and misconception about HIV transmission routes have contributed to stigma and discrimination leading to fears of contagion through casual contact. The study has revealed that access to the right information could significantly reduce HIV/AIDS stigma and discrimination by alleviating fears related to the virus and correcting misconception.</p>

<p>Influence of pastoral counseling on HIV/AIDS stigma and discrimination</p>	<p>Majority of the respondents indicated that pastoral counseling improves self esteem, cultivates positive attitude, helps the infected live positively with the virus and helps people to take care of the infected, treating them with respect and dignity. Pastoral counseling encourages a supportive friendly environment in which individuals can discuss HIV/AIDS openly</p>
<p>Influence of advocacy on HIV/AIDS stigma and discrimination</p>	<p>The study has revealed the need for a collective responsibility in the fight against HIV/AIDS stigma and discrimination. All the respondents strongly agreed that church ministers have a very important role to play in combating HIV stigma. Majority of the respondents strongly agreed that HIV positive persons should be involved in seminar/workshops, in policy making/program development and implementation. Involving people living with HIV/AIDS improves self esteem, decreases isolation and helps them to live.</p>

### 5.3 Discussion

According Gennrich (2004), pastoral care involves undertaking a person's many social, personal, physical, cultural and spiritual needs and responding to them in an integrated way. In this study pastoral care has been administered focusing on pastoral support to people living with HIV/

AIDS, provision of information as a way of empowering people on how to deal with HIV related stigma and discrimination, pastoral counseling in order to deal with self stigma and enacted stigma and advocacy geared towards sensitizing the church and the PLHA's on the need to take a participatory role in the fight against HIV Stigma and discrimination.

### **5.3.1 Influence of Pastoral Support**

The research findings have revealed that the church has been very supportive to the people living with HIV/AIDS. 100% of the HIV positive respondents said that the Methodist Church Kaaga Synod initiated the formation of HIV/AIDS support groups. Such initiative is further supported by the presiding Bishop of the Methodist Church in Kenya (2011) who urged the church to provide pastoral support to individuals' families and relatives of those inflected with HIV/AIDS. Through HIV/AIDS support groups, the church is able to reach with God's love, prayers, material and medical assistance to the suffering thus reducing HIV/AIDS stigma and discrimination. The initiative is meant to counteract enacted stigma which according to Thomas (2008) occurs when individuals are actively discriminated as a result of their HIV status.

All the HIV positive respondents agreed that the church has assisted them to start income generating projects such as making soap, table cloths, baskets, rearing goats, rabbits and chicken to avoid dependency. This is supported by Magezi (2006) who looks at pastoral care as sustaining and empowering among other functions. The HIV positive persons are empowered with livelihood skills so that they can be self sustaining and self supporting instead of being dependants.

The study through the documentary analysis (Annual synod rep. 2011) has been able to establish that Kaaga Synod through HIV/AIDS support groups is currently supporting over 200 children in primary schools, secondary schools and also in colleges. This concurs with Sonja W & Christoph B (2004) who says that the church should develop home care programmes to support orphans and other needy children with food, school fees and uniforms.

### **5.3.2 Influence Information on HIV stigma**

Fears due to misconception have been expressed indicating absence of the right information. According to the findings 76% of the respondents indicated that people fear eating food prepared by HIV positive persons. The respondents 63% indicated that people are afraid of sharing plates, cups, spoons, and other utensils for fear of being infected. This is an indication that more information is required to address such fears. This agrees with Overt (2006) who said that complete knowledge on how HIV is not transmitted translates into a greater degree of acceptance of people living with HIV and their family members. According to the findings all the respondents felt that access to the right information could significantly reduce HIV stigma and discrimination. This opinion agrees with Nyblade (2008) who argues that pastoral care which integrates the provision of accurate information about HIV transmission can significantly reduce HIV stigma and discrimination. This is further supported by Parker and Aggleton (2003) who argued that responses to HIV/AIDS stigma and discrimination should involve a range of strategies including knowledge oriented activities such as providing factual information about HIV transmission as well as stigma, legal and rights oriented strategies, leadership approaches and community level initiatives.



