INFLUENCE OF HIV/AIDS COUNSELLING SERVICES ON THE QUALITY OF LIFE OF CHURCH MEMBERS IN SELECTED CHURCHES IN NAKURU EAST SUB- COUNTY, KENYA

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DECLARATION AND RECOMMENDATION

Declaration

I declare that, this thesis is my original work and has not been previously presented for the award of a degree in this or any other university.

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Recommendation

This work has been submitted for examination with our approval as University Supervisors.

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DEDICATION

With gratitude to my Heavenly father who has enabled me to come this far. This work is dedicated to my beloved husband Moses Njenga and daughters Anna Njenga and Priscilla Njenga from whom I have received constant love, support and tireless encouragement throughout my study and research time.

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ABSTRACT

Globally and in the continent of Africa HIV/AIDS has become a pandemic that has affected more than 38 million people. The world has responded to this pandemic in many ways including creating counselling services to improve the quality of life. In Nakuru East Sub County churches are increasingly getting involved in HIV/AIDS counselling services to help improve the quality of life of its members. However, no studies have been conducted to assess the influence of HIV/AIDS counselling services on the quality of life of the church members. The purpose of this study was to assess the influence of HIV/AIDS counselling services on the quality of life of church members in selected churches in Nakuru East Sub County. This study was guided by crisis theory and humanistic theory. This research adopted an *ex Post facto* causal comparative research design. The target population of the study was Shabab Africa Inland Church, Nakuru West -Presbyterian Church of East Africa- and Christ the King Cathedral- Catholic Church with a population of five thousand, six hundred and forty three (5643) members. The churches were selected through purposive sampling based on the fact that they had established and running counselling services. A sample of 225 respondents were involved in the study this involved 3 pastors,48 men,110 women,49 youth and 3 counsellors drawn from the three churches. Questionnaires were used to collect data and a pilot study was conducted at Deliverance Church Nakuru. The reliability of questionnaires was estimated by use of Cronbach alpha reliability coefficient where values of the coefficient above 0.70 were accepted. Data was analysed using descriptive statistics (frequencies and percentages) and inferential statistics such as chi-square, spearman's rho correlations, Linear by linear association and McNemar Bookers test using the Statistical Package for Social Science (SPSS) programme. This study found out that, many people infected and affected still experience various issues that can be addressed by accessing and utilising more counselling services. In addition, many people are not aware of the counselling services available. This study recommends an increase of awareness of the available counselling services in the church and the community. There is a need for the church and government to establish more counselling services to improve the quality of life of the people.

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ABBREVIATIONS AND ACRONYMS

AIC	Africa Inland Church.
AIDS	Acquired Immunity Defiency Syndrome.
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Azydothymidine
CD4	Cluster of Differential.
CHAK	Christian Health Association of Kenya
DFID	Department for International Development
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodefiency Virus.
HTC	Home Testing and Counselling
FAO	Food and Agriculture Organisation
FBO	Faith Based Organisation
FPAK	Family Planning Association of Kenya.
IAEA	International AIDS Economic Association.
KAPC	Kenya Association of Professional Counsellors
KIPC	Kenya Institute of Professional Counselling.
MAP	Medical Assistance Program.
MTCT	Mother to Child Transmission
NASCOP	National AIDS Control Program.
PLWHAS	People Living with HIV and AIDS.
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
SAFAIDS	Southern Africa HIV/AIDS information Dissemination Services.
SPSS	Statistical Package for Social Science
STI	Sexual Transmitted Infections
TASO	The AIDS Support Organisation
UN	United Nations
UNAIDS	Joint United Nations AIDS Programme on HIV/AIDS.
UNESCO	United Nation Educational, Scientific and Culture Organisation
VCT	Voluntary Counselling and Testing
VMMC	Voluntary medical male circumcision
W HO	World Health Organisation

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

Millions of people are devastated by Human Immuno deficiency Virus and Acquired Immuno Deficiency Syndrome (HIV/AIDS) throughout the world. According to United Nations programme on AIDS (UNAIDS, 2015) HIV continues to be a major global public health issue. Since 2000, 38.1 million people have been infected with HIV, 25.3 million people have died of AIDS related illnesses and 2.0 million new infections have been reported (UNAIDS,2015).These statistics indicate the seriousness of the pandemic since it is a problem that has had a global impact this has called for concerted effort from all stakeholders. Recently UNAIDS developed a fast track strategy for Nations to double the number of people on life saving HIV treatment by 2020 through this strategy countries are working on eradicating the pandemic by 2030 (UNAIDS, 2015).

