EFFECTIVENESS OF RELIGIOUS INITIATED PROGRAMMES IN CURBING HIV/AIDS PANDEMIC IN KENYA: SOME SELECTED PROGRAMMES IN MERU SOUTH SUB-COUNTY

Kagema, D.N.[1], Mathai, L.M.[2] and Bururia, D.N.[1]
[1] Department of Humanities, Chuka University, P. O. Box 109-60500, Chuka. Email: dicknkonge@gmail.com
[2] Ikuu Girls High School, Chuka.
Email: lmathai@chuka.ac.ke, mathaimukundi2006@gmail.com, dnkonge@chuka.ac.ke, dbururia@chuka.ac.ke

ABSTRACT
HIV and AIDS pandemic has brought enormous burden upon the lives of many people throughout the world since the first cases of AIDS were identified in USA 1981. Since then, more than 70 million people are living with HIV and AIDS and more than 35 million people have died globally. As the burden of HIV and AIDS escalates, organizations are being formed to help curb its impact. Kenya has about 1.6 million people living with HIV and AIDS and in 1999 it was declared a national disaster. It is in response to this that many development partners including religious organizations, came up with programmes to help combat this scourge, yet there seems to be little success as new infections continue to be reported. The Church in Kenya has not has not been left behind as far as fighting this scourge is concerned. She has initiated many programmes towards this course. This study assessed the effectiveness of Church based initiated programmes in curbing HIV/AIDS in Kenya. We used the Church-based programmes in Meru South Sub-county, purposely selected because of the magnitude of the problem in this particular area. These were Redeemed Gospel Church HIV/AIDs Programme at Chuka, Presbyterian Church of East Africa HIV/AIDS Programme at Ndagani, Salvation Army Church HIV/AIDS Programme at Chuka and Baptist Church HIV/AIDs Programme at Chuka. The target population was 1040 subjects comprising 1000 Church members and 40 beneficiaries. The Church ministers/pastors were our key informants. Data was collected using questionnaires, interview schedule and focus group discussions. Systematic random sampling procedure was used to select 100 Church members. The 40 beneficiaries were obtained using snowball sampling method. The findings were that the selected programmes provided services such as HIV prevention education, orphan care, support of people living with and personally affected by HIV and AIDS, prevention activities that involved campaigns, and caring for the affected and infected. The programmes were found out to be successful particularly in supporting the people orphaned by HIV and AIDS, reducing stigma, organizing training, seminars and workshops, conducting voluntary counselling and testing among others. They were found to be effective in curbing HIV and AIDS, though they face the challenge of lack of adequate funding. There was also lack of trained personnel which hampered effective implementation of programmes. If the government, church, development partners and other well-wishers support these religious initiated programmes, the war against HIV/AIDS pandemic can be easily worn.
Keywords: Religious Initiated Programmes, Church, HIV/AIDS Programmes

INTRODUCTION
HIV stands for Human Immunodeficiency Virus. HIV is a virus that attacks and suppresses the immune system of the body thus compromising the body's defence against infections. AIDS stands for Acquired Immuno Deficiency Syndrome. AIDS is a condition that weakens a person's immune system, making him/her vulnerable to opportunistic infections. AIDS is therefore caused by HIV, through the progressive destruction of the body's defense cells commonly known as white blood cells. Due to the body's inability to defend itself against the infections, the person's health incessantly deteriorates (Lodiago et al., 2007). HIV transmission occurs through various ways such as sexual contact with a person infected; mother to child transmission during birth or while breast-feeding; blood transfusion from an infected person; and also when HIV contaminated instruments for example needles, razor blades and knives are used for cutting or piercing (Barnett & Whiteside, 2003).

Over the years, HIV and AIDS pandemic has brought an enormous burden upon the lives of many people throughout the world. Since the first cases of HIV and AIDS were identified in the United States of America in 1981, millions of people have lost their lives (Goliber, 2009). An estimated 70 million people are living with HIV and AIDS and more than 35million have lost their lives (UNAIDS 2017). Though the whole world is affected by HIV and AIDS, Africa and especially the tropical region has been reported to be the worst affected. This is possibly due to high poverty levels, lack of access to health facilities, and some cultural practices like wife inheritance, polygamy, traditional practice of circumcision and female genital mutilation. For example, Kenya, where many cases of

HIV/AIDs infections have been reported, lies in this region (Goliber, 2009). It is estimated that more than 1.6 million people are living with HIV and AIDS in Kenya since the first case was reported in 1984 (NASCOP, 2016).

