NAIROBI EVANGELICAL GRADUATE
SCHOOL OF THEOLOGY

FACTORS CONTRIBUTING TO THE DEVELOPMENT OF THE HIV/AIDS PROGRAMME IN PCEA LANG'ATA PARISH NAIROBI

BY

DOMINIC OLLURU OCHOLIA

Thesis submitted to the Graduate School in partial fulfilment of equirements for the degree of Master of Divinity (Missions Emphas

MAY, 2003

NAIROBI EVANGELICAL GRADUATE SCHOOL OF THEOLOGY

FACTORS CONTRIBUTING TO THE DEVELOPMENT OF THE HIV/AIDS PROGRAMME IN PCEA LANG'ATA PARISH, NAIROBI

BY
DOMINIC OLLURU OCHOLIA

A Thesis submitted to the Graduate School in partial fulfillment of the requirements for the degree of Master of Divinity (Missions Emphasis)

Approved:

Supervisor : _____
Dr. Henry Mutua

Second Reader : _____
Dr. Alemayehu Mekonnen

External Reader : _____
Dr. Julius Muthengi

May, 2003

Student's Declaration

FACTORS CONTRIBUTING TO THE DEVELOPMENT OF HIV/AIDS PROGRAMME IN THE PRESBYTERIAN CHURCH OF EAST AFRICA (PCEA) LANG'ATA PARISH, NAIROBI

I the undersigned declare that this thesis is my work and has not been presented to any other university or theological college for academic credit. Information from other sources has been duly acknowledged.

The views presented herein are not necessarily those of the Nairobi Evangelical Graduate School of theology(NEGST) or the examiners.

(Signed) _____

Olluru Dominic Ocholia

May, 2003

DEDICATION

This thesis is dedicated to:
My dear friends Mr. James Koen-Boot, Ms. Martha E. Hughell, Mrs. Mary Thuo, Rev. and Mrs. Mungai Wakaba and Rev. and Mrs. Johnson N. Kamau.
My supportive parent, Hisiaha Oliha.
My beautiful wife and best friend, Itana Rejoice.
Our three lovely children, Ikuma, Oliha, and Mariang.

ABSTRACT

The purpose of this research was to investigate and identify factors that led to the development of HIV/AIDS programme at PCEA Lang'ata Parish. The findings of the investigation form a basis for recommendations for evangelizing and planting churches.

The three research questions upon which the study was based were:

1 What is the prevalence of HIV/AIDS at PCEA Lang'ata Parish Congregation?

2 What factors led to the development of HIV/AIDS at PCEA Lang'ata ?

3 What strategies has PCEA Lang'ata parish put in place in the fight against HIV/AIDS ?

The data was collected from a sample of the target group using both open-ended and closed-ended questionnaire and interviews guide. The instrument was administered to seventy (70) respondents. The data obtained was analyzed using descriptive statistics (frequencies and percentage) to identify and from which correlation between variables were discussed.

The following were the major findings:

Concerning factors that led to development of HIV/AIDS programme; a large proportion of both church leaders and members represented by 50 % thought that the main reason for developing the programme was for evangelization. Some thought that the increasing problem of orphans was the main factor that led to the church to develop the programme. Others believed that checking the spread of the epidemics through testing before marriage was the main reason of the church's involvement in HIV/AIDS prevention programme. Another group pointed out that the issue of widows and widower was the reason for the church development of HIV/AIDS programme. In addition, a large proportion of the respondents indicates that the Church felt that HIV/AIDS was a threat to evangelization mission. They felt that the pandemic also infected and affected members of the Church. A fairly large proportion of the respondents said that the church experienced HIV/AIDS cases among its members. This is an indication that the church is not spared the wrath of the epidemic. The respondents also noted that more church members were affected by epidemic because they had close relatives suffering from HIV/AIDS. The respondents also believed that the central concern for the programme was to create awareness among the church members because by educating church members, it was believed that they would in turn spread the message to other members of the community. The respondents urged the church to organize workshops/seminars on HIV/AIDS awareness.

From the findings it was evident that the objectives of the programme was not really achieved. Christian values, evangelism and spiritual development were not fully integrated in the programme.

ACKNOWLEDGMENTS

First and foremost, I would like to thank God for giving me an opportunity to come to NEGST.

This thesis would not have been what it is now without help from several individuals and bodies. I would like to acknowledge with gratitude the assistance of Dr. Henry Mutua my academic advisor who tactfully helped me to put these materials together. His suggestions and encouragement gave me the stamina to move ahead without much difficulty. It is because of his listening skills, patience, kindness, flexibility, correction and encouragement from the beginning of this work to the end that the writing of this thesis has been realized without much pressure. I cannot forget to thank URCO-Foundation who gave me this chance to study. I would like to thank most sincerely the entire NEGST community, especially The Head, Dr. A. Mekonnen, second reader and entire Missions Department for their unceasing prayers, understanding and loving care during my study period.

The Parish Minister, Rev. Johnson N. Kamau, PCEA Lang'ata Parish, entire staff and Mr. Francis Kihoho, Project Coordinator have been of great help vote of thanks to them for their cooperation in availing records and providing me with the necessary data and information for this thesis. Special thanks to the entire PCEA Lang'ata Parish members for their encouragement, prayers, love and support to make this work possible. My family was of great help vote of thanks to them for their encouragement especially when things seemed unbearable.

I would like to express my appreciation to Mrs. Thuo's family and entire Ngei One District for their prayer, encouragement, guidance and material support they gave me during my period at NEGST.

I wish to thank my wife Itana Rejoice for material and moral support she accorded me throughout the tiring period, the same applies to my family members and friends for their encouragement and understanding.

Last but not least I thank everyone who assisted me in one way or another during my study period at NEGST who gave me ideas and suggestions on this thesis and to all lecturers. May God bless you.

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
C.A.E.s	community AIDS educators
HIV	Human Immuno Virus
ICRC	International Committee of the Red Cross
KNH	Kenyatta National Hospital
KPA	Kenya Port Authority
MTC	Mother-to- child
NARESA	A forum by Network of AIDS Research of Eastern and Southern Africa
NASCOP	National AIDS and Sexually Transmitted Disease Control Programme
NGOs	Non governmental organizations
PCEA	Presbyterian Church of East Africa
PLHAs	People living with HIV/AIDS
STD	Sexual Transmitted Disease
UNAIDS	United Nations AIDS Programme
UNICEF	United Nations Children's Fund
WCC	World Council of Churches
WHO	World Health organization

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

The HIV/AIDS epidemic has become a major concern of the world today. It has been recognized as a threat to development specially in many developing countries. This has made developing countries to attempt to mainstream HIV/AIDS into instrument of development. Therefore, this research comes very strategically at the time when the HIV/AIDS is sweeping Christian population. It comes at the time when the church needs fresh insights and challenges because HIV/AIDS has now become the most leading cause of mortality. The way HIV/AIDS is claiming lives, destroying families and leaving orphans worldwide is a living witness. A close look at the shocking statistics from various sources should encourage the church to do something on this frustrating deadly disease.

Currently 40 million people are said to be living with HIV/AIDS. Out of this 28.1 million people with HIV/AIDS are found in Sub-Sahara Africa. It is reported that about a million cases of HIV/AIDS are found in Kenya. This presents a very severe scenario of the HIV/AIDS pandemic in Kenya, Africa and the world in general (Opora 2002, 12-13). For the above mentioned reasons it has become crucial for the church, government, non governmental organizations (NGOs) and other stakeholders to make credible intervention strategies to curb the spread of HIV/AIDS. The church is one of those leading organizations that brings thousands of people together. "Christians comprise 70 to 80 percent of the Kenya population. The church clearly has an important role to play in the AIDS epidemic" (Kiiti and Dortzbach 1996, 129).

The HIV/AIDS pandemic has traversed church beliefs and thus has even affected church members. This has made the church to involve in fight against HIV/AIDS. "The response of the churches should be swift imagination and radical" (MAP International 1996, 19). The church should have compassion for those who are infected and sick and for their families. And that the church should have vigorous and an uncompromising campaign to educate those most at risk because of the danger of sexual irresponsibility. The impact is not only on the strength of numbers but on the fact that "Churches are at the grassroots, integral part of the community life. Churches promote beliefs that guide behavior with either an implicit or explicit system of accountability" (ibid., 130).

The Presbyterian Church of East Africa (PCEA) having started in 1891 with arrival of Scottish Missionaries has spread throughout Kenya having a very large following. The PCEA recognizes the challenge HIV/AIDS posses to the church and society at large. HIV/AIDS seems to have challenged the moral values of the church.

In this regard attempts have been made to response to HIV/AIDS problem with the various level of the Christian community.

Problem Statement

The study tried to discover how certain factors are perceived by registered members of PCEA Lang'ata Parish which have led to the development of HIV/AIDS Programme in the church.

Significant of the Study

Since the first case of HIV/AIDS was reported early 1980s in Kenya, the pandemic has created health, economic and social problems in the country. Among

the stakeholders involved in the fight against HIV/AIDS is the PCEA Church that have set up programme to fight against HIV/AIDS.

The factors leading to the development of HIV/AIDS programme at PCEA discussed in this thesis are of great help, not only to the church but to other church agencies, government and private agencies that are involved in HIV/AIDS prevention programmes. The findings of the study have unlimited missiological implications in Africa and the world at large. While, the study focuses on PCEA Lang'ata Parish, the issues raised concerning HIV/AIDS effect in the church may have implications for other missiological issues.

The study adds to the information on the new trend of HIV/AIDS in Kenya.

The church plays a very active role in every part of the Kenyan society. Christians compose about 80% of the Kenyan population. The church therefore has a very important role to play in the HIV/AIDS epidemic.

The issue concerning HIV/AIDS that faces Christians today challenges the very core of their faith. Many questions are asked and no answers are different. The disease continues to spread, yet, what is the church doing ?

Purpose of the Study

The purpose of this study was to investigate the factors that are contributing to the development of HIV/AIDS programme at PCEA Lang'ata Church with view to their implications for mission.

Research Questions

In this regard, this study attempted to answer the following research questions:

1 What is the prevalence of HIV/AIDS at PCEA Lang'ata Parish Congregation ?

2 What factors led to the development of HIV/AIDS at PCEA Lang'ata ?

3 What strategies has PCEA Lang'ata parish put in place in the fight against HIV/AIDS ?

Research Hypotheses

Hypothesis 1. The church's mission of evangelization led to the development of HIV/AIDS programme at PCEA Lang'ata Parish.

Hypothesis 2. The impact of HIV/AIDS on the church members led to the development of HIV/AIDS Programme at PCEA Lang'ata Parish.

Hypothesis 3. Socio-economic impact of HIV/AIDS on the church members led to the development of HIV/AIDS programme at PCEA Lang'ata Parish.

Hypothesis 4. Some Socio-cultural practices enhances the spread of HIV/AIDS in the society led to the development of HIV/AIDS programme at PCEA Lang'ata Parish.

Limitation and Delimitation

Limitation

Owing to time factors and other logistical problems, the study was limited to PCEA Lang'ata Parish. In other words, the research was confined to PCEA Lang'ata Parish, Milimani Presbytery. This was because the research could not cover the whole PCEA Parishes and Presbyteries. It was too wide to come to a comprehensive conclusion. The research was also limited to the English service congregation at

PCEA Lang'ata Parish. This was because it was difficult to get information from Kikuyu service–Language barrier.

Delimitation

This study was concentrating on describing and analyzing factors that led the development of HIV/AIDS at PCEA Lang'ata Parish, Milimani Presbytery. Other programmes run by the parish were not included. Other PCEA parishes were not also included in the research.

Definitions of Terms

1. **HIV**: (Human Immuno Virus). This describes a group of virus which causes AIDS.
2. **AIDS**: (Acquired Immune Deficiency Syndrome). Related conditions in all those infected with HIV.
3. **Awareness**: Conscientization programme towards helping people become critically aware of their situation.
4. **STD**: Sexual Transmitted Disease
5. **Virus**: A virus is a germ, smaller than bacteria which causes disease.
6. **Presbyterian Church of East Africa (PCEA):** one of the Presbyterian churches founded by the Scottish missionaries.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

This chapter presents a review of literature by other experts on issues related to HIV/AIDS in Kenya, Africa and the Worldwide. The history of PCEA church is also included in this chapter.

History of Presbyterian Church of East Africa (PCEA)

Scottish Mission work in British East Africa was primarily a Kikuyu and, later, a Chuka–Mwimbi enterprise. Initial work, however, was not under the auspices of the Church of Scotland but of the East African Scottish Industrial Mission, an 1891 creation of three of the directors of the Imperial British East Africa Company. Their station, Kibwezi, on the route from Mombassa to Uganda, made no progress among the Kamba.