Although many people are living with the virus it is estimated that currently only 53% of people with HIV know their status. In 2014 approximately 150 million children and adults in 129 middle income countries received HIV testing services. By June 2015, 15.8 million people living with HIV received antiretroviral therapy (ART) up from 13.6 million in 2014. Statistics show that 41% of all adults living with HIV were accessing treatment in 2014 up from 23% in 2010. Between 2000 and 2015 new infections had fallen by 24% with some 7.8 million lives saved as a result of International effort that led to global achievement of the HIV targets of the Millennium development goals. (UNAIDS, 2015) There is also a gap on those receiving HIV Testing and counseling (HTC) services. Efforts have been made to see that more people are access services that can help improve the quality of their lives after knowing ones status one is counseled and introduced to antiretroviral to help bring down the viral load and help fight opportunistic illnesses that come with a low immunity.

The HIV virus is said to be passed from one person to another through transmission of body fluids for example from an infected mother to the child. To reduce or eradicate this problem, services referred to as Prevention of Mother to Child Transmission (PMTC) have been developed, PMTC services have highly reduced the number of children born with HIV. An estimated 370,000 children were newly infected in 2009 (a drop of 24% from five years earlier). The number of annual AIDS related deaths worldwide is steadily decreasing from the peak of 2.1 million in 2004 to an estimated 1.8 million in 2009. The decline reflects the increased availability of antiretroviral therapy as well as care and support to people especially

from middle and low income countries (UNAIDS, 2010).These statistics indicate that HIV/AIDS is still a global problem that has prompted the initiation of counseling services to help curb the pandemic. This statistics also reflect a gap that needs to be addressed since mother to child transmission remain a challenge and more has to be done to further reduce transmission and to have more children free from HIV. Scaling up of PMTC services globally has continued to bear fruits in the fight against the pandemic.

According to UNAIDS, (2014), Sub-Saharan Africa was the leading region in the world with HIV and AIDS epidemic with a total of 25.8 million affected people. This accounted for 70% of the global total of HIV infections. In 2013 an estimated 24.7 million people were living with HIV, (71%), 1.5 million were newly infected and 1.1 million died of AIDS related illnesses (UNAIDS, 2014). HIV prevalence for the region is at 4.7 % but varies greatly between regions within Sub Saharan Africa as well as individual countries. Since the beginning of the epidemic 14.8 million children have lost one or both parents to HIV/AIDS (UNAIDS, 2010). Both HIV prevalence rates and the numbers of people dying from AIDS vary greatly between African countries. In Somalia and Senegal HIV prevalence is less than 1% of the adult population, whereas in Namibia, Zambia and Zimbabwe around 10-15% of adults are infected with HIV (UNAIDS, 2014). This statistic inform this study since they reflect a gap in the lives of people in Africa and globally that is caused by the effects on the pandemic being the most affected continent more lives have experienced these devastating effects that have reduced developments significantly as a result all sectors social and economically have suffered some setbacks. There is also a gap on how infections in Africa have affected people comparing with the global total there is a need for African nations to consider ways to bridge this gaps as indicated by these statistics currently Africa is contributed to 71% of those globally infected this is an alarming level that concerted efforts are required for any nation to succeed.

The largest population living with HIV is found in South Africa, with 5.9 million, with a 17.8% prevalence rate said to be living with the virus. In three other Southern African countries, Swaziland , Botswana, and Lesotho the national adult HIV prevalence rate now exceeds 20% (27.4%, 24.8%. 23.6%, respectively) By comparison HIV prevalence in Western and Eastern Africa is low to moderate ranging from 0.5% in Senegal to 6% in Kenya (UNAIDS, 2014). Today, Africa is still affected by HIV and AIDS, this statistics show that there is much that needs to be done to reduce infections and to help the already infected and affected. This is because the social, economic, mental and spiritual consequences of the AIDS

epidemic are widely felt, not only in the health sector but also in education, industry, agriculture, transport, human resources and the economy in general. This has devastated communities, rolling back decades of development. In addition, many people have lost their lives, have had their social, economic, mental and spiritual lives affected by the pandemic , this calls for all nations in the continent and the world to seek ways to reduce the prevalence rates.