In Meru South Sub- County, the spread of HIV and AIDS and the stigma associated with it are high. According to the Kenya Health and Demographic Survey (2009) report, Meru South District had an HIV and AIDS prevalence of 7.3% which was among the highest in the then Eastern Province (Republic of Kenya, 2009). The high prevalence was attributed to high poverty levels and inadequate income generating ventures that led many people to engage in commercial sex to earn a living. In response to the rise in HIV and AIDS cases, some churches in the Sub County initiated programmes with the aim of curbing the spread of HIV and AIDS pandemic. In spite of this effort by the Church, HIV/AIDS continue to be a real challenge to the inhabitants of Meru South Sub-county just as in other parts of Kenya.

This study that was conducted in selected Churches that are currently running the HIV/AIDS mitigation programmes aimed at investigating the effectiveness of these religious initiated programmes. The selected churches were the Redeemed Gospel Church, Presbyterian Church of East Africa, Salvation Army and Baptist Church. The study was important in that the Church is viewed as one of the most trusted institutions in the society (Nkonge, 2012), and would be vital to underscore its contribution in fighting the perilous HIV/AIDS epidemic that has threatened the lives of many people. It is our strong belief that The Church of Christ has traditional, theological and practical answers for people affected by HIV and AIDS pandemic (Neville, 2006).

The study was guided by the following objectives: To investigate the types of programmes being used by Churches to curb HIV and AIDS pandemic in Meru South Sub-county. To evaluate the effectiveness of religious-initiated programmes in curbing HIV and AIDS pandemic in Meru South Sub-county.

METHODOLOGY

To understand the contribution of the Churches in Meru South Sub- County in curbing the spread of HIV/AIDS pandemic, we carried the study in some four Churches that were purposely selected because they have the HIV/AIDS mitigation programmes. These were Redeemed Gospel Church-Chuka, Baptist Church-Chuka, PCEA-Ndagani and Salvation Army Church-Chuka. According to the Kenya Health and Demographic Survey (2009) report, Meru South Sub County had a HIV and AIDS prevalence of 7.3% which was among the highest in Eastern region that time (Republic of Kenya, 2009). The study employed descriptive survey research design. The descriptive survey research design enabled the researchers to gather in-depth information concerning Church-initiated programmes and HIV and AIDS mitigation in Meru South SubCounty.

The target population for this study was 1040 subjects comprising of all the 1000 church members and 40 beneficiaries of these programmes. The population of Redeemed Gospel Church was 290 members; Baptist Church 210 members; PCEA-Ndagani 230 members and Salvation Army Church 270 members totaling to 1000 members as per the records of these churches.

The Churches for study were purposely selected because they were running the HIV and AIDS mitigation programmes. The researchers used systematic random sampling to obtain the sample size from the Church members. The Church members were got from the Church registers provided by the Church ministers. Every 10th person in the target population was selected and included in the sample. The Redeemed Gospel Church had a population of 290 and therefore 29 members were sampled. Baptist Church had a population of 210 from which 21 members were sampled. PCEA-Ndagani had a population of 230 from which 23 members were sampled. Salvation Army Church had a population of 270 from which 27 members were sampled. The sample size for the Churches was therefore 100 members. The 4 church ministers/pastors of these Churches who were part of the population were key informants for this study.

Snowball sampling technique was used to get the beneficiaries of the programmes. The number of beneficiaries of the HIV and AIDS programmes from each church was as follows: Redeemed Gospel Church- 14 beneficiaries; Baptist Church- 6 beneficiaries; PCEA-Ndagani- 8 beneficiaries; Salvation Army Church- 12 beneficiaries. The total number of beneficiaries was 40.

For more accuracy got views of 40 beneficiaries. Each Church minister/pastor gave one beneficiary of the HIV and AIDS programmes in his church, who in turn helped identify other beneficiaries. The beneficiaries identified from each congregation formed a focus group to discuss questions provided by the researchers. The sample size for the 4 groups was 40. The sample size for this study therefore was 140 comprising of 100 church members and 40 beneficiaries.