### **5.3.3 Influence of pastoral counseling on HIV stigma**

According to the research findings majority of the respondents 84% indicated that pastoral counseling could help in reducing HIV related stigma and discrimination. When asked to give their comments they said pastoral counseling improves self esteem, assists in developing a positive attitude, helps the infected to live positively with the virus and helps people to take care of those within the family who are infected. As Waruta and Hannah (2000) says, the role of pastoral counseling can be fulfilled by any person within the church who is engaged in the task of restoring fellow human being to physical, emotional and spiritual well being. Pastoral counseling is a necessary approach to correct any negative attitude towards HIV positive persons. Such an attitude was evidenced where 38% of the respondents agreed that a morally upright religious person who is God fearing cannot get HIV/AIDS while 62% of the respondents disagreed. This can further be seen where 24% agreed that AIDS is a punishment from God for people to amend their ways while 76% disagreed. On whether to spend money educating a HIV positive child 82% agreed while 18% saw it as wastage. 53% of the respondents indicated that HIV positive persons are denied inheritance and access to good treatment thus concurring with Hevel (2008) that caring for HIV persons is pointless because the disease is incurable. The purpose of pastoral counseling would be to address such misconceptions and the false notion that people living with HIV/AIDS are awaiting to die therefore, have no need for education, jobs, skill upgrading, good medical care, property, marriage or otherwise live normal lives.

### **5.3.4 Influence of advocacy on HIV stigma**

There is synergy in sensitizing all the players to work as a team in the fight against HIV stigma and discrimination. As shown by earlier studies (UNAIDS 2007) HIV related stigma and discrimination have been identified international as main barriers to HIV control and prevention

posing challenges to providing adequate care, support and treatment. This indicates the need for a combined effort by both the clergy, the laity (men, women and youth) and HIV positive persons. All the respondent 100% strongly agreed that church ministers have a very important role to play in helping the church to fight against stigma and discrimination related to HIV/AIDS. A similar view is held by HIV positive persons where 100% said that the service of a minister (pastor) would be useful to them in their groups .The finding concur with the studies done by Macmaster, Thompson & Sanders (2006) who stated that churches exercise a vital ministry through encouraging discussion and analysis of information, helping identify problems and supporting participation towards constructive change in the community.

According to the findings, 84% strongly agreed that people living with HIV/AIDS should be given a chance to share their experiences while 16% agreed. The same respondents indicated that involving people living with HIV/AIDS in seminars /workshops would be very useful in fighting HIV Stigma and discrimination. The findings also revealed 84% as strongly being of the opinion that involving people living with HIV/AIDS in policy making/program development and implementation would significantly reduce stigma and discrimination. This is supported by Parry (2008) who said that experiences have shown that when communities are proactively involved in ensuring their own well being, success is more likely. According to USAID (2010), engaging people living with HIV/AIDS improves self esteem and boosts morale, decreases isolation, depression and improve health through access to better information about care and prevention.

#### **5.4 Conclusion**

The study has revealed that pastoral care has a significant influence in combating HIV/AIDS related stigma and discrimination. The church has initiated the formation of HIV/AIDS support groups through which it has been able to give moral, spiritual and material support to HIV positive persons. The church has also assisted them to start income generating projects as well as empowering them with livelihood skills to enable them become self supporting instead of being dependants. Lack of information about HIV/AIDS and misconception about HIV transmission routes contribute to stigma and discrimination against people living with HIV/AIDS. Pastoral counseling is a necessary intervention in the fight against HIV/AIDS stigma and discrimination. Combating HIV stigma and discrimination should be a collective responsibility involving the clergy, the laity and the HIV positive persons.

#### **5.5 Recommendations of the Study**

1. On the basis of the study findings the following recommendations were made:-

The church should have zero tolerance for HIV/AIDS stigma and discrimination and do all that is necessary to eliminate rejection, fear and oppression of the infected and affected in the community. It should start home care programs to support orphans and other needy children with basic necessities.

2. The church should provide accurate information about transmission, risk and prevention of HIV/AIDS, about lawful and safe sex, about the economic and social pressures that make (especially women and girls) vulnerable to unsafe sex, about where to get care, support and medical treatment for those infected.

3. The church should offer pastoral counseling to those infected with HIV/AIDS since it reduces the experience of stigma and discrimination, increases the number of those who seek voluntary testing for HIV treatment and helps them to live positively regardless of the challenges.
4. People living with HIV/AIDS should be encouraged to take a participatory role in HIV/AIDS seminars/workshops, including sharing their own experiences living with the virus. Their involvement in program and policy making improves the relevance, acceptability and effectiveness of the programs.

### **5.6 Suggestions for further Study**

The findings of this study are indicative rather than conclusive; hence the following research action has been suggested:

- (i) Further research can be done in other institutions apart from the church to determine how stigma and discrimination can be combated in the specific institutions.
- (ii) Further studies could also be done to determine other challenges people living with HIV/AIDS undergo.
- (iii) Further studies could be done on the factors contributing towards low enrolment of men into HIV/AIDS support groups.

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**Appendix 1**

**Transmittal Letter**

**Harun M. Kiruja  
P.O. Box 340,  
MAUA**

May, 2012

**The Bishop  
MCK Kaaga Synod  
P.O. Box 269,  
MERU.**

Dear Sir,

**RE: LETTER OF TRANSMITTAL OF DATA COLLECTION INSTRUMENTS**

This is to inform that I am carrying out a research study leading to the Award of Master of Art in Project Planning and Management of the University of Nairobi. The study focuses on the “influence of pastoral counseling in combating HIV-related stigma and discrimination in MCK Kaaga Synod.