Kenya has the third largest population of people living with HIV in Sub-Saharan Africa, and the highest national HIV prevalence of any country outside Southern Africa (UNAIDS 2008). An estimated 1.6 million people are infected, 1.1 million children have been orphaned, in 2014 nearly 62,000 people died from AIDS-related illnesses (NASCOP, 2014). From the Kenya AIDS indicator survey in 2012 more than half of Kenyans living with HIV did not know their HIV status, 16% had never tested (or received test results if tested) and 37% believed they were negative based on self reporting. Over 680,000 persons including 60,000 children aged 0-14 received antiretroviral treatment. More than 70% per cent of HIV positive pregnant women received antiretroviral prophylaxis to prevent transmission to their new born babies. About 65% of new HIV infections in Kenya occurred in nine counties: Bomet, Homabay, Kisii, Kisumu, Migori, Nakuru, Nyamira, Siaya and Turkana (Otieno, 2015). These statistics reflect a gap in the higher number of people infected in Kenya as compared to other nations in Africa that must be addressed. These statistic show HIV/AIDS is still a major problem in Kenya with so many people living with the virus, reporting fresh infections and losing their lives. The Government has responded to this gap by scaling up services and creating awareness on the need for people to utilize established HTC that respond to various challenges brought by the pandemic by encouraging people to know their status and utilizing available services that can improve the quality of their lives.

According to the Ministry of Health estimates of 2013, show Nakuru County, which has a population of 1,825,229, there are 61,598 people living with HIV; new infections were estimated at 4,127 people. The County experienced 3,065 HIV related deaths and 26,255 people needed ART (NASCOP, 2014). These statistics are relevant to this study since HIV/AIDS has greatly affected the lives of people in Kenya and Nakuru County specifically which is the focus of this study. There is a need to bridge the gap that has been brought by high infection levels. HIV infections are still high in Nakuru county as the government attempts to reduce infections at a national level efforts must be made at grassroots to completely succeed. Nakuru County has many people are who are affected or infected by

HIV/AIDS the county has to continually develop and implement policies and relevant activities that can result in reduction of the number of infections and deaths brought by the pandemic.

Kenya's HIV prevalence peaked during the late 1990s, According to the latest figures, this has dramatically reduced to around 6.2 percent (UNAIDS, 2012). This decline is thought to be partially due to an increase in education and awareness, and also from the high death rates (UNGASS, 2008). Whilst many people in Kenya have not received HIV prevention and treatment services, access to treatment has increased. 72 % of affected adults are receiving treatment this shows an increment of around 200,000 people in 2011 compared to 2009 (UNAIDS, 2012). Unfortunately, like in many countries, the proportion of eligible children receiving antiretroviral treatment is much lower. The gap that needs to be addressed as indicated by these statistics is the need to reduce infections and deaths that occur due to HIV/AIDS infections. This demonstrates that Kenya still has a challenge in providing universal access to treatment, prevention and care. The Kenyan government is committed to provide prevention and treatment services; the government has also encouraged other stake holders to join in the fight against the pandemic.

According to the Head of the monitoring and evaluation unit at the National AIDS Control Council, Muslim women do not have a high prevalence rate they are at 2.8%; Protestant women registered a prevalence rate of 8.4% while their Catholics counterparts are at 8% (NASCOP, 2014). These statistics are significant to this study since they indicate the fact that HIV/AIDS prevalence is still high although counseling services have been increased. These statistics also show a gap between prevalence levels from different religious backgrounds this gap needs to be reduced since the Christians seem to be more affected. The religious community is greatly affected by the pandemic this calls for the religious community to respond to the pandemic by creating awareness and programmes to cater for their members and the community. These statistics also inform this study since the influence of HIVAIDS counseling services on the life of church members is the focus of this study.

A significant part of church's ministry is counseling members so that they may cope with spiritual, social, psychological and physical challenges that they face on a day to day basis. The church guides the parishioners through the use of scriptures in solving their problems. It is through counselling that, the church attempts to provide encouragement and guidance for those who are facing losses, indecisions, or disappointments. Counselling stimulates

personality growth; development and helps people cope effectively with the problems of living with inner conflicts and crippling emotions (Chacha and Bowers, 2005). The church also provides hope, reconciliation, and a purpose for living by counselling those infected or affected by the HIV/ AIDS pandemic. It is in this regard that the work of Churches in Nakuru County was important to this study.