Only in 1898 when Thomas Watson abandoned Kibwezi for Kikuyu, near Dagoretti west of Nairobi, and when two years later the foreign missions committee of the church of Scotland assumed responsibility, did the real thrust of Scottish missions begin in Kenya (Oliver 1965, 43). Clement Scott, the experienced missionary from Nyasaland, took charge of the Kikuyu station the following year. Convinced that both African and European development in East Africa could be closely drawn under Christian influence, Scott under took a major agricultural scheme and as a consequence, associated the mission with the commercial and political life of the country (Ibid., 60). But the experiment failed and with the death of Scott in 1907

the Church of Scotland mission decided to reappraise its policies. Prior to 1907 emphasis had been on settler cooperation; after 1907 it was shifted to administrative cooperation. Clement Scott's successor, Dr. Henry E. Scott, was concerned with evangelism, and the corollary to him was education, for through education Africans would be trained as Christian workers in what was to be a "white man's country." Despite his concern for detribalization, Scott opened a boarding school at Kikuyu, and he began scholastic work in chief Kinyanjui's village. A. R. Barlow who as a young man had managed clement Scott's farm near Kiambu, joined the mission and took charge of the first major expansion northward. In mid 1909 he opened a second station at Tumutumu near Nyeri, and began medical and education departments. From the death of Henry Scott in 1911 until 1937, Dr. J. W. Arthur, a medical missionary, was incharge of the mission. In 1919 a young doctor, A. Clive Irvine, joined the mission at Tumutumu and three years later opened the third Scottish station at Chogoria among the Chuka and Mwimbi, east of Mount Kenya (Oliver 1965, 76).

The Presbyterian Church of East Africa is a well established church which was founded by Scottish missionary Dr. James Steward, Livingstone's successor. In Sept. 19, 1891 with a party of seven missionaries Steward had a purpose to go as far as Kikuyu land but due to turbulence among the Gikuyu, he decided to settle at Kibwezi. At Kibwezi the mission encountered numerous misfortunes. Not only was the mission decimated by famine but a number of people were killed through raids. It was decided that the mission to be transferred to Kikuyu forthwith. Rev. Thomas Watson led the Scottish Mission to Kikuyu in 1898. By 1899 a mission station had already been built at Thogoto (Anderson 1974, 133-4). The PCEA is now Independent Church and has African leadership as well as membership.

Today, the PCEA is one of Kenya's largest churches with between two to three million members. It is divided into 26 Presbyteries (which in turn are divided up into Parishes) that cover the whole of Kenya and limited parts of Tanzania and Uganda.

PCEA HIV/AIDS Control Programme

The Presbyterian Church of East Africa (PCEA) has been a noticeable exception among churches in its efforts to approach the whole issues of HIV/AIDS. However initially the response of the PCEA to the HIV/AIDS issue was confirmed to outreach programmes by its three hospitals in Chogoria, Tumutumu and Kikuyu. Its health policy (1995) states the need for accurate, complete and on-going HIV/AIDS information. The recommendation that came out of its national HIV/AIDS symposium (1996) identified further education as the paramount requirement in containing HIV/AIDS (Rukenya 1996, 14).

The PCEA established a HIV/AIDS control committee in 1996. This committee is a join committee of the Health Board, the Projects Department and the communication Department.

In 1998, the PCEA HIV/AIDS control project began its "trainer of trainers" or TOT course. Their objective was to train TOT in every Parish within the church. He/she would then go on to train community AIDS Educators both within and outside of the church. These community AIDS Educators would in turn create HIV/AIDS awareness in community.

In the 1999, General Administration Committee of the PCEA, a resolution was passed which encouraged the employment of HIV infected individuals and people living with AIDS both within the church and other working places in Kenya((Ibid., 16).

PCEA Lang'ata Parish

The PCEA Lang'ata Church belongs to Milimani Presbytery. It started early 1970s as a small prayer group. The members were first meeting in houses for a period of two years. From there, the church began to grow both in ministry and membership. The church began to learn to be self-reliance for her self in late 1970s. It began to buy the land where it is now built.

PCEA Lang'ata Parish is the most growing church in the Lang'ata area; Southland. It has around 600 full members and around 200 unregistered members.

PCEA Lang'ata Parish HIV/AIDS Control Programme

The programme began in early 1996 as strategic planning for HIV/AIDS prevention and care but it was at the Presbytery level. In the parish level, the programme was established later in the year with the purpose to reduce the incidences and prevalence of HIV/AIDS and hence to prevent and control the rapid spread of it in the urban center, Nairobi. In 1998, the PCEA HIV/AIDS Control Project began its "Trainer of Trainers" or TOT course (Rukenya 1996, 19).

This came about after the church leaders realized that many people were dying and others were infected with HIV and some of them were parents with young children. The parish experienced a catastrophic increase in numbers of children living with AIDS affected household or struggling to survive after the death of the parents. This supports the report that "by the end of 1999 according to WHO and UNAIDS, the number of children worldwide or orphaned by AIDS had reached 13.2 million of whom 92% were in Sub-Saharan Africa." (Byamughisha, 1998, 28).

PCEA Goals and Objectives

The PCEA Lang'ata church has the following objectives:

1. Control the spread of HIV/AIDS and improve the care and support of those infected and affected
2. Increase awareness, interest and responsive in the PCEA: the HIV/AIDS health and socio-economic issue.

The general objective is that to create awareness, provide training in basic biblical counseling and increase the number of Kenyan church leader effective involved in Pastoral AIDS counseling at the local parish level (Health for all by 2020).

Action Plan

By the end of February 2004 the church will have:

1. Twenty community AIDS educators (C.A.E.s) trained in HIV/AIDS prevention and control in Lang'ata Parish.
2. Awareness created in and around Lang'ata Parish.
3. Home based care programme established to reach at least 20 people living with HIV/AIDS (PLHAs) and their families.

Substantive Literature Review

Scholars have revealed more on human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). HIV/AIDS is caused by the Human Immunodeficincy Virus (HIV) (Sandrock and Simon 1994, 5). HIV/AIDS is a condition, which causes the body system to collapse. It does not cause death itself but the sufferer to the prey to a rage of other illness (Byamugisha 1998, 4).

It is believed that the HIV virus causes damage through direct attack on human immune system. The infection bring long implication of human existence. HIV virus as generated AIDS as a epidemic and has spread at unimaginable proportion every part of the world. Already it has been alleged that the disease is incurable and all those affected will ultimately die of its infection. This means that, experts have conceded the challenge poised by the epidemic in modern technology. Attention given by the health practitioners to the method of transmitting the virus is the direct result of absence of the vaccine for AIDS (Stanecki 2000, 17).

The study by (Calver 2000, 10) confirms that so far, of those who have developed full-brown cases of AIDS, no single person has been known to recover. Therefore it is important to develop and test alternative measures to combat the causes and the spread of HIV/AIDS.

HIV/AIDS in African Continent

Curci reports that HIV/AIDS was first identified in Uganda in 1982 in a small fishing village on Lake Victoria. The local people initially believed that the new disease nicknamed slim was caused by witchcraft. People suspected of having Aids were left to waste away. Neighbors refused to shake their hands, share plates cups and even to talk with them. Since then the disease has become a national disaster and the government of Uganda has called for international help to fight the pandemic.

In Zambia's capital city, Lusaka, there are two cemeteries known as the "Aids graves". They are pitiful sites; 90% of the people buried there died of Aids. More than 40 burials take place there every day (Curci 2002, 1). In 1993, the World Health organization (WHO) estimated that over the following seven years 20 million people could become infected with the Aids virus. It said however, that by spending about

US $ 2 billion every year, more than half of those infections could be prevented. This would have slowed the epidemic and saved US $ 90 billion in associated costs. However, the latest count, in fact, suggests that today 40 million people are living with HIV, and that within the next 20 years 70 million people will die unless drastic action is taken. Only last year, 2.2 million people died of Aids in Africa alone. Africa accounts for 70% of all HIV/AIDS case in the world, although the continent represents only 10% of the global population. In Botswana, it is reported that nearly 39% of the adult population is HIV infected (arise of 3% since 2000). One-third of the adults in Zimbabwe and Swaziland were infected at the end of 2001 (up from about 20% in 1999). In Cameroon, HIV transmission is accelerating rapidly up to 12% against 4.5% from 1988 to 1996 (UNAIDS and World Health Organisation 2000, 23).

A report presented at the 14th international Aids conference, held in Barcelona, Spain last July (2002) stated that only 30,000 people of the 28.5 million living with HIV/AIDS in Sub-Saharan Africa were being given the drugs that in the west kept infected men and women alive, well and working. But there is no prospect of a total cure for HIV/AIDS in the foreseeable future (Ibid., 2).

There is another shocking result of Aids in Africa; the disease will leave 20 million children without one or both parents by 2022. That is nearly double the current number (11 million). African Aids orphans represent 92% of all the Aids orphans in the world ((UNAIDS and World Health Organization 2000, 2).

In the last two decades of the 20th century, the HIV epidemic has swept through Sub-Saharan Africa with increasing destructive force. According to the World Health Organization and UNAIDS, the epidemic has so far claimed the lives of over 14 million men, women and children in Africa South of the Sahara (UNAIDS

and World Health Organisation 2000, 4). Worldwide about 53 million people contracted HIV and 18.8 million have died of AIDS since the epidemic began in the late 1970s Although HIV is a global phenomenon, Sub-Saharan Africa is bearing the main brunt of the epidemic. With only 10% of the world's population, Sub-Saharan Africa accounts for 71% of the 34.3 million men, women and children estimated to be living with HIV at the start of the twenty-first century. In the most severely affected African countries, up to 25% of the adult population are infected with HIV ((De Vries 2001, 3). A close look at African's AIDS situation is alarming. It has been recently reported that "17 million Africans have died since the AIDS epidemic began in the late 1970s, more than 3.7 million of them children. An additional 12 million children have been orphaned by AIDS. An estimated 8.8% of adults in Africa are infected with HIV/AIDS." (De Vries 2001, 49). Of the 36 million adults and children living with HIV/AIDS in the world in 2000, more than 70% were in sub-Saharan Africa. 3.8 million African were newly infected last year. 79% of these who died of AIDS last year were Africans, life expectancy is falling by 30% in many places in Africa. Many of these people are unable to afford adequate health care (UNAIDS and World Health Organisation 2000, 10). In all these reports, one can say that HIV/AIDS is actually one of the major causes of death in the World. The HIV epidemic has exacted a terrible threat on African population.

In Africa, every African city or big trading center is a special target for HIV/AIDS. More than villages, African cities are exposed to the rapid spread of the virus. It is rightly reported that "few governments have the capacity to prevent the demographic explosion or to serve the needs of new people arriving" (Greig 1999, 32). No wonder then that the death toll due to AIDS is higher in cities than in rural areas. The issue of HIV/AIDS constitutes both a social and economic problem

especially in Sub-Sahara Africa. In the continent, the disease is commonly transmitted through heterosexual contacts. It is held that the core of the problem is risky sexual practice and not sexual orientation (Davison and Neale 1998, 395). Sexual contacts usually increase the risk on women owing to their physiological conditions, such as greater exposed surface area in female genital tract. AIDS was first recognized as a threat to women in the third world countries, particularly in Africa, and the Caribbean basin, where heterosexual transmission was identified and is responsible for hundreds of thousands of deaths. It has been estimated that approximately half of the reported AIDS cases in Africa originate from East Africa-Kenyan, Uganda, Tanzania, Rwanda and Burundi (Aleman 1995, 30) and (Borghorff 1994, 12).

Since most victims of the disease are women, especially those in the productive age, this suggests that mother-to- child-transmission (MTC) is another prominent mode of HIV/AIDS acquisition in children. There are several factors that have favored the escalation and spread of HIV/AIDS in Sub-Sahara Africa. The major ones include the lack of health policy, knowledge, and awareness; poverty and poor health policy and planning. These aspects cause increasing incidences of prostitution, overcrowded living conditions, inadequate health service deliveries and malnutrition among others. Furthermore, lack of realization of women rights that influences sexual health for women increases their vulnerability to HIV/AIDS and other sexually transmitted diseases (STDs) that hinder the control of the disease. Thus efforts to protect women against HIV should be viewed in the context of complex set of social, cultural and economic factors. Women for example, may not refuse unsafe sex or use of condoms because of their gender roles. These factors put women at higher risk of infection. People in the sprawling slum settlements are no

exception from this infection rate of HIV/AIDS because of poverty; lack of economic opportunities; inadequate access to education; training; lack of knowledge; and negative attitudes among others towards HIV/AIDS disease. Some of the HIV/AIDS consequences include reduction on population size; family break-up; widowhood; dependency; homelessness breakdown among others.