The data was collected using questionnaires for church members, interview schedule for church ministers/pastors and focus group discussion for the programme beneficiaries. This study used triangulation method of data collection (John & James, 2006). This method involves the use of two or more research instruments to collect the necessary data (Ogula, 1998).

After collection of data it was checked for logical consistency. Any unnecessary data was removed. Descriptive statistics including frequency counts and percentages were used to analyze quantitative data using Statistical Package for Social Sciences Version 21 for windows. Data elicited by interview and focus group discussion questions were analyzed qualitatively by arranging the responses thematically after which the main themes in the responses were identified and used to determine their adequacy, usefulness and consistency. This enabled the researchers to identify data segments that were critical in addressing the research questions. Data was analyzed according to the research objectives and presented using tables. We then calculated the percentages of responses which were used to make statements about the results, identify findings and make conclusions.

RESULTS

Types of programmes being used by Churches to mitigate HIV and AIDS

We sought to find out the type of Church-initiated programmes being used to mitigate HIV and AIDS in Meru Sub-county. The members were asked to name the programmes that deal with HIV and AIDS mitigation in their Churches and also cite the main activities of the programmes. Specifically, this research examined in detail the operational activities of the Redeemed Gospel Church-Chuka, Salvation Army Church-Chuka, PCEA-Ndagani and Chuka Baptist Church in the fight against the HIV/AIDs scourge.

The data established is captured on Table 1 below. Church response to HIV and AIDS pandemic refers to the various initiatives by the Church to address the impact caused by HIV and AIDS. This may take various forms: HIV and AIDS awareness raising and sensitisation in the Church and the community, Church leaders mobilisation of their congregations by motivating and inspiring them to act, formation of support and care teams to offer home-based care, advocacy in support of HIV and AIDS programmes, training some members of the congregation in HIV and AIDS issues, for instance counselling skills and involvement of Church social groups like, women groups, workers clubs, married people's clubs to widen the support base.

A total of 96 respondents including 92 church members who returned the questionnaires and 4 Church ministers/pastors who were the key informants provided responses to this objective. Participants were asked mainly about the types of HIV and AIDS intervention programmes used in their churches. Key informants were consulted to verify information obtained from the Church members. We also visited the Participating Churches to further evaluate their HIV and AIDS programmes.

Table 1. Church Members' Responses on HIV and AIDS Mitigation Programmes

Program	Frequency	Percentage
Orphan care	16	17
Support of people living with and personally affected by HIV and AIDS	8	8
Prevention activities that involve campaigns	16	17
Pastoral care and support	9	9
Outreach programmes	9	9
Voluntary counselling and testing	9	9
Palliative care	7	8
Seminars and workshops	22	23
Total	**96**	**100**

From the data shown on Table 1, it is evident that Churches are taking part in the fight against HIV and AIDS using different approaches. Among the programme activities ran by the Churches included orphan care, support of people living with and personally affected by HIV and AIDS, prevention activities through campaigns, pastoral care and support, outreach programmes, voluntary counselling and testing, palliative care and seminars and workshops.

In order to further support the Church to respond to the HIV and AIDS pandemic, there was need to establish the existing prevention, care and advocacy activities that the Church was undertaking and identify the resource capacities that the Church requires to implement these interventions with a recognised impact. This study has presented an analysis of the Church responses to HIV and AIDS and provided

conclusions and recommendations for future action as the Church continues its fight against the HIV and AIDS pandemic.

In this study, qualitative data was analysed to strengthen the quantitative findings. An interview and a focus group discussion were conducted among the Church ministers and the beneficiaries respectively.

Excerpt 1 (Interview)

Researchers: What is the name of the programme that deals with HIV and AIDS mitigation in your Church? What are the main activities of this programme?

Church Minister 1: We have a programme called Redeemed Gospel Church HIV and AIDS programme. The main activities of the programme include: care and support of affected and infected. Specifically, we offer social support to orphans and the vulnerable children like paying their school fees and encouraging those infected to take ARVs. The programme also deals with HIV testing and counselling, behaviour change communication through awareness campaigns, posters and brochures. At times we train opinion leaders and peer counsellors through workshops on issues pertaining to HIV and AIDS and gender. The programme has also incorporated a youth programme called Visionary Art that goes to schools and colleges to meet peers and offer advocacy.