The Africa Inland Church has an AIDS division which addresses HIV/AIDS related issues. This division has three programmes for HIV prevention through awareness creation. The first programme is "Choosing hope" where a training curriculum has been developed that targets youth in college and universities. The Second programme is 'Why Wait' which is taught to primary and secondary students in church sponsored schools. These two programmes take place during the school term. The third programme is for the whole church and it runs throughout the year. The Africa Inland Church also offers counselling services through its hospitals which include Kijabe, Tenwek, Litein, Kapsowar, Bethsaida and Parkview. (Mulonzya, 2003). Africa Inland Church has no statistics on the impact of its work or the beneficiaries of the different counselling services, this created a need for this study. This church (A.I.C) has developed a fully operational Counselling services at Bethsaida clinic within AIC Shabab in Nakuru County.

The Presbyterian Church of East Africa began its work on HIV/AIDS in late 1980's when its three hospitals Chogoria, Tumutumu and Kikuyu started to include HIV/AIDS information in their outreach programme within their catchment areas. The hospitals also offer voluntary counselling and testing services. While the bulk of the church's work is in the prevention of HIV/AIDS it has also addressed issues of work and human rights for people living with and affected by HIV/AIDS. Unfortunately, the church has no statistics of the people reached by its HIV/AIDS programmes (Mulonzya, 2003). Although the church has established the programmes in response to the pandemic its lack of documented evidence created the need for this study. This church runs a fully operational HIV counselling centre at Nakuru West Dispensary in Nakuru County.

The Roman Catholic Church in Kenya responds to HIV/AIDS in a holistic way and approaches it as a suffering of the human person. The Roman Catholic Church responds to this pandemic in five areas. Through collaboration with the ministry of education the church provides formal education in schools and informal education which is provided to out of school youths with an emphasis on behavior change. The church provides treatment which

entails institution and home based care. Institution based care is done in the church's hospitals and clinics spread across the country. Home based care entails the visit of affected people in their homes offering them treatment, counselling and meeting other needs such as food or cleaning. Stigma reduction attention is given to people living with and affected by HIV/AIDS; they are encouraged to live positively. The Catholic Church is also involved in taking care of orphans this is accomplished through institutional care or community based care. Prevention of mother to child transmission of HIV is done in the church's 39 hospitals and over 500 health centres spread throughout the country. The Catholic Secretariat and the Christian Health Association of Kenya created the Mission for Essential Drugs (M.E.D.S.) which is the only Pharmaceutical entity that provides cheap antiretroviral in the country. The church in collaboration with the ministry of Health and National AIDS Control Council has participated in the formulation of guidelines and policies on laws to prevent and manage HIV/AIDS. The church has no statistics of the beneficiaries of the different HIV/AIDS interventions or an indication of the impact of its work (Mulonzya, 2003). This lack of documented evidence of the outcome of these services created the need for this study. The Catholic Church has established the Catholic Diocese of Nakuru (CDN) Voluntary Counselling Testing centre (VCT).

Counselling in HIV/AIDS has become a core element in a holistic model of health care in which psychological issues are recognized as integral to patient management. HIV and AIDS counselling has two general aims, the prevention of HIV transmission and the support of those infected and affected by HIV these dual aims are vital because the spread of HIV can be prevented by changes in behavior. One to one counseling has a particular contribution in that it enables frank discussion of sensitive aspects of patients' life and such discussion may be hampered in other settings by the patients concern for confidentiality or anxiety about a judgment response. Also when patients know that they have HIV they may suffer great psychological stress through fear of rejection, social stigma, disease progression and the uncertainties associated with future management of HIV (Chippindale& French, 2001). HIV/AIDS counselling continues to be a vital component in the fight against the pandemic effort. There is still a gap on the influence of these services on the quality of life of church members. Many church members still have reservation on seeking counselling because of the fear of stigmatization, rejection and lack of confidentiality. These gaps on confidence in our counselling services must be address to encourage church members to access these services to change their lives.