In Kenya National AIDS and Sexually Transmitted Disease Control Program-NASCOP (1999) estimated that in 1998, there were 1.9 million people infected with HIV including 100,000 children. These figures are under estimated since the deaths among youth and adults have often increased rapidly, and that 2.2 million people have died of HIV/AIDS in the country. The situation of HIV/AIDS is a serious problem in Kenya-in November 1999, the then president, ~~president~~ Moi declared AIDS as a national disaster. Some 700 to 800 people dying daily of the disease (Curci 2002, 2). The manifestation of the infection indicates that there is increase in hospitalization and home care for HIV/AIDS patients. Moreover affected victims discharged from hospitals for terminal care and home nursing often die unattended due to lack of knowledge and negative attitude among service providers. "Christians are denying the facts and misery of HIV/AIDS"(Morgan 2000, 40). HIV/AIDS is "well known among church leadership that there is a great deal of immorality." (Morgan, 2000, 10).

Concerning Aids and the Church Curci reports that it is becoming increasingly evident that in Roman Catholic church priest have been, and are, falling victims to the HIV/AIDS in growing numbers. He wonders by asking questions "what is the church expected to do?" How can she deal with this phenomenon?" For him, although the church knows itself to be a community of saints, but it must in the case of HIV/AIDS also recognize itself as a gathering of sinners, individually and

collectively often falling below the expectations of its Christian calling. The church as simultaneously holy and sinful must now form a basic point of Christian pedagogy in the context of the Aids pandemic (Curci 2002, 1). The church is realizing the effect of HIV/AIDS on the society. Estate reported that top religious leaders from all major faiths in Kenya were to meet over Aids orphans in Kenya. They were to meet during a two- day conference at Tigoni, Limuru starting Dec. 17. The leaders were to discuss the swelling numbers of orphans and children made vulnerable by the HIV/ Aids pandemic during the meeting dubbed national Religious leaders Conference on HIV/Aids and children. The meeting was also expected to explore new ways in which religious communities could respond the over-increasing number of children made destitute by Aids which kills 800 people daily in Kenya. The conference was a follow–up of the African Religious Leaders Assemblies held in Nairobi in June, 2003. In June, leaders from sub- Saharan Africa discussed collective solutions to the HIV /Aids scourge and its Socio-economic impact on children (Estate 2002, 6).

Ndichu said that Church leaders were to play a greater role in creating awareness about HIV/ Aids and prevention. He said religious organizations have a unique audience must use the advantage to influence behavior change. He urged the leaders to take the responsibility of guiding Kenyans on moral and ethical issues. He derided the rising numbers of children orphaned by HIV/ Aids. "Africa has over 80 percent of the children orphaned by Aids in the world. Kenya alone has one million such orphans" He said the challenge of the Aids epidemic had further been compounded by poverty. "Africa is the most impoverished and poorest in the world despite the wealth of natural resources. He urged governments in Africa to take the issues of human resource more seriously saying that hundreds to thousands of Africans have migrated to elsewhere to look for employment (Ndichu 2002, 6).

Since the first case of HIV/AIDS was reported early 1980s in Kenya, the epidemic has created health, economic and social problems in the country. Among the stakeholders involved the fight against HIV/AIDS is the church. The PCEA is among churches that have set up programmes to fight against HIV/AIDS.

The causes of the spread of HIV/AIDS

In history, hardly has there been a disease that kills like HIV/AIDS. 'No single sexually transmitted disease (STD) has a greater impact on sexual behavior and created more public fear in the last decade than AIDS' (Ibid., 6). It is necessary to be repeated that HIV/AIDS are acronyms for human immune deficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). It is believed that Human Immuno deficiency virus (HIV) causes AIDS by attacking the white blood cells through the mucus membranes or broken skin. In doing so the body Immune system is impaired and made unable to fight off diseases. These viruses reproduce in body defense cells. The process may take several months or years. People who are infected by HIV may look and feel well for a long time. HIV is spread from one person to another through sexual intercourse and through infected blood transfusion. It can also spread by infected pregnant woman to her unborn child. Other ways of transmissions include the use of unsterilized instruments. Some of the early signs of the disease include rapid loss of weight, severe skin rashes, persistent fever and recurrent diarrhea and cough.

The disease and its opportunistic agents are silent killers leading into a crisis proportion on social, economic and security development of society. Worldwide Immuno deficiency virus and acquired Immune syndrome is on increase. The disease is serious because it has no cure and eventually leads to death. The spread of HIV/AIDS especially in developing countries results from complex interaction

between different kinds of mechanisms related to sexual behaviors, lack of knowledge, negative attitudes to education messages, social environment, availability of health care facilities and access to them ((Morgan 2000, 7).

In Sub-Sahara Africa, the disease has reached an epidemic proportion. Its prevalence in the continent is mostly transmitted through heterosexual contacts particularly among adults. Women and their partners, particularly prostitutes and their clients are important agents in the continued transmission of HIV infections in the Continent (Gutsthal 1999, 68).

In the past few years there have been several reviews of HIV/AIDS status especially among women. The Dutch Royal Tropical Institute-KIT/WHO (1995, 27-37) found that worldwide that the proportion of women with HIV/AIDS has increased dramatically. By 1994 women represented 40 percent of all aids cases. Up to 50 percent of all these were of age 15-44 years of age bracket. In its (1992, 2-18) annual report, the United Nations programme estimated that each day, further 3, 000 women become infected and 500 infected women die. Most of these women are said to be between 15 and 35 years old.

Many factors have been blamed for women vulnerability to HIV/AIDS infections and these include lack of knowledge, negative attitudes and inappropriate practices related to the disease. Other factors that have escalated the spread of the infections women them include their conditions, multiple sexual relationships, unprotected sexual contacts, sexual favors in exchange for economic income and loss of traditional social control mechanisms. A forum by network of AIDS Research of Eastern and Southern Africa (NARESA 1994, 15-21) found that the factors which are responsible for high STD/HIV prevalence in sub-Sahara Africa include the rapid growing population of adolescents and young adults; rural and urban migration

weakening family and cultural tradition endemic poverty; literacy, and low status given to women in society. This suggests that severe impact of HIV/AIDS of women with their partners and children are already apparent. Unexpectedly these variables have disproportionate consequences for those at the bottom of society, as they undermine their family life in a particular destructive way. Such families have all social, economic and psychological disadvantages that HIV/AIDS impact on them negatively.

Knowledge and Attitude of people about HIV/AIDS

Leading experts have targeted women for reason of accessibility and opportunity to follow them up for research purposes. They have found that more women than men acquire HIV infections through sexual contacts. Theorists have also reached the HIV infections to factors such as, lack of knowledge, attitudes, cultural practices, and economic incentives. A research was carried out in New York and was concluded that current knowledge about HIV infections and derived standards affects women differently than men (De Hovitz 1995, 22). He noted that the effect is merely due to differences in physiological and income; risk behaviors, and lack of access to medical care.

In Kenya like any other Sub-Sahara Africa country, various studies on knowledge about HIV/ AIDS have been conducted especially in Nairobi. There was also survey carried out on Nairobi prostitutes and showed that women of low-economic status are susceptible to unprotected sex and their social status may limit their ability to set the terms of sexual encounter particularly with regard to the use of condom (Kreiss 1986, 20). Therefore prostitution, multiple sexual partners,

unprotected sexual intercourse; poverty; lack of economic and cultural practices being linked to the current spread of HIV infections.

The study of 418 prostitutes in Nairobi found out that 62 percent of them were HIV positive. The study also found that higher infection rate was (66%) among lower economic class and (8%) for middle class (Sanders 1991, 2-13). In a more recent study postulated that although science has made discoveries, knowledge of HIV/AIDS and its mode of spread is not powerful enough to fully dispel the public sense of mystery, fear, prejudice and denial (Juju 1996, 23). In Africa polygamy, wife inheritance and multiple sexual partners are still common. It is reported that an estimated 8 million Kenyans are threatened with HIV/AIDS infection. Nyanza where inheriting wives and polygamy are acceptable practices among Luo, the phenomenon promotes the increase of the disease HIV/AIDS in the area. In year 2002 it is reported that a survey in Nyanza by health authorities conceded 30 percent of pregnant mothers on antenatal clinics have HIV virus(Simons 1999, 5).

The Trends Of HIV/AIDS Spread

HIV/AIDS scenario especially in the 21st century has become a frightening phenomenon. The World Health Organization WHO estimated that by the year 2000, more than thirty million adults and ten million children will have become infected by the virus (Giddens 1993, 21). The spread of HIV has not been stopped in any community or country. In the United States, at least 40,000 to 80,000 new HIV infections were anticipated during 1992. In 1997 more than 75,000 new HIV infections occurred in Europe. In just five years the accumulative number of HIV infected Africans has tripled from 2.5 million to over 7.5 million today (Tarantora 1994, 6). In many developing countries, the HIV/AIDS is spreading rapidly. In

major cities of Argentina Brazil, Cambodia, India and Thailand, more than 2% of pregnant women now carry HIV (World Bank 1997, 3).

United Nations Children's Fund reported that each day 8,500 children and young people around the world are affected with HIV and 2,500 women die from AIDS. In 1998 alone, the number of women killed by HIV/AIDS was 900,000 (UNICEF 2000, 50).

A study by International Committee of the Red Cross asserts that 33.4 million people worldwide are living with HIV virus. Of these more than 90 percent live in developing world, and that 50 percent new HIV infection occur in young people between 15-44 years (ICRC 1999, 8-9).

In a survey finding in South Africa in 1993 concluded that 400 people become infected with HIV each day. This findings amounts to more than 12,000 new infections per month in the country. In similar survey they identified there was a prevalence of one new infection every ten seconds and almost half of this occurred to women (O'Donohue 1996, 9). During the 13th conference on AIDS in Durban-South Africa July 2000, it was projected that by 2010, life expectancy will be 29, in Botswana, 30 in Swaziland, 33 in Namibia and Zimbabwe, and 36 in South Africa. Without AIDS life expectancy would have been 70 in these countries (Stanecki 2000, 8). Hence there are many people that are in ultimate terminal and more pathetic stage. This further suggests that the epidemic has instituted catastrophic combinations, uncertainty fears, losses, and dependency on social institutions and additional threat in family.

Over all the figures translate into an upward trend in HIV infections. It is therefore, an indication towards harsh reality for human existence. On the other hand governments especially in developing countries are constrained by lack of resources

and continue to avoid the magnitude of the pandemic which then facilitates the spread and threat of the disease further. The epidemic, therefore, has severe social and economic impact on countries worldwide including Kenya. Surprisingly, it was projected that by 2010, life expectancy will be 29, in Botswana, 30 in Swaziland, 33 Namibia, and 36 in South Africa, Malawi and Rwanda. Without Aids, it would have been 70 in these countries (Akolo 2003, 16).

In Kenya, the deaths among young adults have significantly increased. It has contributed serious health and developmental problem. It was reported that 2.2 million Kenyans are living with HIV and 250,000 have AIDS. It is further estimated that 700 Kenyans die every day from the disease and that a total number of 1.5 million have died of AIDS leaving one million orphans (Shimoli 2001, 1). The most immediate and visible impacts of HIV/AIDS on the education system could already be seen and felt. Most children infected at birth through MTC have not lived to enroll in school. Some of those enrolled have dropped out of school in order to earn money for their families and for all relatives. Teachers have equally fallen ill and died of AIDS (NASCOP 1998, 12). Kiarie comments that in Kenya, the new government's major challenge is to address the AIDS pandemic with about 2.2 million living with AIDS, Kenya ranks fifth in the world in terms of infections. AIDS accounts for 5 percent of the people living with AIDS in the world. For him these are sobering statistics and should propel all of us in to action. He stresses that we need to keep in mind that we are talking about an epidemic that kills those at their most productive age. It is further reported that a every year, it is estimated that 200,000 Kenyans die from AIDS. In the first 15 years, Kenyans had a conspiracy of silence in the country. In the past two years, the government and NGOs have stepped up the fight against AIDS (Kiarie 2003, 10). The drastic spread of HIV/AIDS infection threatens human

survival and therefore has negative impacts on social and economic fabrics of societies worldwide.