Church Minister 2: Our Church runs a HIV and AIDS prevention programme known as Baptist Community Initiative. The activities carried out under the programme include: VCT that involves testing, counselling and referral; There is a youth programme called True Love Waits (TLW) that teaches the youth on abstinence. This program has an elaborate support group that meets once every month to share experiences and support the OVCs. The Church conducts seminars and workshops where mothers are educated on PMCT (Prevention of Mother-to-Child Transmission) and the youth given cards, banners and T-shirts written “True Love Waits” and “True Love Stays” to distribute to the youth and married people respectively as a way of reaching the public.

Church Minister 3: Our Church runs a HIV and AIDS prevention programme known as PCEA-Ndagani HIV and AIDS programme. This programme deals with awareness and education of members and the community on HIV and AIDS. This is done through information education and communication where the youth mainly distribute materials with HIV and AIDS information to the community. Through this initiative, we have been able to offer home-based care for victims and home visitations to promote HIV and AIDS awareness. The Church also organizes workshops and seminars that provide a forum to train peer counsellors, distribution of condoms and advocacy. We have initiated motorcycle income generating projects for the youth where the youth are helped to buy motorcycles. This has helped to keep our youth busy and prevents them from engaging in sexual activities that may predispose them to HIV and AIDS.

Church Minister 4: Our HIV and AIDS mitigation programme is known as Salvation Army Community Caring Ministry (CCM). This program has its roots in the Church and goes beyond to the community. Under this programme, the Church conducts several activities. Indeed we care for orphans and widows, educate the youth on dangers of premarital sex and encourage people to disclose their HIV status. We have a prevention strategy called Prevention With Positives (PWP) where we appeal to infected persons not to infect others. We also visit the sick in hospitals and offer them some basic needs such as food and clothing. Through workshops and seminars we implore on discordant couples to use condoms to avoid spread. Lastly, through our Community Caring Ministry we offer counselling services.

Excerpt 2 (Focus Group Discussion)

Researchers: What HIV and AIDS Church programmes are available in your locality? Which among them do you participate in?

Focus Group 1: The programmes we are aware of are Baptist Community Initiative, Redeemed Gospel Church HIV and AIDS programme. We participate in the Redeemed Gospel Church HIV and AIDS programme.

Focus Group 2: The programmes we are aware of are Redeemed Gospel Church HIV and AIDS programme and Baptist Community Initiative. We are members of the Baptist Community Initiative programme.

Focus Group 3: The Church HIV and AIDS programmes available in this region include Redeemed Gospel Church HIV and AIDS programme, Baptist Community Initiative and PCEA Ndagani HIV and AIDS programme. We are members of the PCEA-Ndagani HIV and AIDS programme.

Focus Group 4: We are aware of the the Salvation Army Community Caring Ministry and the Redeemed Gospel Church HIV and AIDS programme. We participate in the Salvation Army Community Caring Ministry. All the beneficiaries indicated that they were not receiving support from elsewhere apart from the Church-initiated programmes.

From the information given by the Church members, Church ministers and the beneficiaries, it is evident some Churches in Meru South sub-county are running HIV and AIDS prevention programmes. Among the Church we had purposely selected for the purpose of this study including the Redeemed Gospel Church-Chuka, Chuka Baptist Church, Salvation Army-Chuka and PCEA-Ndagani, we found that these Churches were involved in a variety of HIV and AIDS activities, ranging from counselling, orphan care, pastoral care and support, voluntary counselling and testing, seminars and workshops, distribution of information and resource materials in the region, home visits and behaviour change communication through awareness campaigns, posters and brochures to orphan support and home-based care.

The purpose of this study was to examine what Churches Meru South Sub-county were doing to deal with the impact of HIV and AIDS in their communities. It was therefore noted that there is a considerable effort to respond to the multifaceted aspect of the pandemic through Church initiatives. It can be adduced that the church is carrying out her mission in response to the HIV/AIDS pandemic in Meru South Sub-county.