According to Muraah & Kiarie (2001).AIDS has become a public health problem with negative impacts on development in all sectors in Kenya. In the education sector the pandemic is a significant obstacle to children accessing education since many drop out of schools when they become orphans or attend to sick parents. Teachers are often absent or die since they are also infected and affected by the pandemic. HIV/AIDS has a high prevalence in the police and military who are mostly separated from their families. This has seen a large number of those in the security sector affected and infected by the pandemic. Jackson, (2002) says that the health sector has experienced an increased burden for those infected by HIV/AIDS. More beds in hospitals are occupied by People living with HIV and AIDS (PLWHAs) and more resources are allocated to HIV/AIDS compared to other diseases like malaria. The agriculture sector has also felt the impact of the pandemic through the loss of labour, reduced farming income and lowered household food security. Socially households are greatly affected by the pandemic and experience stigmatisation, isolation, rejection, poverty, poor nutrition and increased workload on women and children. This implies that HIV/AIDS continues to have a negative economic and social effect to the families as sick parents and children lack basic necessities for survival hence resulting to dependency on the already overburdened extended families.

The quality of life (QOL) is an important component in the evaluation of the well-being of people living with HIV and AIDS (PLWHA), especially with the improved long life brought by use of antiretroviral. Moreover, limited studies had been conducted in Kenya on how PLWHA perceive their life (Folasire O.F, *et*. (2012). World Health Organization define quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (Taffa&Nyamongo, 2004). This is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment.

The Constitution of the World Health Organization defines health as "A state of complete physical, mental, and social well-being not merely the absence of disease "(Taffa &Nyamongo, 2004). It follows that the measurement of health and the effects of health care must include not only an indication of changes in the frequency and severity of diseases but also an estimation of well being and this can be assessed by measuring the improvement in the quality of life related to health care. Although there are generally satisfactory ways of

measuring the frequency and severity of diseases this is not the case in so far as the measurement of well being and quality of life are concerned (Taffa&Nyamongo, 2004). Quality of life of an individual is very important and greatly influence the way an individual evaluates themselves and their perception to life one who is infected or affected by HIV/AIDS needs to live a satisfactory life even with the challenges they face daily. This study on the quality of life seeks to address the gap of limited studies conducted in Kenya on the quality of life of church members. There is a great need to understand the quality of life of PLWHA since today PLWHAs are living longer because of the access and utilization of counselling services. The way an individual perceives himself greatly affects his wellbeing that is reflected in his quality of life.

Kenya has made tremendous strides in the fight against HIV/AIDS pandemic as indicated by Kenya AIDS Response Progress Report 2014 the HIV epidemic has evolved since the first case was diagnosed in Kenya in 1984 to become one of the major causes of mortality and has placed tremendous demands on the health system and the economy in general. The pandemic has affected all sectors of society this includes children, young people and adults. The country's response to the pandemic has also evolved over the years from a health sector led response to a Multisectoral one coordinated by one national authority that has worked on one strategic framework that has a national outlook. The government in conjunction with WHO, UNAIDS and other stakeholders has shown their commitment in the fight against the pandemic. The government and stakeholders have seen the development and establishment of relevant HIV/AIDS counselling services in the country to ensure those infected and affect access and utilize counselling services to improve the quality of lives.

1.2 Statement of the Problem

Globally and in Africa HIV/AIDS has continued to affect millions of people, those not infected are affected in one way or another. This has affected the society since many households have people living with the virus. The Government of Kenya encourages everyone to know their HIV status and has put in place policies and strategies that provide for HIV testing and counselling in different settings. The Government has also encouraged other sectors like the churches to join in the fight against the pandemic through the creation of testing and counselling services. Churches in Nakuru County have established HIV/AIDS counselling centers; however, there seems to be no correlation between this growth in establishment of counselling services and reduction of HIV/AIDS infections. There is also a lack of information on how the counselling services offered improved the quality of life.

Proper statistical documentation of evidence of how counselling services influence the quality of life among church members was lacking. This study therefore sought to address this gap by investigating the influence of HIV/AIDS counselling services on the quality of life of people with special reference to selected churches in Nakuru East Sub County.

1.3 Purpose of the Study

The purpose of this study was to assess the influence of HIV/AIDS counselling services on the quality of life of church members in selected churches in Nakuru East Sub County.