The Social Impact of HIV/AIDS

Since the epidemic was first described in early 1980, Sub-Sahara in Africa has had greater population of HIV/AIDS Infection. Most of the victims are women of reproductive age (15-45 years). HIV/AIDS has the potential to create severe social impact in on individual, communities and country. It gives high increase on health care for the victims(Kiarie 2003, 11). And increases the pressure on extended family members involved on the victims' care and other dependants. The productive household members are diverting time and resources to care for AIDS patients. The disease has severe repercussions on population growth leading to its decline, owing to the rise of morbidity and mortality rates (Kamau 2002,1). It causes break-ups in marriages and exerts burden on women who are household heads and windows. There is also evidence of increased numbers of households headed children and orphans due to the disease. The disease also forces both women and children to live in the streets and result to crimes and other deviant behaviors. It creates conditions of mistrust and mistreatments of the victims, excessive disparities on income distribution and use, and discrimination against the victims.

United Nations AIDS Programme categorizes that two million more women than men carry HIV virus that causes AIDS (UNAIDs 2000,9). The report noted that by 2000, ten times the number of deaths occurred in Sub-Sahara Africa is due to HIV/AIDS pandemic rather than the region's wars and civil conflicts. For example in 2000, the South Africa HIV prevalence rate among pregnant women rose to its highest level ever

(24.4%) bringing the estimation to 4.7 million of the population living with the virus (UNAIDs and World Health organization 2000, 9).

In Kenya, HIV/AIDS demographic impact is devastating as more citizens succumb to the epidemic. The current state of the epidemic therefore suggests that there is significant impact on the entire social fabrics. The disease also has its impacts on economic sector, where productivity and competitiveness are compromised by investors and discouraging news.

Economic Impact of HIV/AIDS

HIV/AIDS has devastating economic impact of a country. Most evidences include reversal in areas of efficiency, productivity, and profitability of individual and the concerned country. Today it threatens development and economic security of many nations. Hence the issue of the disease HIV/AIDS and its associated complications has overwhelmed the economic sector of the state and their services. Its impacts are felt by individual, family, community, and extends to firms and businesses. The epidemic causes severe reduction in the size and experiences of the labor force. It increases health care expenses, raises the cost of medical research, and reduces savings and investments across the country. Further more the disease takes series of events during the progression, these effects include reduction of productivity through HIV/AIDS related illnesses; absenteeism, loss of skilled work force; loss of expenses due to recruitment and training. In a family, the consequences include members becoming sick. In some cases, a family may be forced to sell properties leading to its becoming poorer, and thus reducing standards of living.

In Kenya, the HIV/AIDS situation in the country is still grim despite the prevalence rate having dropped from 13 percent to 10.2 percent. It is reported that the

chairman of the Kenyatta National Hospital (KNH) HIV/AIDS committee, Dr. Sobbie Mulindi, warned that the worst impact of the disease will be felt between 2000 and 2010. Mulindi said it is projected that by 2010 cumulative Aids deaths will have hit 4.5 million. He noted that of grave concern was the escalating poverty, unemployment and called for a strong political will in order to have projects a lined at reversing the trend changed. He urged for the strengthening of the health sector response so as to have the monitoring and evaluation of the disease improved (Akolo 2003, 6). He urged that voluntary counseling and testing be encouraged to check on the spread of the disease and to identify and support couples diagnosed with the disease.

In Kenya, highly trained professionals such as administrators, teachers, police, and military officers among others have succumbed to the epidemic. The disease reduces the earning capacity of the family member optimally. Further more a loss on one member of a family results in social and economic loss to the whole family. HIV/AIDS affects mostly the sexually active members of the society (15 - 45 years) since this group is the most socially or economically active. Deaths in this age category severely impacts the economy. There is marked evidence on the increase in the number of cases of HIV/AIDS in Kenya countrywide and therefore negative consequences in the economic sectors of the state. However, many Kenyans continue to die from complications related to AIDS yearly despite concerted efforts by the government and other organizations to intensify the war against the problem. The current strategies such as improvement of the knowledge, attitudes and cultural practices towards HIV/AIDS have not been successfully incorporated to minimize and control the spread of HIV/AIDS infections (Akolo 2003, 6).

Economic implications and control are already apparent. In highly affected countries, the disease now threatens development and security. Kenya Port Authority (KPA) has spent more than 210 million shillings daily on HIV/AIDS related cases (Kamau 2002, 1). The epidemic impact in Kenya's public institutions has become enormous and that economic cost is expected to reach 4.1 billion shillings (Muganda 2000, 13). Hence Kenyans continue to die from complications related to AIDS each year despite concerted efforts by the government and other organizations to intensify the war against the problem. The marked increase in the number of cases of HIV/AIDS intensifies the challenge and strain on health care delivery system and extended family responses. The current strategies to prevent the spread of the virus such as provision of knowledge on prevention and positive attitudes against the disease, especially due to gender inequality have not been successful in making the women protect themselves from HIV infections. Many studies reveal that even well informed young and active males and females, have fallen victims of the infection. Hence awareness of HIV/AIDS does not automatically translate into safer sex behavior. Therefore, economic factors, attitudes and practices seem to be important aspects in the escalation of the spread of the disease.

Concerning the Church, Curci reports that it is becoming increasingly evident that in Roman Catholic church, priest are falling victims to the HIV/AIDS in growing numbers. He wonders by asking questions "what is the church expected to do?" How can she deal with this phenomenon?" For him, although the church knows itself to be a community of saints, but it must in the case of HIV/AIDS also recognize itself as a gathering of sinners, individually and collectively often falling below the expectations of its Christian calling. The church as simultaneously holy and sinful must now form

a basic point of Christian pedagogy in the context of the Aids pandemic (Curci 2002, 2).

Holistic Ministry to the whole Person

Tetunao yamamaori, professor and director of intercultural studies at Biola University, delineates the main conceptual presuppositions of holism as follows: 1) The whole is more than the sum of its parts 2) The whole determines the nature of its parts, 3) Parts cannot be understood if considered in isolation from the whole, and 4) The parts of an organic whole are dynamically interrelated or inter-dependent (Yeir 2000, 2).

Holism, in other words, creates a synergistic effect and indeed the whole is more than the sum of its parts, The whole (namely, God's mission) determines the mature of the church's many missions. Holism implies the identity and distinctiveness of various parts in their relationship to the whole and, at the same times their relationally inseparable nature. I consider Yamamori's delineation very helpful in discussing the concept of holistic ministry. The idea of holistic ministry has deep biblical roots. Throughout the old and New Testaments, the Bible mandates that the church minister to the whole person. This means addressing both physical and spiritual needs through approaches that are inseparably linked but functionally separate. We see this idea in the three distinct forms of ministry common in the old Testament roles of Judge, prophet and priest. The unique and complementary ministries of Moses and Aaron. For example, were fused together to buttress Israel's total life as God's covenant community. Moses delivered God's mandates and prophetic messages to the people. Aaron was a shepherd who helped people obey God's laws. Samuel's holistic ministry assumed all three distinct roles of Judge,

prophet and priest. Each of these offices was functionally separate, but all were necessary to strengthen and enrich Israel's community life. The idea of holistic ministry is also evident in the prophet's lives and teachings. Hosea described the vertical relationship as " Knowledge of God" and advocated its pursuit. Isaiah called on Israel to fulfill the horizontal relationship: seek Justice, encourage the oppressed. Defend the cause of the fatherless, plead the case of the widow" (Isaiah 1:17)

The New Testament also affirms the holistic ministry concept. Jesus ministry embodied the idea of welding evangelism with social action. Matt .4: 23 says that " Jesus went throughout Galilee, Teaching in their synagogues, preaching the good news of the kingdom, and healing every disease and sickness among the people " Though teaching, preaching and healing were separate functions, they were all essential to the ministry of Jesus. The apostle Paul's teaching and the life of the early church continued the theme. In Romans and Ephesians, Paul says that this body consists of diverse members, each with his/ her own functions all working together as a single unit (Romans 12: 4,5; Eph. 4:11-13).

The role of missions and compassionate ministries such as those under taken by PCEA is becoming more urgent as we're entering 21st century. Research shows that by the end of this century, nearly a quarter of the world's population (1.25 billion people) will be completely un-evangelized for Christ, with most of them living in closed or restrict countries (Yeir 2000, 4).

Further research indicates that Islam is the world's fastest growing religion. Analysts expect that to day's Muslim population of one billion will double by 2020 an will grow from 19% of the world's population to 25%. Today, about 33% of the world's population is Christian. This is expected to grow to only 35% by 2020. Followers of Allah out numbers Christian believers of all denominations except

Catholicism (Barret 1980, 17-25). Clearly we have made slow progress in meeting our challenge to "make disciples of all nations" (Matt. 28:19-20).

We must meet to say's mission context with a strategy that recognizes the new dynamics surrounding us. This strategy must allow us to use our resources to penetrate areas of the world that are controlled by HIV/AIDS epidemic, poverty and repression and spiritual deprivation. It must give individuals the means to lift themselves out of stigmatization and poverty -both physical and spiritual.

Concerning Church development or growth, one can see it as a science which investigates the nature, function and health of Christian churches as it relates specifically to the effective implementation of God's commission to make disciples of all nations. "Church growth strives to combine the eternal principles of God's Word with the best insights of contemporary social and behavioral sciences" (McGavran 1970, 24). This shows that: a) Church development or growth is a complex topic which requires scientific study b) evangelism is priority c) the Bible is the final authority d) Sociology, psychology, anthropology and other related disciples are essential tools for Christian mission.

Using social scientific approach, this study can also be guided by the functionalism as a distinct methodology and model of society originated first in the work of Comte, Spencer and Darwin. Emile Durkhein is often cited as the dominant influence of the development of sociological functionalism for his argument that social institutions exist solely to fulfill specific social needs (Abraham 1993, 89). This model of society stresses the elements of harmony and consistency not those of conflict and contradiction. The functional unity of a system is defined in terms of social order.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

Introduction

This chapter describes the methodology that was used in data collection sampling techniques, research instruments, administration of the research instruments and data analysis.

In carrying out this research, the study considered a kind of research techniques that would enable researcher gather accurate information as precisely as possible. Consequently, the study was guided by a central theme namely, "Factors that led to the development of HIV/AIDS programme at PCEA Lang'ata Parish." Sixteen Districts from within the Parish enabled the research to tap as much information as possible.

Entry

A letter of introduction from NEGST's Department of Missions was given to PCEA Headquarters *Jetegemea* House, addressed to Mr. Francis Kihoho, project coordinator. The letter stated the intention of the study and the importance of the research. Gaining entry to Lang'ata PCEA was also made possible by the fact that the researcher is a member of PCEA Lang'ata Parish from 1996. This made it easy to approach the relevant authority and this also helped him to have great chance to gain access to all information needed for this particular study.

The study site

PCEA Lang'ata Parish is found on the outskirts of Nairobi City, in Lang'ata constituency. It is situated around 300 meters off the Lang'ata-Road, opposite Lang'ata Barracks.

The Population

The population is "aggregate of all cases that conform to some designated set of specification" (Nachmiash and Nachmiash 1996, 179). Population in this study consists of all members of PCEA Lang'ata Parish. Therefore, the study population was make up of elders, ministers, deacons, and all members of the Lang'ata Parish. The PCEA Lang'ata Parish is headed by a parish minister and elders. It has 18 committees and 16 districts. Each district is led by a district elder. The parish has around 600 registered members and around 200 unregistered members. The church community members come from different ethnic groups but majority are from Kikuyu. All the PCEA Lang'ata Parish members was the population.

Sample and Sampling Techniques

The study employed both probability and non-probability sampling methods. This was aimed at obtaining relevant and adequate data from the respondents.

In order for the study to achieve its objectives, it employed a non-probability sampling techniques known as purposive sampling. With this sample (occasionally referred to as judgement samples), researcher select sampling units subjectively in an attempt to obtain a sample that appears to be representative of the population (Nachmiash and Nachmiash, 184). In other words, the chance that a particular sampling unit will be selected for the sample depends on the subjective judgement of the researcher. This was necessary in identifying respondents who are leaders of the

church who have been assigned responsibilities that are relevant to the concerns of this study. This gave the study a size of 22 church leaders.

In identifying a sample size for the church members the study employed a multi-stage sampling technique. The Lang'ata parish was divided into its respective 16 districts which formed the study's clusters. From the clusters, or districts, three members were selected using simple random method. This gave the study a sample size of 48 church members.

The sample size of the population of this study was seventy (70). It comprised two groups of respondents selected from 8 of the 16 districts in the parish. The first group comprised church leaders. The second group consisted of members of the church.

The researcher, prior to administering the questionnaire had together with the supervisor analyzed the questions in the questionnaire with a view of restructuring them in such a way that they had clear wording and avoided any ambiguity in soliciting the necessary responses from the respondents.