Effectiveness of Church Initiated Programmes in HIV and AIDS Mitigation

This research assessed Church-initiated programmes and HIV/ AIDS mitigation in Meru South Sub-county. The evaluation was meant assess the effectiveness of Church HIV and AIDS mitigation programmes in achieving their goals. To measure views and attitudes of the respondents to the programmes, a five point Likert scale was used in the questionnaires. Respondents were to say whether they "Strongly disagreed, Disagreed, Agreed, Strongly agreed or were neutral on the activities that the Churches were undertaking to fight HIV/AIDs through their programmes. Table 2 below shows the percentage of responses for each question item that corresponded to the points on the rating scale used by respondents to provide their answers.

Table 2. Effectiveness of church initiated programmes in HIV and AIDS mitigation

Effectiveness	SA	A	N	D	SD	Total
Your Church has made sufficient support for people orphaned by HIV and AIDS.	40	46	7	2	1	**96**
Your Church has made great contribution to reduce stigma on people living with HIV and AIDS.	43	45	7	1	0	**96**
Your Church organizes trainings that help reduce the impact of HIV and AIDS in society.	37	54	5	0	0	**96**
Your Church has elaborate care centres that benefit people living with HIV and AIDS.	23	29	14	14	16	**96**
Your Church has an effective voluntary counseling and testing programmes.	42	13	2	19	20	**96**
Your Church has developed support programmes for people living with and affected by HIV and AIDS.	28	52	13	1	2	**96**
Your Church has effectively involved its members in prevention campaigns.	28	49	15	3	1	**96**
Your Church organizes seminars and Workshops on HIV and AIDS.	50	36	7	2	1	**96**

The results shown indicate that about 40(41.7%) of the respondents strongly agreed that their respective Churches had made sufficient support for people orphaned by HIV and AIDS while 46(47.9%) agreed. Those that remained neutral accounted for 7(7.3%), those that disagreed were 2(2.1%) and those that strongly disagreed accounted for 1.0%. From this it can be adduced that the majority (89.6%) of the Church members attest to the effectiveness of the Church in supporting children orphaned by HIV and AIDS.

With regard as to whether the Church had made great contribution to reduce stigma on people living with HIV and AIDS, 43(44.8%) strongly agreed, 45(46.9%) agreed, while 7(7.3%) remained neutral as 1(1.0%) disagreed. This shows that the Church was doing enough to reduce stigma on people living with HIV and AIDS with 91.7% consenting.

Regarding whether the Church was effective in organizing training that helped in reducing the impact of HIV and AIDS in society, majority 54(56.3%) of the

Church members agreed while 37(38.5%) strongly agreed. Those that remained neutral on this aspect accounted for 5(5.2%). This implies that Churches were effectively fighting the impact of HIV and AIDS through training programmes.

When asked whether the Church they attended had elaborate care centres that benefited people living with HIV and AIDS, 29(30.2%) of the Church members on one hand agreed while 23(24.0%) on the other hand strongly agreed. Those that were either neutral or disagreed totaled to 14(14.6%) and 16(16.7%) strongly disagreed. The majority of the Church members therefore believed that the Church did well in caring for PLWHAS.

With regard to whether the Churches had effective voluntary counselling and testing programmes, 42(43.8%) church members strongly agreed, 13(13.5%) agreed, 2(2.1%) were neutral, 19(19.8%) disagreed while 20(20.8%) strongly disagreed. Inferring from the findings it can be said that most of the Churches in the study location had effective voluntary counselling and testing programmes as 57.3% of the church members affirmed.

When it came to the Church members' evaluation of the effectiveness of the Church programmes that were developed to offer support to people that were living with and affected by HIV and AIDS, 52(54.2%) agreed that the Church did support them while 28(29.2%) strongly agreed. Those that remained neutral, disagreed or strongly disagreed were 15(15.6%), 3(3.1%) and 1(1.0%) respectively. From these responses, we concluded that the Church had effective programmes offering support to the people living with HIV and AIDs (PLWHA) and their relatives or caretakers.