1.4 Objectives of the Study

The objectives of this study were to determine:

i. The issues that affect the quality of life of church members receiving HIV/AIDS counselling services in selected churches in Nakuru East Sub County.
ii. The access and utilization of HIV/AIDS counselling services in selected churches in Nakuru East Sub County.
iii. The perceptions and attitudes of church members towards HIV/AIDS counselling services in selected churches in Nakuru East Sub County.
iv. The influence of gender, age, education and social economic status on the uptake of HIV/AIDS counselling services by church members in selected churches in Nakuru East Sub-County.
v. The influence of HIV/AIDS counselling services on the quality of life of church members in selected churches in Nakuru East Sub County.

1.5 Research Questions

i. What issues influence the quality of life of church members receiving HIV/AIDS counselling services in Nakuru East Sub County?
ii. Do church members access and utilize HIV/AIDS counselling services to improve the quality of life in selected churches in Nakuru East Sub County?
iii. What is the perception and attitude of church members towards HIV/AIDS counselling services in selected churches in Nakuru East Sub County?
iv. Does gender, age, education and socio-economic status influence the uptake of HIV/AIDS counselling services to improve the quality of life in selected churches in Nakuru East Sub County?

1.6 Hypothesis

i. Ho1 there is no statistically significant influence between HIVAIDS counselling services and the quality of life of church members who are infected by HIV/AIDS in Nakuru East Sub County.

1.7 Significance of the Study

The results of the study show that the following issues affect the quality of life of PLWHAs; People occasionally lack food, they are unable to pay hospital bills, and experience emotions like denial, anger, bitterness, guilt, shame, regret, fear, hopelessness, despair and discrimination. As counselors counsel those affected and infected by HIV/AIDS they need to address these issues through appropriate counselling services. The results of this assessment may be used by clinicians to identify and make judgments about the areas of need of PLWHAs this will assist during planning with the overall aim of improving the quality of life. This study has also made suggestion on ways the government and other stakeholders can create more policies and strategies of increasing the uptake of counselling services to help improve the quality of life in Kenya. The results may be used to create more programmes focusing on the various demographic characteristics (targeting the young and the old). It is hoped that more PLWHAS in society will be motivated to seek counseling services that would help them improve and prolong their lives. Based on the results of the study, counselling services need to be improved to be able to effectively address the various challenges faced by those infected and affected by HIV/AIDS. There is a need to scale up awareness campaigns of available counselling services through public meetings, support groups and mass media to bridge the gap between awareness and uptake of services.

1.8 Scope of the Study

The study was conducted in three selected churches in Nakuru East Sub- County namely Africa Inland Church- Shabab, Presbyterian Church of East Africa- Nakuru West and Catholic Church Christ the King Cathedral. The three churches were purposively selected because they had fully operational counselling services. Nakuru East Sub County was chosen because of the prevalence of HIV/AIDS in the Sub County. It was also thought that since the Sub County was highly cosmopolitan the findings of this study could be generalized to all other parts of the country given the same terms of reference.

1.9 Assumptions of the Study

The following were the assumption of the study

i. The respondents that were requested to participate in the research gave honest and accurate information.
ii. There are people utilizing the counselling services in the selected churches.

1.10 Limitations of the Study

The following were the limitations of the study:

i. The bureaucracy of some of the churches delayed the implementation of the study in some areas because of the requirements for meeting elders to ratify the study. To deal with this limitation the researcher booked an appointment to meet with the elders. The Elders allowed the researcher to conduct the study and supported the study as a necessary tool to know the influence of HIV/AIDS counselling services on the quality of life of church members.
ii. The cultural values held by people in Nakuru East Sub County could influence the results of the study. To deal with this limitation the researcher addressed the respondents before carrying out the research to dispel any cultural barriers. The researcher found out that since Nakuru is highly cosmopolitan with people with diverse cultures people have slowly moved away from strong cultural values and have embraced each other and live comfortable even with diverse cultural values.
iii. The responses from church members could be influenced by religious doctrines. To deal with this limitation the researcher addressed any religious doctrines that would have influenced the study. The study addressed this doctrines because religious beliefs influence personal attitudes and actions leading to accepting or rejecting those infected and affected by HIV/AIDS.

1.11 Definition of Terms

The following terms were operational and conventionally defined

Acquired Immune Deficiency Syndrome (AIDS): This term has been used to mean a condition in which the human body loses its ability to fight infections because of a weakened Immunity system.

Acquired Immune Deficiency Syndrome also means the body has been affected by something from the environment not inherited from one's parent.

Counselling: This is a term has been used in the study to mean dialogue between a person with a problem and a caregiver (counsellor) with the aim of helping the person in need to deal with their problems and help them make decisions that will improve the quality of their lives.