As pointed out earlier, 8 districts were selected to participate in this study as a way of having all other districts involved in the sample survey. This criteria was useful in the obtaining information from a broad based sample population and minimized any bias since each district was randomly selected.

The sample was chosen from 16 districts of PCEA Lang'ata Parish. The entire population studied were members of the church and church leaders (elders, pastor and deacons). Systematic random sampling procedure was used to obtain the desired sample of the church.

Research Instruments

The main instruments of data collection utilized in this survey was the questionnaire. The study employed two types of questionnaires, one questionnaire was designed for church leaders and the other for church members. The questionnaire contained both open-ended and closed-ended questions. open-ended questions allowed the respondents to give his/her opinion in detail to the best of his/her knowledge. However, follow up interviews were conducted after administering the questionnaire. The purpose of the interview was to seek further clarification on the responses given and allow for supplementary questions which could relate to factors contributing to the development of HIV/AIDS programme at PCEA Lang'ata Parish. The questions were also designed to assess the respondent's perceptions and feelings towards the programme.

These interviews were considered appropriate research instruments for their flexibility in enabling the researcher solicit additional information from the respondents than the questionnaires could provide.

Church leaders' questionnaire was a twenty-five (25) items tool. It sought their view on the development of the HIV/AIDS programme. It also sought their opinion on the administration of the programme and guidance and the role they play in alleviating the programme. Most of the questions were closed ended questions except a few where their personal opinion was required. This enabled the researcher to get in depth information.

The church members' questionnaire of a thirty (30) item tools and were more or less the same with the church leaders but sought more details concerning the major factors led to the development of HIV/AIDS programme. They were also required to identify the best way forward in improving this programme.

All the respondents were required to respond as accurately and honestly as possible. Closed ended questions were convenient because the respondents could freely give their feelings or views as they were confined to boxes from where they could choose their answers. They also minimized time spent on the exercise of data collection.

Reliability and Validity of the Instrument

In view of the sensitivity of the topic a pre-test study was an important tool for the researcher and field assistants. The tool was to reshape the questionnaires and prepare the respondents for the study.

The questionnaire was presented to the academic advisor and other members of NEGST faculty to read and critic. This helped the questionnaire to be restructured. Secondly, the research questionnaire was pre-tested to members of a different parish, PCEA Nairobi West Parish, Millimani Presbytery. The returned instruments appeared to be appropriate and hence were administered to the research sample directly without adjustments.

Data Collection and administering the instrument

After the pre-test and restructuring the instrument, the questionnaires were prepared and administered to the sampled respondents by the researcher. Some of the questionnaires were been collected by church leaders after been filled while a majority were collected by the researcher. On collecting the questionnaires from the elders, the research further interviewed them on specific items of the questionnaire which related to HIV/AIDS programme. Their responses were compared with those in the questionnaire. The findings formed the basis of the suggestions and recommendations.

Also the research survey was geared towards collection of primary data and selected literature review as part of secondary data. In primary sources, the researcher used descriptive survey. Descriptive survey is a research study in which data are collected from members of a sample. Descriptive research is "concerned with the analysis of the relationships between non-manipulated variables, and the development of generalization"(Best and Khan 1989, 196). This procedure is characterized by systematic collection of data from members of a given population through questionnaires and interviews.

According to Ghosh the purpose of survey research is to "describe specific characteristics of a large group of persons, objects or institutions" (Ghosh 1992, 98).

Questionnaire Returns

A total of seventy (70) questionnaires (22 for church leaders and 48 for church members) that were administered to investigate the factors that led to the development of HIV/AIDS Programme at PCEA Lang'ata Parish. Out of this number 50 (12 questionnaires from church leaders 54.5% and 38 from church members 79.2%) were returned making a total of 71.4% returned. These are just enough to be used for making analysis.

DATA ANALYSIS

All dully completed questionnaire and responses to the interview schedules carried out were analyzed under various sub-headings and the general picture and feelings of the respondents reached. Much of the information that was given was qualitative and for this reason, descriptive statistics was used. The descriptive statistics involved tallying respondents' answers for each response given and calculating percentages for each responses. Tables drawn reflected the responses.

The highest percentage for each response indicated the general opinion of the respondents as concerns the major factor that lead to the development of HIV/AIDS programme.

The hypothesis were tested against the responses and they were accepted or rejected on the basis of the research findings.

CHAPTER FOUR

DATA ANALYSIS, FINDINGS AND INTERPRETATION

Data Analyses

The data collected from the field was edited, classified and coded. The data was analyzed and presented by using qualitative and descriptive statistics techniques. These approaches provided in-depth analysis of information collected from specific elements. Hence the data was analyzed using simple frequency tables and percentages-tabulation form. After data had been analyzed, it was presented in simple percentages and frequencies.

Analysis of Church Leaders' Questionnaires

Table 1(A). Sex

Category (c)	Frequency(f)	Percentage (%)
Male	9	75
Female	3	25
Total	12	100

A large proportion of the respondents were males represented by 75 % , 25 % were females.

Table 1 (B). Age

Category(c)	Frequency (f)	Percentage (%)
41-50	6	50
51-60	4	33.3
61+	2	16.7
Total	12	100

A large proportion of the church leaders were between 41-50 years represented by 50 percent, followed by between 51-60 represented by 33.3 percent. Those above 61 were 16.7 percent.

Table 1 (C). Position in the Church

Category (c)	Frequency (f)	Percentage (%)
Elders	8	66.7
Deacons	2	16.7
A/Administrator	1	8.3
Minister	1	8.3
Total	12	100

A large proportion of the church leaders were elders represented by 66.7 percent (%) . 16.7 % were deacons and 8.3 percent administrators and another 8.3 percent were ministers.

Table 1 (D). Period Spent at Lang'ata Parish

Category (years)	Frequency	Percentage
0-10 years	4	33.3
11-20 years	5	41.7
over 20 years	3	25
Total	12	100

Majority of respondents represented by 41.7 % have being members of PCEA Lang'ata Church for between 11-20 years, 33.3 percent of the respondents have been members for between 1-10 years. While 25 percent have been members for over 20 years.

Table 2 (A). Knowledge of HIV/AIDS

Category (c)	Frequency (f)	Percentage (%)
Yes	12	100
No	0	0
Total	12	100

It was evident that all the church leaders had knowledge about HIV/AIDS as represented by 100 percent.

Table 2 (B). Source of Knowledge of HIV/AIDS

Category	Frequency	Percentage
Lost Relatives	3	25
Attended training	5	41.7
Heard from other people	1	8.3
From the media	3	25
From the church	0	0
Total	12	100

A large proportion of the respondents represented by 41.7 percent obtained information on HIV/AIDS from training. 25 percent had lost their relatives, therefore they are directly affected by HIV/AIDS. Another 25 percent obtained information from media while small proportion of the respondents got information from other people. It is important to note that no respondent indicated to have received HIV/AIDS information from the church.

Table 3. Reason For HIV/AIDS being a Problem to the Church.

Category (C)	Frequency (F)	Percentage (%)
Yes	12	100
No	0	0
Total	12	100

C	F	P
Claim church members	7	58.3
Problem of orphans	1	8.3
Economic burden to the church	2	16.7
Members stay away from church	2	16.7
Total	12	100

One hundred percent of the respondents agreed that HIV/AIDS is a problem to the church and a large proportion of them represented by 58.3 percent indicated that

HIV/AIDS claims church members, 16.7 of the respondents felt that the epidemic had economic impact on the church, a similar percentage 16.7 percent indicated that members stay away from the church because of attending to the infected relatives while 8.3 percent felt that the epidemic has increased the problem of orphans to the church.

Table 4. Prevalence of HIV/AIDS At Lang'ata P.C.E.A Parish

Category (C)	Frequency(F)	Percentage (%)
Less than half	3	25
More than half	0	0
Do not know	9	75
TOTALS	12	100

A large proportion of the respondents did not know the prevalence of HIV/AIDS at the parish while 25% indicated that less than half of the church members had been affected or infected with HIV/AIDS. The high population of those who don't know may be due to the fact that the church leaders have not considered the epidemic as a serious threat to their church members.

Table 5. HIV/AIDS as a Threat o Evangelization

Category	Frequency	Percentage %
Yes	8	66.7
No	4	33.3
Totals	12	100

A large proportion of the respondents indicates that the Church felt that HIV/AIDS was a threat than evangelization mission while 33.3% felt that the epidemic was not a threat to their mission of evangelization. The reason for the

church members feeling that HIV/AIDS was a threat to their mission of evangelization was that the epidemic infected and affected members of the Church Community.

Table 6. How the Church uses the Mission of Evangelization to Intervene in HIV/AIDS Problem.

Category	Frequency	Percentage %
Preach on salvation	6	50
Preach about HIV/Aids	1	8.3
Do nothing	3	25
Do not know	2	16.7
TOTAL	12	100

Half of the respondent represented by 50% indicated that the church uses its mission of preaching on salvation as a way of intervening in the HIV/AIDS epidemics. 25% of the respondents believed the church was doing very little in intervening in the epidemic while 16.7% did not know.

Table 7. Whether The Church Has Programme In Response To HIV/AIDS

Category	Frequency	Percentage %
Yes	7	58.3
No	2	16.7
Do not know	3	25
TOTAL	12	100

A fairly large proportion of the respondents represented by 58.3% felt that the Church had programme in response to HIV/AIDS. 16.7% believed the Church did not have any programme while 25% did not know whether the church had such programme.

Table 8. Type of Programmes Provided by PCEA Lang'ata Parish

Category (C)	Frequency (F)	Percentage (%)
HIV/AIDS awareness Home based care Counseling	4	33.3
Clothing Spiritual support Testing for young people Intending to marry	6	50
Do not know	2	16.7
TOTAL	12	100

The above table shows that 33.3 % of the respondents felt that the church provided HIV/AIDS awareness, home based care and counseling to its members. Majority of the respondents, 50 % felt that church provided clothes to the affected and infected, spiritually care and testing for couples intending to get married. 16.7 % of the respondents were not sure of the programme the church provides.

Table 9. Reasons for the Church Developing a HIV/AIDS Programme

Categories	Frequency	Percentage %
Church using time and materials for evangelism	5	41.7
Problem of orphans	3	25
Problem of widows/widowed	2	16.7
Infecting through marriage	2	16.7
TOTALS	12	100

A large proportion of church leaders represented by 50 % thought that the main reason for developing this programme was for the church members to spend their time and materials for the purposes of evangelism. A percentage of 25% thought that the increasing problem of orphans was the main reason for the church developing HIV/AIDS programme. 16.7% believed that checking the spread of the

epidemics through testing before marriages was the main reason of involvement in HIV/AIDS prevention programme. Another 16.7% pointed out that the issue of widows and widower was the reason for the church development of HIV/AIDS programme.

Table 10. Goals and Objectives of the PCEA HIV/AIDS Programme

Category	Frequency	Percentage %
Minimize spread of the disease	5	41.7
Care of infected	2	16.7
Counseling	2	16.7
Awareness	3	25
Do not know	0	0
TOTAL	12	100

A large proportion of the respondents thought the church's objective was to minimize the spread of the disease this was represented by 41.7%.

16.7% felt that care of the infected was the main objective while another 16.7% considered counseling as the main goal. 25% felt that awareness was the key goal.

Table 11. The Church's Support to Orphans

Categories	Frequency	Percentage %
Have a special programme	1	8.3
Support them at relative's place or home care	4	33.3
No special programme	7	58.3
Do not know	-	-
TOTALS	12	100

On the issue of orphans the church leaders indicated that there was no special programme for orphans. This was represented by 58.3%. 33.3% said the church supports orphans put their guardians place while 8.3% indicated that the church had a special programme for orphans.

Concerning cultural practices hampering the fight against HIV/AIDS, all the church leaders believed that the following traditional practices enhance the spread of HIV/AIDS. These are:-

- Wife inheritance
- Circumcision
- Female genital mutilation
- Cultural cleansing in some tribes

What the church does about practices is that the church leaders indicated that during seminars and church services they condemn such tradition practices. It was also noted that through counseling the church leaders encourages their members to stop practices that enhance the spread of HIV/AIDS such as those mentioned.

Table 12. Problems Encountered by the Church Leaders

Categories (C)	Frequency(F)	Percentage(%)
Resistance	3	25
No problem	2	16.7
Does not know	7	58.3
TOTALS	12	100

A large proportion of the respondents, 58.3% indicated that they did not know the problems faced by the church in the spread of HIV/AIDS. This could be attributed to lack of a serious programme that involves the general members of the public other than the usual church services. 25% felt that people were resistant to HIV/AIDS awareness programme.