When the research is successfully completed it is expected that the findings will enable the church ministers and the members in the fight against HIV related stigma and discrimination within their circles.

Your permission and assistance is therefore very important in making this study a success.

Thanks in advance.

Yours faithfully,

**Harun Murithi Kiruja**

## Appendix 2

### QUESTIONNAIRE

Dear respondent,

Below is a list of questions you are kindly requested to answer.

Please respond to each item by putting a tick ( √ ) next to the appropriate space or by writing to the spaces provided. You are hereby assured that the information you provide will be confidential and used for academic purposes only.

#### PART A

1. What is your gender?

Male

Female

2. Indicate your age.

Less than 25 years

25 – 35 years

36 – 45 years

46 and above

3. What is your marital status?

Single

Married

Divorced

Widowed

4. What is your level of education?

Primary

Secondary

College

University

**PART B**

**NB: Question 5 to 11 is for HIV positive persons only**

5. Do you attend Church service regularly?

Yes

No

6. Do you have any leadership responsibility in the Church?

Yes

No

7. What problems do HIV positive persons experience?

Rejection

Condemnation

Lack of Financial support

Lack of livelihood skills

Hopelessness

8. (a) How useful is HIV/AIDS support group to you?

.....

.....

(b) Do you have any project you are doing together as a group?

.....

.....

9. How often do you meet?

(i) Once a month

(ii) Once in two months

(iii) Once in three months

(iv) Others explain.....

10 (a) Does the group get any assistance from the Church?

Yes

No

(b) Explain your answer.....

11(a) Do you think the services of a minister (pastor) would be useful to the group?

Yes

No

(b) Explain your answer.....

.....

**12. Answer Yes or No**

(a) Do people fear eating food prepared by HIV positive persons?

Yes

No

(b) Are people afraid to share plates, cups and other household utensils with HIV positive persons?

Yes

No

(c) Do eople fear sharing toilet and bathrooms facilities with HIV positive persons?

Yes

No

(d) Do people fear sleeping in the same room with an infected person?

Yes

No

(e) Are HIV positive persons sometimes denied inheritance?

Yes

No

(f) Are HIV positive persons sometimes denied education by their parents/spouses?

Yes

No

(g) Are HIV positive persons sometimes neglected by family members?

Yes

No

(h) Are HIV positive persons sometimes denied treatment?

Yes  No

13(a) Do you think pastoral counseling can help in reducing HIV related stigma discrimination?

Yes  No

(b) Comment.....  
 .....

**Please tick the most appropriate in the boxes provided.**

		<b>I strongly agree</b>	<b>I agree</b>	<b>I disagree</b>	<b>Am not sure</b>
1	AIDS is a punishment from God for people to amend their ways.				
2	HIV positive persons should be guided to confess the sins which led to infection to receive spiritual healing.				
3	HIV Positive persons sometimes receive unkind treatment by church members through whispers, gossip and outright rejection.				
4	HIV positive persons are sometimes labeled as sinners, immoral and lacking self control.				
5	Having a separate service for people living with HIV is a noble idea.				
6	In this Era of HIV/AIDS people are afraid to partake in the holy communion for fear of being infected.				
7	VCT is for persons who are suspicious to have been infected with HIV due to their sinful behavior.				

		<b>I strongly agree</b>	<b>I agree</b>	<b>I disagree</b>	<b>Am not sure</b>
8	Access to the right information on HIV/AIDS would reduce stigma against people living with HIV.				
9	HIV positive persons can live normal lives if only they take good care of themselves.				
10	Teaching young people about safe sexual behavior encourages them to experiment with sex. They should not be taught about these issues.				
11	Condoms encourage immorality and therefore should not be talked about.				
12	It is not wise to spend money educating a child who is HIV positive when there are other children who need education.				
13	A morally upright religious person who is God fearing cannot get HIV/AIDS				
14	A HIV positive person should not be given any leadership position in the church because he or she is not a good example as a Christian.				
15	The church should make it compulsory for people intending to marry to be HIV tested				
16	Church ministers have a very important role to play in helping churches to fight against stigma and discrimination related to HI/AIDS.				
17	People living with HIV/AIDS should be given a chance to share their experiences during a Sunday service				

		<b>I strongly agree</b>	<b>I agree</b>	<b>I disagree</b>	<b>Am not sure</b>
18	Involving people living with HIV/AIDS in seminars/workshops would be very useful in fighting HIV stigma.				
19	Involving people living with HIV/AIDS in program development/implementation and policy making would reduce HIV stigma.				

**Thank you.**