A dialogue between a counsellor and a client with the intention of seeking and providing guidance on issues clients are experiencing related to HIV/AIDS.

Counselling Services: these terms have been used in the study to mean a variety of services provided to an individual (counselee) that access counseling. In the case of HIV an individual is provided services like pre and post test counseling, (PMTC), antiretroviral therapy and nutrition information.

Also means various programmes offered to the health facilities to deal with the various opportunistic ailments experienced by people who are HIV positive.

Human Immunity Virus (HIV): This is a virus/ small organism that cannot be seen by the naked eye and lives and reproduces or replicates within other larger cells whose functions it manipulates for its own survival and propagation.

Also refers to the virus that destroys the immunity of human body.

Improved sexual behavior: Refers to informed decision when engaging in sexual activity.

Refers to changes experienced by a person after undergoing counselling they make informed decisions before engaging in sexual activities.

Influence: this term has been used to refer to the effect that the counseling services will have on the thinking and behavior of an infected and affected person.

Also refers to the extent to which counselling has an impact on the life of a person who receives it.

Quality life: The term has been used to refer to an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.

Also refers to their physical, psychological, level of independence, social relationships religious beliefs and their relationship to their environment that affects the wellbeing of an infected and affected person.

Syndrome: Refers to a collection of specific signs and symptoms that occur together and that are characteristic of a particular condition. A person infected and affected with HIV/AIDS will show the following characteristics: shock, denial, depression, anger and a feeling of displacement.

Also refers to a condition that develops after the body's immunity has been destroyed.

Utilization of counselling service: the terms have been used to refer to the willingness to seek and use professional help/assistance provided by those working in the health facilities.

Also means how people go to the counselling centers to seek services that can help them cope with HIV/AIDS.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter is a review and summary of literature on the prevalence of HIV/AIDS pandemic, psychological issues that affect the quality of life, access and utilization of HIV/AIDS counselling services. The influence of HIV/AIDS counselling services on the quality of life in selected churches, the attitude of people to HIV/AIDS counselling in selected churches and the relationship between selected demographic characteristics (gender, age, education and social economic status) and uptake of HIV/AIDS counselling services. The literature review also includes a theoretical framework for the study.

2.2 HIV/AIDS Pandemic

HIV/AIDS has been acknowledged as a global health crisis and has been describe as an epidemic a term that denotes the presence of a new disease in a region or an existing disease which rises to higher levels than normally found in the population. The Webster dictionary also defines epidemics as diseases affecting the greatest number of people in communities at a certain time. It further describes pandemics as widespread epidemics (Muraah and Kiarie, 2001). The spread of HIV/AIDS fits this definition as it has swept around the world and in recent years has center on African Countries. According to Bekele (2000), the Director of UNAIDS, briefing on AIDS in Dakar, Senegal, Sub-Saharan Africa is the worst hit region by the global AIDS pandemic with almost 26 million of the estimated 40 million infected with HIV world-wide. Almost five million new HIV infections recorded in 2005, 3.2 million were in Africa. HIV/AIDS is a major concern to this study since many people in Africa and especially in Kenya are affected and infected by the pandemic.

When a person is infected with the HIV virus the person may show different signs and symptoms. According to the Family Planning Association of Kenya (FPAK) the following signs and symptoms are commonly associated with HIV; acute unexplained weight loss, pneumonia (lung infection), diarrhea lasting for several weeks, a white coating on the tongue, enlarged or sore glands in the neck or armpit, a cough that persists for more than one month, persistent fever and night sweats, vaginal infection, loss of appetite and skin problems like rashes, wounds/ulcers. Although, these symptoms may characterize other diseases for example persistent coughs may be a symptom of tuberculosis, diarrhea may indicate intestinal illness therefore a test should be carried out to confirm the presence of the virus

(FPAK, 2001). Many people do not know they are infected because they have not fallen sick or gone for testing. These symptoms are relevant to this study because they indicate the experience many PLHWAs are going through and their need to cope with these symptoms.