When Church members were asked to reflect their level of agreement to the fact that the Church they attended was effectively involving its members in HIV transmission prevention campaigns, the majority 49(51.0%) agreed while 28(29.2%) strongly agreed. The rest 15(15.6%) and 3(3.1%) were either neutral or disagreed altogether. From the findings it can be concluded that the Church was involving its congregants in the efforts to fight HIV and AIDS through awareness campaigns. The results also show that the Church was effective in organizing seminars and workshops on HIV and AIDS to the community as attested by 50(52.1%) Church members who strongly affirmed that the Church actually did organize seminars and workshops aimed at sensitizing people on HIV/AIDs prevention. On a similar vein, 36(37.5%) supported the idea while 7(7.3%) were neutral as 2(2.1%) and 1(1.0%) disagreed and strongly disagreed respectively.

The effectiveness of Church-initiated programmmes in reducing HIV and AIDS spread was evaluated by the eight outcomes as indicated on Table 2 above. The effectiveness of the Church in HIV and AIDS mitigation in Meru South sub-county can be attributed to a number of identifiable characteristics. This study has found that churches have implemented several interventions such as media campaigns, increased access to VCT, and sex/HIV education workshops and seminars which were among the evaluation measures.

In an effort to enlarge the quantitative data obtained from the Church members using questionnaires, this study gathered qualitative information from key informants who were the Church ministers and the beneficiaries of Church initiated HIV and AIDS mitigation programmes. With regard to whether the Church-initiated programmes had helped to reduce the spread of HIV and AIDS, the Church ministers/pators interviewed (Redeemed Gospel Church-Chuka, Chuka Baptist Church, PCEA-Ndagani and Salvation Army Church-Chuka) held the opinion that they cannot certainly report that there has been a reduction in the spread of HIV as a result of the scaled efforts by the Church. It was not possible to quantify because many people in the Church have not been tested for HIV and their HIV status is thus not known. The Church has also not kept an epidemiological data on HIV and AIDS prevalence. However, they were quick to point out that Churches indeed had a comparative advantage in promoting the needed types of behaviour change to reduce the spread among its congregants and the society at large by advocating behavioural change since these behaviours conform to their moral, ethical, and scriptural teachings.

The Church ministers were also categorical in reporting that they had the power to believe that the ministry of health statistics showing a decline in HIV prevalence in the division could be attributed to Church programmes that have continued to give clear messages about sexual activity and condom or contraceptive use and continually reinforcing that message in their campaigns. The Church ministers reported that the programmes which have been effective in HIV and AIDS mitigation included: Support for people orphaned by HIV and AIDS, reducing stigma through education, organizing trainings that help reduce the impact of HIV and AIDS in society, Voluntary Counselling and Testing programmes, organizing seminars and workshops. In addition, they seemed to recognise that there are factors which contribute to the spread of HIV and AIDS which the Church may not

adequately mitigate and in particular poverty, which generally leads to rural exodus, migration and prostitution and certain cultural practices including polygamy and wife inheritance among others. Some Church ministers also pointed to National statistics supporting their argument by referring to secondary data that HIV prevalence in Kenya had fallen from a peak of 10% in adults in the mid-1990s to 6.1% in 2010. However the decline is not uniform throughout the country (UNAIDS 2011).

This study gathered qualitative information from the key beneficiaries to compare with that elicited from the Church ministers with regard to the effectiveness of the Church-initiated programmes in mitigating HIV and AIDS. In order to establish effectiveness, a focus group of the beneficiaries was required to provide the benefits that they had accrued from engagement in HIV and AIDS programmes initiated by the Church if any. The results generated show that there are a number of ways through which such programmes have benefited the participants. Two themes that were generated from the focus group discussions relating to prevention of spread of HIV and AIDs included:

i) **Psychosocial support:** Beneficiaries acknowledged receiving aid from Church members in the form of food, clothing and sharing of experiences. Beneficiaries were involved in numerous activities such as visiting each other and group saving all of which helped improve their involvement in the programme. This promoted active awareness of HIV and AIDs prevention that helped them integrate the information into the context of their own lives.

ii) Establishment of prevention networks: The beneficiaries indicated that the Church programmes provided them with a platform through which they were able to solicit for support from NGOs through their networks. Typically, the programmes provided information about skills, demonstrated the effective use of those skills, and then provided some type of skill rehearsal and practice for example verbal role-playing. Some of the programs taught them different ways to say "No" to sex or unprotected sex, how to insist on the use of condoms or other methods of contraception and how to use body language that reinforced the verbal message.