In addressing the issue of stigmatization of the infected and affected, the church leaders indicated that they address issue of stigmatization and discrimination by preaching the gospel and Jesus' love for all. They insist on love for ones neighbor and lack of discrimination.

Table 13. Provision of Adequate Information, Education and Communication Material or HIV/AIDS

Categories	Frequency	Percentage %
Yes/agreed	4	33.3
No/disagreed	8	66.7
TOTALS	12	100

The table shows that 66.7% of the respondents felt that the Church did not provide any adequate information, education and communication material to its church members while 33.3% felt the church provided this materials. The reason for this high response was due to the fact that even the church leaders themselves have not fully participated in the HIV/AIDS programme.

The church leaders also believed that the key to nurturing HIV free society was for the society to uphold God's teaching and hang on one partner. In addition, the leaders pledged to organize more workshops and seminars for its members.

Concerning the factors leading to development of Lang'ata PCEA HIV/AIDS programme, the leaders believed that the central concern was to create awareness among the church members because by educating church members, it was believed that they would in turn spread the message to other members of the community.

Analysis of Church Members' Questionnaire

Table 1. Age Distribution of Respondents

Categories	Frequency	Percentage %
1-15	6	15.8
16-30	9	23.7
31-45	12	31.6
46-60	11	28.9
TOTALS	38	100

A majority of the respondents were between the ages of 31-45 this was represented by 31.6%, 28.9% were between 46-60, 23-7% between 16-30 and 15.8%

were between 1-15 years. This shows that the responses were drawn from different age categories thus representing different age groups.

Concerning the question whether they have knowledge of HIV/AIDS, all the respondents indicated that they had information about HIV/AIDS. They indicated that they knew it has no cure and is mostly spread through sexual contact, from mother to child, and through blood or body fluids.

Table 2. If HIV/AIDS as a Problem to the Church

Categories	Frequency	Percentage %
Yes	31	81.6
No	7	18.4
TOTALS	38	100

A large population of the respondents represented by 81.6% felt that HIV/AIDS was a problem in their church while 18.4% felt it was not a threat.

Table 3. What one can do to avoid contracting HIV/AIDS

Categories	Frequency	Percentage %
Abstinence	10	26.3
Use of condoms	3	7.9
Be faithful to one another	11	28.9
Be saved	14	36.8
TOTALS	38	100

From the above table it is evident that a majority of the respondents represented by 36.8% believed that salvation was the key to avoiding contraction of HIV/AIDS. While 28.9 believed people should be faithful to one partner. However a very small proportion of the respondents believed that condoms can be used as a preventive measures this was represented by 7.9%.

Table 4. Source of Information on HIV/AIDS

Categories	Frequency	Percentage %
Media	26	68.4
Training	11	28.9
Church	1	27
TOTALS	38	100

The major source of information as observed by the respondents was the media represented by 68.4%. Only 27% got information from the church. From the above information it is likely that there was rare talks about issues of HIV/AIDS inspite of developing its aids programme. HIV/AIDS education plus training was represented by 28.9%.

When asked where they would like to get more information about HIV/AIDS from, all the members indicated that they would like the church to do more in terms of providing HIV/AIDS awareness through church services by the pastors and other leaders.

Table 5. Whether the Church has Active Programme in Response to HIV/AIDS

Categories	Frequency	Percentage %
Yes	9	23.7
No	26	68.4
Don't know	3	7.9
TOTALS	38	100

From the table above it is evident that a majority of the respondents, 68.4% felt that the church had no active programme in response to HIV/AIDS. It may be deduced that the programme purported to be put in place do not involve the entire church members. 23.7 % agreed that the programme existed but did not do much on HIV/AIDS awareness.

Table 6. Whether The Church Has Experienced HIV/AIDS Cases

Categories	Frequency	Percentage %
Yes	16	42.1
No	9	23.7
Don't know	13	34.2
TOTALS	38	100

A fairly large proportion of the respondents said that the church experienced HIV/AIDS cases among its members. This is an indication that the church is not spared the wrath of the epidemic. The respondents also noted that more church members were affected by epidemic because they had close relatives suffering from HIV/AIDS.

Table 7. Whether the Church Organizes Workshops/Seminars on HIV/AIDS

Categories	Frequency	Percentage %
Yes	9	23.7
No	27	57.9
Don't know	7	18.4
TOTALS	38	100

23.7% of the respondents indicated that the church organizes for workshops/seminars on HIV/AIDS. However they were quick to point out that this was done only once and the attendance was poor. This factor could explain why this response is low. 57.9 % said that the church was not organizing such seminars, while 18.4 % have no idea.

Table 8. Reasons For Developing HIV/AIDS Programme at PCEA Lang'ata

Categories(C)	Frequency(F)	Percentage(%)
Spiritual concern	11	28.9
Members affected/infected	19	50
Don't know	8	21.1
TOTALS	38	100

A majority of the members interviewed, 50 % believed that the church developed HIV/AIDS programme because its members were either affected or infected. A further interview revealed that the church provides counseling, nutrition support and testing for couples intending to get married. 28.9 believed that the church uses the programme for the purpose of evangelism, while 21.1 % had no idea.

Table 9. Whether the Programme has Succeeded

Categories	Frequency	Percentage %
Yes	9	23.7
No	19	50
Don't know	10	26.3
TOTALS	38	100

A majority of the respondents represented by 50% felt the programme had not succeeded. 26.3% did not know. In essence 76.3% of the respondent either believed the programme had failed or did not know about it. This is a serious pointer to the way the programme has impacted on the congregation. Therefore much is still needed to be put in place.

The respondents also felt that the church should step up its practices and adopts a multi dimensioned approach to the fight against HIV/AIDS.

Table 10. Whether the Programme Targets Church Members only

Categories	Frequency	Percentage %
Yes	7	18.4
No	20	52.6
Don't know	11	28.9
TOTALS	38	100

A large proportion of the respondents, 52.6 % feel that the programme does not target church members only. While did not know.

A further investigation revealed that the members were not satisfied with the operation of the programme since they felt that even majority of the members of the church had not benefited in anyway from the programme.

Table 11. Response of the Community

Categories	Frequency	Percentage %
Provide service	4	10.5
Provide material support	5	13.2
Do not take part	23	60.5
Do not know	6	15.8
TOTALS	38	100

A majority of the respondents represented by 60.5% felt that the church so far do very little in supporting the community to fight against HIV/AIDS. The explanation could be that both the church and the community has not seriously addressed a collaborations approach to the fight against the epidemic. Both parties need to have together and intervene suitable strategies to fight the disease.

Table 12. Church Support to those Infected /Affected

Categories	Frequency	Percentage %
Counseling Nutrition	19	47.4
Medical support	0	0
Spiritual support	17	44.7
Don't know	3	7.9
TOTALS	38	100

From the above table, it is evident that the church provides counseling and nutrition to those infected and affected. This is represented by 47.4%. 44.7% believed that the church provided spiritual support to its affected and infected members. The table indicates that there is no medical support, while 7.9 % have no idea.

Table 13. How the Church Handles Issues of Stigmatization and Discrimination

Category	Frequency	Percentage %
Talks to church members during church sermons	2	5.3
Sensitize people through their programme	5	13.2
Does very little	30	78.9
Don't know	1	2.6
TOTALS	38	100

A large proportion of the respondents, 78.9 % indicated that the church does very little in terms of sentisations of the church members as pertains stigmatization and discrimination of those affected and infected. They feel that this effort on destigmatization and non-discrimination of the affected or infected should be addressed. 13 % revealed that the church does to sensitize people through this programme, while 5.3 reported that the church usually talks to church members during sermons.

Table 14. Provision Of Information, Education And Communication (IEC) Materials to Church Members

Categories	Frequency	Percentage %
Yes	8	21.1
No	21	55.3
Don't know	9	23.7
TOTALS	38	100

Majority of the respondents, 55.3 % believed that the church does not provide much information, education and communication (IEC) materials in HIV/AIDS to its members. In further interview they wished the church could provide IEC materials to the entire congregation. 21.1% know that the church provides IEC material to its members while 23.7 % have no idea.

Table 15. Problems Facing the Church in the Fight against HIV/AIDS

Categories	Frequency	Percentage %
Financial	12	31.6
Resistance	14	36.8
Secularization	9	23.7
Don't know	3	7.8
TOTALS	38	100

Majority of the church members believed that the church is resistant in addressing openly the issues of HIV/AIDS. This is represented by 36.8 %. Others felt that secularization was the key problem, represented by 23.7 % While 31.6 % felt that financial problem was the main hindrance to the church in addressing the issue. 7.8 % have no idea.

Table 16. Best Way Forward

Categories	Frequency	Percentage %
Salvation/to be saved	13	34.2
Encourage	7	18.4
Be faithful	6	15.8
Church to step up	12	31.6
TOTALS	38	100

A majority of the respondents represented by 34.2 % felt that it is much better for people to come to Christ so that worldly pleasures can be put aside. For them, the church is to strive to evangelize the whole population so that HIV/AIDS issue can come to an end. 31.6 % felt that the church should step up in fight against HIV/AIDS Pandemic. 18.4 % said that the church should encourage those who are both affected or infected, while 15.8% felt that the best way to curb the pandemic was for the partners to be faithful to one another.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

This study was an attempt to investigate factors that led to the development of HIV/AIDS programme at PCEA Lang'ata Parish. The study survey 8 districts and sought to find out the following research questions: How is the prevalence of HIV/AIDS at PCEA Lang'ata Parish congregation ? What factors that led to the development of HIV/AIDS at PCEA? and What strategies has PCEA Lang'ata parish put in place ?

The sample consisted of 50 respondents. Data collected was by means of questionnaires and interview guide. Data was analyzed using qualitative methods as well as simple descriptive statistical method. On the basis of the above research questions, the following conclusions were made:

Concerning factors that led to development of HIV/AIDS programme, large proportion of both church leaders and members represented by 50 % thought that the main reason for developing the programme was for evangelization. Some thought that the increasing problem of orphans was the main factor that led the church to develop the programme. Others believed that checking the spread of the epidemics through testing before marriage was the main reason of the church's involvement in HIV/AIDS prevention programme. Another group pointed out that the issue of widows and widower was the reason for the church development of HIV/AIDS programme. In addition, a large proportion of the respondents indicates that the Church felt that HIV/AIDS was a threat to evangelization mission.

They felt that the pandemic also infected and affected members of the Church. A fairly large proportion of the respondents said that the church experienced HIV/AIDS cases among its members. This is an indication that the church is not spared the wrath of the epidemic. The respondents also noted that more church members were affected by epidemic because they had close relatives suffering from HIV/AIDS.

The respondents also believed that the central concern for the programme was to create awareness among the church members because by educating church members, it was believed that they would in turn spread the message to other members of the community. The respondents urged the church to organize workshops/seminars on HIV/AIDS awareness.

From the findings it was evident that the objectives of the programme was not really achieved. Christian values, evangelism and spiritual development were not fully integrated in the programme.

Concerning challenges faced in developing the programme , a large proportion of the respondents-church members, 58.3% indicated that they did not know the problems faced by the church. This could be attributed to lack of a serious programme that involves the general members of the church other than the usual church services. 25% felt that people were resistant to HIV/AIDS awareness programme.

CONCLUSIONS AND RECOMMENDATIONS

Several aspects noted above in the study could be adopted by other churches in an effort to enhance evangelism and church planting in urban areas. In light of the above conclusions, the researcher made the following recommendations:

Holistic ministry to be emphasized as a person with HIV/AIDS may be fully integrated physically, emotionally, mentally and spiritually the individual victims will comfortably fit in Christian community.

There is a need for the PCEA church to extend HIV/AIDS programme to the families of the victims.

The entire PCEA Church Community should be involved in helping the HIV/AIDS patient if the church is to be effective. This can strengthen the church of Christ to become a caring community to those who may be infected or affected with the pandemic.

One of the things that the PCEA can also do is to educate her members on the issue. This can be done through seminars where the members can be given the chance to ask questions about HIV/AIDS. Having sound knowledge about this disease will help the church members to sort out facts from false speculations about the causes of AIDS. Pastoral counseling courses should be offered to the church leaders and if necessary, it should be integrated in their leadership training requirements.

The PCEA can also provide practical help since a person with HIV/AIDS often tires easily; simple tasks such as cleaning a house or cooking become challenge. The members of the church can where possible, visit the AIDS patient and assist in doing this chaos, especially where the AIDS patient is too sick.. This will go a long way in uplifting the AIDS patient's spirit.

Another area is the need for shelter or housing since many of those with AIDS destitute due to unemployment and rising medical bills. The PCEA can collectively agree to contribute monthly or even spare some of its funds to assist in payment of rent for the housing of the AIDS patient. Part of the money can be used to assist in offsetting the medical bills.

Praying with and for the person infected with AIDS can also help. Terminally ill patients, and those living with AIDS, may be open to talk and prayer about faith, God and the Afterlife. This is far the most important support that the patient requires. By sharing Jesus Christ and the hope of living and his forgiving grace the AIDS patient can have a chance to repent and be relieved of the burden of guilt which often encroaches on the AIDS patient. Other prayers offered include emotional or physical healing, the need for more volunteers, a change in the churches view of those with AIDS and a care for the AIDS patient.

The Church should also minister compassionately and sensitively. This is through use of important phrases such as "person with AIDS" and "Living with AIDS and a care for the AIDS patient. This can be a very trying time for the AIDS patient's family who have to deal with rejection from society and it can give the church a part of contribute towards easing the pain caused by AIDS.

PCEA can develop a church policy statement that will convey compassion to those with AIDS with the understanding that fear of AIDS is great. They can relieve fears on serving and cooking of food especially in church activities such as Holy Communion where the cups are common and weddings, where spoons and plates are shared.

PCEA can also provide care to the AIDS patients through caregivers. Some trained nurses in the congregation may assist the AIDS patient. This is because the AIDS Volunteers who are working in the hospitals may be discouraged in their work especially after experiencing many deaths of the AIDS patients they are taking care of.

The church should provide sex education for its youth. PCEA can sponsor seminars and workshops for couples and families on the HIV/AIDS topic. This is because AIDS could affect any member of the family. Such knowledge can prevent a

calamity for example when a couple gets married without knowing that one or both of them have the HIV virus and consequently passes the virus to the children.

The Church should network closely with the Ministry of Health, NGOs and other individuals in their communities to share its unique contribution to HIV/AIDS prevention and care. The church can get material on AIDS from the NGOs as well as the expertise knowledge of the Ministry of Health.

It is important for the church to be educated on the facts about AIDS so that people will stop fearing the disease and those infected by it.

Churches are grassroots, and integral part of community life. The church should promotes beliefs that guide behavior with a system of accountability. The church is a community itself with particular expectations from its members, involving a sense of accountability and caring leadership and structure. It is an institution that is capable of educating large numbers of people. In addition, the church responds to the community outside the walls on numerous ways, often seeking to bring reconciliation between God and man and to meet needs, recognizing the inseparable physical and spiritual nature of man.

The church is healing community, practicing healing in many different ways, but most commonly through a sense of caring and strong belief in hope, both for this life and the life to come. AIDS patients and their families need hope a purpose for living that the church can offer. PCEA can play a more important role as a healing community to respond effectively to HIV/AIDS epidemic and make significant impact on HIV prevention as well as care of AIDS patient. This must happen through looking at the deeper factors contributing to the epidemic such as breakdown of family structures, unfaithfulness in marriage, sexual activity among the youth and the lack of the relevance for the value of life. Who then should be involved? HIV/AIDS programmes must target all the cadres of church leaders and clergy, Woman's Guild,

Presbyterian Church Men Fellowship (PCMF), youth and Sunday school–everyone should be involved.

The resources of the PCEA spread beyond the most comprehensive HIV/AIDS programme budget. PCEA is endowed with the tools to address the global health crisis of the century not with power or science but with the truth and love in the power of God. The Church has existing infrastructure for social, personal and family networks. It embodies a sense of community; it shares common goals and purposes. The AIDS challenge is the PCEA's challenge. In addition, the government is also urged to provide money through the church to the needy HIV/AIDS victims. This is because the findings show that HIV/AIDS victims are marginalized hence their families have no source of income except from the few well-wishers.

Issue for Further Research

The researcher wishes to call on other researchers to carry out studies on the factors that influence churches into developing HIV/AIDS programmes.

REFERENCE LIST

Abraham, Francis. 1993. *Modern sociological theory: An introduction.* Delhi: Oxford University Press.

Akolo, Judith. 2003. Aids still a threat despite drop in figures-medic*: East Africa Standard*, 10 February, 6.

Aleman, C. J. 1995. Children, families and HIV/AIDS: Psychosocial and therapeutic issues. *New York Missio Journal,* 10 October, 23-40.

Anderson, Gerald , and Thomas Stransky. 1974. Crucial issues in missions today. *Missionary trends,* 24 May, 142-201.

Barbie, Earl. 1993. *Survey research methods.* Belmond, CA: Wad worth Publishing Company.

Barret, B., ed. 1980. *The development of Kenya Christianity: Kenya churches handbook*. Kisumu: Evangel Publishing House.

Best, W., and J. V., Khan. 1989. *Research in education.* 6th ed. Engle Wood Cliffs, NJ: Prentice Hall.

Bogdan, Robert and Taylor, J. 1975. *Introduction to qualitative research methods.* New York: John Wiley and Sons.

Borhorff, M. 1994. *Epidemiology of HIV infection in Mwanza.* Tanzania: The Dar-salam Press.

Byamugisha, Gideon. 1998. AIDS, the condom and the church: The theological and pastoral implication of HIV/AIDS to Uganda. Ecumenical Association of sthird World Theologians, Kampala. 10 (June): 2-184.

Calver, V. 2000. AIDS orphans in Africa*: Lessons learned and possible strategies* for the l*ocal church and the World Relief.* Nairobi: World Relief HIV/AIDS team.

Clarke, Donald. 1994. *AIDS: The biblical solution.* Zondervan Bible Publishers.

Confronting AIDS: Public priorities in global epidemics. 1997. Washington: World Bank.

Curci, Carmine. 2002. Aids in Africa. *New people Magazine*, 18 November, 81.

Davison, C., and M. Neale. 1998. *Abnormal psychology*. New York: John Wiley & Sons Inc.

De Hovitz A. J.1995. *Natural history of HIV infection in women*. Raven Press.

De Vries, Christina. 2001. *The global health situation: Priorities for the churches health ministry beyond AD 2000*. New York.

Dixon, Patrick. 1994. *The truth about AIDS*. 3rd ed. Eastbourne: Kingsway Publications.

Dortzbach, Debbie. 1996. AIDS in Africa: *The church's opportunity*. Nairobi: MAP International.

_____.1998. AIDS in Kenya: *The church's challenge and the lessons learned*. Nairobi: MAP International.

Dortzbach, K and Ndunge Kiiti, eds. 1996. *Helpers for a healing community: A pastoral counseling manual for AIDS*. 2d ed. Nairobi: MAP International.

Dossier, Pat. 1989. *AIDS and the third world*. Panos Institute.

Estate, Diana. 2002. Clerics to meet over AIDS: *East African standard*, 16 December, 6.

Facing AIDS: The challenge, the churches' response study document. 1997. Geneva: World Council of Churches.

Frankfort-Nachmias, Chava, and David Nachmias. 1996. *Research methods in the social sciences*. 5th ed. New York: St. Martin's Press.

Gall, D. Meredith, Walter R. Borg, and Joyce P. Gall. 1996. *Education research: An introduction*. NY: Longman.

Gatu, John. 1999. Presbyterian in East Africa. *PCEA theology and research panel*, 29 November, 5-9.

Ghosh, B. N. 1992. *Scientific method and social research*. New Delhi: Sterling Publishers.

Giddens, Anthony. 1993. *Sociology*. Polity Press.

Goodrich, D. 1996. *Christians respond to HIV/AIDS across the world*. Nairobi: World Relief.

Greig, A. 1999. *Beyond awareness raising: Community lessons about improving response to HIV/AIDS*. London: Alliance.

Gusthall, K. 1999. *The AIDS epidemic: Hope for the future*. St. Lawrence University.

Jitegemea: The magazine with a Christian touch. 1996, 19 August, 12-56.

Jitegemea: *The magazine with a Christian touch. 1996, 27* August.

Juju, R. 1996. *AIDS*: *Understanding the challenge.* Nairobi: ACE communication.

Kamau, W. 2002. HIV in the Rift*: Daily Nation,* 13 July, 1.

Kiarie, William. 2003. Government must take the lead in campaign against AIDS: *Daily Nation,* 5 February, 10.

Kiiti, Ngunge, Petrida Ijumba, and Debbie Dortzbach. 1996. *AIDS prevention and Kenya's church leaders: Assessment of knowledge, attitudes, and practices.* Nairobi: MAP International.

Kreiss, Koech, and F. Plummer. 1986. *AIDS virus infection in Nairobi Prostitutes*: *The spread of the epidemic to East Africa.* UK: London.

Krishnaswami, R. 1993. *Methodology of research in social* sciences. Delhi: Himalaya Publishing House

Makau, Larry Niemeyer, and N. Okello. 1995. *The response of Kenya churches to the AIDS epidemic and their perceived barriers to behaviour change.* Nairobi: MAP International.

Manifesto of evangelical churches.1998. Geneva, Switzerland: World Council of Churches.

MAP International. 2000. *AIDS challenges is the Church's challenge: A small group bible study series to help you face the Challenges of AIDS.* Nairobi: MAP International.

MAP International. 1996. *AIDS in Africa: The church's opportunity.* Nairobi: MAP International.

MAP International. 1999. *The AIDS Challenge is the Church's Challenge: Small Group Bible Study Series to help you face the challenges of AIDS.* Nairobi MAP International.

McGavran, Donald, and Peter Wagner. 1970. *Understanding Church Growth.* Grand Rapids, Michigan: Eardmans.

Morgan, Timothy. 2000. Christianity today. *A magazine of evangelical conviction,* 7 February, 8-31.

Muganda, R. 2001. HIV/AIDS Crisis in Kenya. *Daily Nation,* 13 May, 13.

NARESA. 1994. *Prevention and management of sexually transmitted diseases in eastern and southern Africa.* Nairobi: NARESA Publishing.

NASCOP .1998. *Second National HIV/AIDS Conference*. Nairobi: Ministry of Health Publishers.

Ndichu, Lucy. 2002. Clerics tipped on HIV /Aids: *East Africa standard,* 18 December, 6.

Njoroge Mwaura . 1995. *Today in Africa: Kenya church growth.* Nairobi: Daystar University.

O'Donohue, M., and R. Vitilio. 1996. *Caritas training manual on the pandemic of HIV/AIDS.* Nairobi: Pauline Publications Africa.

Oliver, Roland. 1965. *The Missionary Factors in East Africa.* London: Longmans.

Opora, Caleb. 2002. HIV/AIDS in Kenya: National AIDS Control Council. *Maisha Newsletter,* 12 July, 15-25.

Sander, D. and S. Abdulrahman. 1991. *Aids in Africa: The implication of economic recession and structural adjustment.* London: Oxford University Press.

Sandrock, J. W., and A. Simons. 1994. *Human adjustment.* Lowa: Brown and Benchman Press.

Shimoli, E. 2001. 300 millions condoms to be imported in AIDS battle. *Daily Nation,* 11 July, 1.

Simons, M. 1999. Kenya torn up by AIDS. *Los Angeles Times*, 17 August, 5.

Sorokin, P. 1957. *Social and cultural dynamics extending horizons books.* Boston: Porter Sargent Publishers.

Spencer, Leon. 1975. *Christian missions and African interests in Kenya: 1905-1924.* Chicago: Syracuse University.

Stanecki, K. 2000. AIDS likely to lower life expectancy to 30 years. *Daily Nation,* 12 July, 8.

State of the world's children annual report. *United Nations Children's Fund.* 2000, 10 January, 14-54.

United Nations AIDS. 2000. *A case study on HIV/AIDS.* UN Report, 4 December, 5-17.

UNAIDS and World Health Organization. Report on the global HIV/AIDS epidemic. 2000, *23 June, 11-24.*

Yeir, A. 2000 . Donors to Pull out of AIDS Plan. *Daily Nation,* 1 September, 20.

APPENDIX A:

Questionnaire

Introduction

The following questionnaire is intended for use as self-administered questionnaire. The respondent must be a registered member of Presbyterian Church of East Africa (PCEA) Lang'ata Parish. The purpose of the research is to find out the factors that led to the development of HIV/AIDS Control Programme at PCEA Lang'ata Parish. The research findings could be used to make important decisions that would enhance this ministry. Please answer as fully as possible, expressing your thoughts freely concerning each of the questions.

The researcher is a member at PCEA Lang'ata Parish who is student at Nairobi Evangelical Graduate School of Theology (NEGST). As part of his study he is supposed to undertake a field based research. This is the prime reason why he needs your information. The researcher promises to treat information handed to him confidentially. I do not need to know who is giving information. So please do not write your name on the questionnaire. Feel free to use the backside of the paper if necessary.