The findings from the Church members, the Church ministers and the beneficiaries show that HIV and AIDS mitigation programmes have been effective in Meru South sub-county as majority of the respondents indicated. Although Churches were found to possess a number of distinct advantages in delivering HIV and AIDS interventions, they were also found to suffer from certain limitations that hampered their effectiveness. When asked what challenges they faced in carrying out HIV and AIDS initiatives, most of the Church ministers identified their need for training in HIV and AIDS-related technical skills that prevented them from establishing or expanding their activities. The second most important challenge identified was lack of funding. Having embarked on HIV and AIDS activities, the Churches now have an overwhelming desire to be more effective but inadequate funds to implement these programmes was a real setback. The Church ministers also indicated that one important constraint faced was that they lack personnel with the necessary skills to implement effective HIV and AIDS activities. The beneficiaries on the other hand indicated that the challenges that were facing the Church in her quest to mitigate HIV and AIDS were lack of funds to roll up their programmes to a large scale to reach many people in the community.

When asked to provide suggestions that can be incorporated in order to make the existing Church-initiated HIV and AIDS mitigation programmes more effective, a great deal of responses were elicited from the Church members. The responses generated are captured on Table 3 below.

Table 3. Strategies to enhance effectiveness

Proposed strategies	SA	A	N	D	SD	Total
i) Establishing well-coordinated outreach programmes.	75	21	0	0	0	**96**
ii) Open up more VCT centers to increase accessibility	77	19	0	0	0	**96**
iii) Encourage expectant mothers to attend antenatal clinic with their partners	84	12	0	0	0	**96**
iv) Encouraging attendance to VCT at night for those who fear to be seen during the day	32	64	0	0	0	**96**
v) Construction of a centre to support PLWHA/orphans and the most vulnerable members of the Church	86	10	0	0	0	**96**
vi) Develop a community based program of action	87	9	0	0	0	**96**

Results from Church members' responses show that 75(78.0%) of them strongly agreed that the Churches can consider establishing well-coordinated outreach programmes to reach more people. The members also strongly held the opinion that Churches should open more Voluntary Counselling and Testing (VCT) centers to increase accessibility with 77(80.0%) assenting. The majority of members 84(87.0%) further suggested that expectant mothers should be encouraged to attend antenatal clinics with their partners for a check-up to prevent mother-to-child transmission. Further responses from the Church members reveal that 64(67.0%) agreed that Churches would be more effective in mitigating HIV and AIDS by encouraging attendance to VCT at night for those who fear to be seen during the day. An overwhelming 86(90.0%) of the Church members suggested that construction of a centre to support PLWHAs/orphans and the most vulnerable members of the Church would go along way in scaling the fight of the pandemic. To enhance effectiveness of Church-initiated HIV and AIDS mitigation programmes, 87 (91%) of the Church members strongly agreed that the Church needed to develop a community based program of action.

The study elicited qualitative responses from the Church ministers and beneficiaries regarding the strategies that may be employed by the Church to effectively mitigate HIV and AIDS. Most of the Church ministers interviewed (3 out of 4) had the opinion that supporting the development of local networking initiatives would be an important strategy for strengthening Church HIV and AIDS initiatives. To raise awareness about HIV prevention, Church ministers suggested that the Church should strengthen its awareness campaign programmes and develop appropriate HIV and AIDS messages in the church in line with the existing Church policies. All the beneficiaries (40) supported formation of support groups that would help them to establish income generating activities to enable them provide care and support for those infected and affected by HIV and AIDS, orphans and vulnerable children care. Further, the beneficiaries suggested the following strategies through the focus group discussions:

i) Organizing HIV and AIDS awareness programmes in various Church congregations during a Sunday service. This may include having speakers to address relevant topics.
ii) Hosting Bible studies and/or educational seminars about HIV and AIDS in respective Church congregations, targeting specific age groups and single sex groups.
iii) Having a set time during the week when the Pastor and/or trained counsellors are available for confidential counselling to anyone affected or infected by HIV and AIDS.
iv) Having educational and informational posters displayed in the Church.
v) Making information available in respective Churches detailing where people can access 'harm reduction' programmes and/or free local testing if the Church does not offer such services.
vi) Encouraging congregation and community members to go for voluntary counselling and testing so that they can know their status and know how to live positively or remain negative.
vii) Sponsor a voluntary counselling and testing (VCT) centre at respective church facilities. Making sure the service is well advertised in the community and that community members know and believe that the service is confidential.
viii) Organize community events focused on HIV and AIDS awareness such as concerts, drama productions, health fairs, fun runs or football games.
ix) Order HIV and AIDS educational materials from available local AIDS education, information and training centres. Display these materials in respective Churches or in a relevant location accessed by the community.
x) Sponsor training for congregation and community members in counselling, home-based care, and basic HIV and AIDS education. This invests in the community as these people can go on to train others in what they have learnt.

From the above suggestions from the beneficiaries, Church members and the Church ministers, the Church needs to incorporate more programmes to strengthen HIV and AIDS initiatives.

Religion is an important component of culture as it influences the thinking and behaviour of society members. According to the results, more than 82 (85%) of the respondents agreed that they benefited from the Church-initiated programmes that are geared towards mitigating HIV and AIDS. This is through change of sexual behaviour, reducing stigma, taking care of the infected and orphans in the society.

CONCLUSION

Religions play a significant role in transforming the societies in which they are found. For instance the impact of Christianity in Kenya, where it is followed the majority of the population (about 83.6%) cannot be overstated. This can be affirmed by the Church's effort to fight the HIV and AIDs pandemic which is a national disaster in Kenya. As this study reveals the programmes ran by the Church to fight the HIV and

AIDS scourge are effective. Using some selected Churches in Meru South Sub-county: Redeemed Gospel Church-Chuka, PCEA-Ndagani, Salvation Army-Chuka and Chuka Baptist Church that were already implementing HIV and AIDS mitigation programmes, it clear that the place of the Church in curbing this pandemic cannot be under-rated. Most of the programmes that churches are operating including Orphan care, support of people living with and personally affected by HIV and AIDS, prevention activities that involve campaigns, pastoral care and support, outreach programmes, voluntary counseling and testing, seminars and workshops seem to be doing well. The analysis of the data provided, showed that the programmes were effective in mitigating HIV and AIDS in Meru South Sub-county.

Therefore if these Church programmes are supported the government, church and other development partners, major strides can be made in fighting the HIV and AIDs disaster in Kenya. The results show that although the Church initiated HIV and AIDS programmes are effective in curbing this pandemic, they face a serious challenge of lack of funds. The government and other development partners therefore can support them through funding. This way the war against HIV and AIDS can easily be won.

REFERENCES

Barnett, T., and Whiteside, A. 2003. *AIDS in the Twenty-First Century.* New York: Palgrave Macmillan.

Goliber, J. 2000. *Exploring the Implications of the HIV/AIDS Epidemic for Educational Planning in Selected African Countries*. Uppsala: Swedish Institute of Mission Research.

John, W. and James, V. 2006. *Research in Education*. Boston: Pearson Education Inc.

Kenya Health and Demographic Survey (2009

Lodiago, M., Kimani, E. and Wanjama, L. 2007. *HIV and AIDS. The Pandemic*. Nairobi: Jomo Kenyatta Foundation.

NASCOP. 2016. Report on National HIV and AIDS Prevalence in Kenya. Nairobi: NASCOP.

Neville, R. 2006. A call for care: HIV/AIDS challenges the Church. Journal of Theology for Southern Africa 125:38-50.

Nkonge, D.K. 2012. Developing Church Leaders in Africa for Reliable Leadership: A Kenyan Perspective. *Dutch Reformed Theological Journal (NGTT),* 53 and 54(2):228-240.

Ogula, A. 1998. *A Handbook on Educational Research*. Nairobi: New Kemit Publishers.

Republic of Kenya. 2009. Kenya Health and Demographic Survey 2008-2009 Report.

Nairobi: Ministry of Planning and National Development.

UNAIDS. 2017. Report on the Global Aids Epidemic. http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp. Accessed on 30/8/2017