QUESTIONNAIRE FOR CHURCH LEADERS

1. (a) Survey number of the respondent ☐ (b) Sex of the respondent M ☐ F ☐

   (c) Age of the respondent ☐

   (d) Position in the Church_____ and for how long have you been in this position_____

   (e) Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Others ☐

   (specify).....

   (f) For how long have you been a member of PCEA Lang'ata Parish ?_____

2. Do you have any knowledge about HIV/AIDS ? Yes ☐ No ☐

   If yes what do you know ?.....

3. Do you think that HIV/AIDS is a problem in the church ? Yes ☐ No ☐
If yes, in which Way?.....

4. How is the prevalence of HIV/AIDS at PCEA Lang'ata Parish ?.....

5. Does the church feel HIV/AIDS threatens its mission of evangelization ? Yes ☐ ☐ No

If yes, in which way ?

6. How does the Church make use of its mission of evangelization to intervene in the
spread of the epidemic ?.....

7. Does the church have any Programme in response to HIV/AIDS ?
[ ] Yes [ ] No

If yes, what programmes are provided by PCEA Lang'ata Parish ?
a) [ ]HIV/AIDS awareness
b) [ ]Provision of condom
c) [ ]Home base care
d) [ ]Counseling
e) [ ]Medical/health care
f) [ ]Nutritional support
g) [ ]Clothes
h) [ ]Spiritual support
i) [ ]Other(specify).....

8. What are the reasons that led to the development of the above mentioned programme(s) ?.....

9. What are the goal(s) and objectives of these/this programme(s) ?.....

10. What is the impact of HIV/AIDS on the church ?.....
11. In what way has the church been affected by HIV/AIDS ?.....
12 . How does the church address the issue of orphans ?.....

13. Does the church view that some cultural practices enhance the spread of HIV/AIDS ?
Yes ☐ No ☐ If yes what are these cultural practices.....
14. What has the church done about these practices ?.....

15. What are some of the problem(s) encountered by the church in providing HIV/AIDS control program ?.....
16.What does the church intend to do about the mentioned problem?..... Does the church collaborate with other organizations in providing HIV/AIDS program? [ ] Yes [ ] No.
If yes, how is this done? If no, why?.....

17. Does the church provide training to community members?
[ ] Yes [ ] No
If yes, what kind of training and what is the target group?.....
What programme(s) does the church have for those infected and affected?.....
18. How does the church handle issues of stigmatization and discrimination of those infected by HIV/AIDS?.....
19. What program for HIV/AIDS does the church have for the youth?.....
20. Does the church provide forums for discussion among the various groups of the church?.....
21. Does the church provide information, education and communication materials about HIV/AIDS to the church members?.....
22. What is the best way forward for nurturing a HIV free society?.....
23. Finally, could you in detail comment on the factors that led to the development of HIV/AIDs Control Programme at PCEA Lang'ata Parish ?

CHURCH MEMBERS

1. (a) Survey number of the respondent ☐ (b) Sex of the respondent M☐ F ☐

(c) Age of the respondent ☐

(e) Marital status: Single☐ Married ☐ Divorced ☐ Widowed ☐Others (specify) ☐

(g) For how long have you been a member of PCEA Lang'ata Parish ?_____

2. Do you have any knowledge about HIV/AIDS ? Yes☐ No ☐
If yes what do you know ?.....

3. What does HIV/AIDS stand for ?.....

4. Do you think that HIV/AIDS is a problem in your church ? [ ]Yes [ ]No
Why ?.....
5. Is there anything that a person can do to avoid getting AIDS, or HIV the virus that causes AIDS? [ ]Yes [ ]No. Explain.....

6. From which source of information or persons have you heard about AIDS in the recent years? [ ]Person [ ] church member [ ]Parents [ ]Friend [ ]community [ ] AIDS educator's [ ]Newspaper [ ]Television [ ]Specify source.....

7. Where would you like to get more information about AIDS.
[ ]Friends [ ]CAE [ ]Pastor [ ]Radio [ ]Television [ ] Other (specify).....

8. How often do you attend church service? [ ]Always [ ]Sometimes [ ]Rarely [ ]Never

9. Do you know of any church organization or program assisting people to know more about AIDS? [ ]Yes [ ]No If yes which one .....

10. How often does your church program discuss about HIV/AIDS matters? [ ]Often [ ]Rarely [ ]Sometimes [ ]Never

11. How do you think the church can help you to deal with relationships, sex and AIDS?
12. Does your church have any program in response to HIV/AIDS? [ ]Yes [ ]No.
    (a) If yes which program?.....
    (b) Who is served by the program?.....
    (c) To which extend does the program serve the target audience ?.....
    (d) Where are the services provided?.....

13. Has the church experienced any HIV/AIDS cases for the last one year?
    [ ]Yes [ ] No
    If yes, what is the magnitude of HIV/AIDS problem among the church members?

14. Has the church organize any worship/seminar on HIV/AIDS awareness ?
15. Does the church have HIV/AIDS program for the community in general?
    [ ] Yes [ ] No
    If yes, what HIV/AIDS program does PCEA Lang'ata Parish have?
    j) [ ]HIV/AIDS awareness
    k) [ ]Provision of condom
    l) [ ]Home base care
    m) [ ]Counseling
    n) [ ]Medical/health care
    o) [ ]Nutritional support
    p) [ ]Clothes
    q) [ ] Others(specify).....
16. What are the reasons that led to the development of HIV/AIDS program at PCEA Lang'ata
    Parish?.....
17. In your opinion has this program succeeded in curbing the epidemic? [ ] Yes[ ] NO
18. Why is it so for your response above?.....
19. What are the strategies that your church has employed in the fight against HIV/AIDS?.....
    ....
20. Is the program targeting church members only or entire community ?
21. How has the community responded to the church fight against HIV/AIDS?
22. What support does the church get from the community?
23. Does the church collaborate with other organizations in providing HIV/AIDS program? [ ] Yes [ ] No.
    If yes, how is this done? If no, why?.....
24. Does the church provide training to community members?
    [ ] Yes [ ] No
    If yes, what kind of training and what is the target group?.....
25. What program does the church have for those infected or affected?.....

26. How does the church handle issues of stigmatization and discrimination of those infected by HIV/AIDS?.....
27. Does the church provide information, education and communication materials about HIV/AIDS to the church members?.....
28. What are the main problems experienced by the church in the fight against HIV/AIDS?.....
29. What is the best way forward for nurturing a HIV free society?
30. Finally, could you in detail comment on the factors that led to the development of HIV/AIDS Control Program at PCEA Lang'ata Parish ?

December 16, 2002

Mr. Francis N. Kihiko
Co-Ordinating Director
The Presbyterian Church of East Africa
Board for Social Responsibility
P. O. Box 48268
Nairobi

Dear Sir,

RE: PERMISSION FOR DOMINIC OLURRU TO DO RESEARCH ON HIV/AID RESOURCE MATERIAL – PCEA HEAD OFFICE

Warm Christmas season greetings in His name. This is to inform you that the above named is a third year student M.Div (Missions emphasis) student here at NEGST.

Dominic has been involved as a student on field ministry at your PCEA-Langata parish for the last two years. Currently he is working on his thesis and wish to research on "factors contributing to the development of HIV/AIDS program at PCEA-Langata Parish".

I am writing as his academic advisor/mentor to kindly request your permission for him to access your resource material on the noted subject.

Thank you.

Henry N. Mutua, Ph.D
(Lecturer – Missions department)
e-mail: henry.mutua@negst.edu

Appendix B

P.C.E.A. HIV/AIDS CONTROL PROGRAMME

PARISH:	LANG'ATA
CONTACT PERSON:	REV. J. WAKABA P.O. BOX 56780 NAIROBI, TEL: 607090
NAME OF T.O.T.:	JOYCE K. GITHINJI P.O. BOX 56780 NAIROBI, TEL: 601676
BUDGET:	KSHS. 40,570.00

GOAL: HEALTH FOR ALL BY 2020

OBJECTIVES: BY FEBRUARY 2002

(i) TWENTY COMMUNITY AIDS EDUCATORS (C.A.E.s)
TRAINED IN HIV/AIDS PREVENTATION AND CONTROL IN LANG'ATA

(ii) AWARENESS CREAETD IN AND AROUND LANG'ATA PARISH

(iii) HOME BASED CARE PROGRAMME ESTABLISHED TO REACH AT LEAST
20 PEOPLE LIVING WITH HIV/AIDS (PLHAs) AND THEIR FAMILIES

MAIN TASK/STRATEGY	TOPIC / ACTIVITY	DATE	VENUE	METHODOLOGY	RESOURCES	REMARKS
IEC CREATING AWARENESS	Programme for IEC activities market places, schools, Barazas other churches, all youths in the community, Health week	15/10/2001	Langata Church	Drama, skits health talk	lunch, transport Honorarium Faciliators Pamplets, Handout	
	Reporting CAEs submit written reports on monthly basis		"	Formal internal Activity report forms		
	Collection of data C.A..E. update Observing worlds AIDS day		"	Discussion Handouts with recent statistics, procession with placards & posters	Lunch placards posters	
HOME BASED CARE	(i) Identify PLHAs and their needs (ii) Identify PLHAs facilitators and services i.e. Networking with local health centres community based organisations in the area.	Open	Langata Parish	Informal discussion with members of community with members of affected families. Reports from CAE's	transport donations	
	• Fundrising for home-base care ~~community~~ Community mobilize other donors • Home base care services social support, spiritual support, education, nursing care, refferal dealing with opportunistic infections e.g. T.B., skin infection, mouth sores etc		"	Home-visits by C.A.E. Get treatment from local health centres	Jumbo sales Home care kit.	
	• Counselling of PLHAs and their families to live positvely and cope with infected • CAEs to follow up the PLHAs home care kit.		"	visiting PLHAs regularly	food stuffs clothes	

MAIN TASK/STRATEGY	TOPIC / ACTIVITY	DATE	VENUE	METHODOLOGY	RESOURCES	REMARKS
Training	Planning meeting with parish minister, health committee • TOT training update • Introduce HIV/IDS programme • Subject of C.A.E. training • Selection criteria of CAEs (qualification) • CAE training dates, venue and requirements	February 15th 2001	P.C.E.A. Langata Church office	Formal Internal discussion, consultation	tea/snacks	
	• Training needs assessment (T.N.A.) • Visit secondary and primary school • Visit other local churches outside P.C.E.A. • Visit opinion leaders and local administrators/NGO's	From 16/2/2001 to 2/3/2001		Interviews, discussions literature review visit relevant offices e.g. NGO's, DASCO	Transport stationery Human Resources	
	• Recruitment • Intimations, shortlisting, interviews	17/3/2001 18/3/2001	Langata Parish Area	Oral literature Advertisement	Stationery tea/snacks Lunch	
	• Preparation for CAE training • Identify training venue, facilitators, materials required, drawing program • Resource mobilization e.g. fund raising	24/3/2001	Langata Parish Area	Discussions and consultation	tea/snacks	
	• C.A.E. training, 1st group is P.C.E.A. local congregation and ecumenical groups • 2nd group schools/institutions	9/4/2001 6/11/2001	"	Lecture, discussion demonstration, consultation question and answer, fishing, drama, bush fire	Fact sheets, tea/lunch hand outs from M.A.P. international models, posters facilitators, charts stickers, video.	
	• Graduation after training the C.A.E. will create awareness for 3 months under T.O.Ts supervision issuing certificates 1st group graduate 2nd group graduate	15/7/2001 15/7/2001 3/12/2001	Langata Church	TOT to give a speech drama & music	Certificate fee Honorarium Lunch and refreshment	
IEC	• Planning meetings for creating awareness		"			

CURRICULUM VITAE

Name	Olluru Dominic Ocholia
Date of Birth	15th July 1968
Nationality	Sudanese
Marital Status	Married with three children

EDUCATION BACKGROUND

1997 – 1998	:	The Catholic University of Eastern Africa (Kenya) Post – Graduate Diploma in planning and management of Development projects.
1994 – 1997	:	The Catholic University of Eastern Africa (Kenya) Bachelor of Arts Degree in Social Sciences.
1985 – 1988	:	Comboni Senior Secondary School (Sudan)
1982 – 1985	:	Rejaf Junior Secondary School (Sudan)
1974 – 1980	:	Hilieu Primary School (Sudan)

WORK EXPERIENCE

1998 – 2000	:	Instructor / Trainer of Trainers and church planter
1992 – 1994	:	Bible Translator
1990 – 1992	:	Social Worker / Store Supervisor
1988 – 1990	:	Relief Worker with African Inland Church (AIC)

PUBLICATION

A dissertation entitled "The Impact of Social Change on Marriage and the effects it has on the Family Structure – A case study on the Otuho People in South Sudan, Torit County".