HIV/AIDS affects the society in a great way since infections are seen to affect people of all ages and all walks of life this has had a great impact in the society. HIV/AIDS is known to be transmitted when there is contact of infected mother's blood and infant's blood during delivery, through transfusion of HIV contaminated blood to an uninfected person, or when infected blood is mixed with uninfected blood of another person through an open wound gotten through circumcision or surgery this could happen when the same knife is used or the sterilization technique is not used or is broken (FPAK, 2001).HIV spreads from person to person when body fluids especially blood of an infected person mixes with blood of a person not infected. The pandemic has continued to spread silently through; unprotected sexual intercourse (vaginal, oral, and anal) with an infected person (Jackson, 2002). The spread of HIV is a concern to this study, since the church and society have been greatly affected by this pandemic many people continue to lose their lives or have the challenge of living with the virus or having to take care of someone affected by the pandemic. This information indicates there is a need for people to understand how HIV is transmitted this will help in reducing the spread of the epidemic. HIV can affected anybody this calls for everyone to uphold hygiene standards and avoiding body fluids from other people by using protective measures like using gloves.

2.3 Churches Involved in HIV/AIDS Counselling Services

Churches have also joined to support those infected and affected since many of them are church members or have relatives who are church members. The Africa Inland Church addresses HIV/AIDS through its AIDS division. The AIDS division has three programmes for HIV prevention through awareness creation. The first programme is "Choosing hope" which targets youth in college & universities. A training curriculum has been developed for this. The Second programme is 'why wait' this is a programme for primary and secondary schools and is taught to students in church sponsored schools. There is also a programme for the church as a whole which continues throughout the year while the other two take place during the school term. The Africa Inland Church also offers counselling services through its hospitals like Kijabe, Tenwek, Litein, Kapsowar, Bethsaida and Parkview (Mulonzya, 2003). Africa Inland Church has no statistics on the impact of its work or the beneficiaries of the

different counselling services this creates the need for this study the church has developed AIC Shabab (Bethsaida clinic) in Nakuru East Sub County that has a fully operational Counselling services.

The Presbyterian Church of East Africa began work on HIV/AIDS in late 1980's when its three hospitals Chogoria, Tumutumu and Kikuyu started to include HIV/AIDS information in their outreach programme within their catchment areas. The hospitals offer voluntary counselling and testing services. While the bulk of the church's work is in the prevention of HIV/AIDS it has also addressed issues of work and human rights for people living with and affected by HIV/AIDS. The church has no statistics of the people reached by its HIV/AIDS programmes (Mulonzya, 2003). Although the church has established the programmes in response to the pandemic its lack of documented evidence creates the need for this study. The church has established Nakuru West Dispensary that runs a fully operational HIV counselling center in Nakuru East Sub County.

The Roman Catholic Church in Kenya responds to HIV/AIDS in a holistic way and approaches it as a suffering of the human person. The Roman Catholic Church responds to the disease in five areas. Through formal education in schools in collaboration with the Ministry of Education and informal education provided to out of school youths with an emphasis on behavior change (Mulonzya, 2003). The church provides treatment this entails institution based care and home based. Institution based is offered to people living with HIV/AIDS and it's done in the church's hospitals and clinics spread across the country. Home based care entails the visit of people living with and affected by HIV/AIDS in their homes offering treatment and counselling and meeting other needs such as food or cleaning. Stigma reduction attention is given to people living with and affected by HIV/AIDS they are encouraged to live positively. The church is also involved in taking care of orphans this is accomplished through institutional care or community based care. Prevention of mother to child transmission of HIV is done in the church's 39 hospitals and over 500 health centres spread throughout the country (Mulonzya, 2003). The Catholic Secretariat and the Christian Health Association of Kenya created the Mission for Essential Drugs (M.E.D.S.) which is the only Pharmaceutical entity that provides cheap antiretroviral in the country. The church in collaboration with the Ministry of Health and National AIDS Control Council has participated in the formulation of guidelines and policies on laws to prevent and manage HIV/AIDS. The church has no statistics of the beneficiaries of the different HIV/AIDS

interventions or an indication of the impact of its work (Mulonzya, 2003). This lack of documented evidence of the outcome of these services creates the need for this study. The church has established the Catholic Diocese of Nakuru (CDN) VCT, which is fully operational.

2.4 Quality of Life of Church Members

World Health Organization (WHO) define quality of life (QOL) as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns(Taffa & Nyamongo, 2004). This definition emphasizes the importance of an overall subjective feeling of well-being pertaining to aspects of morale, happiness and satisfaction. QOL, therefore, relates to both an adequacy of material circumstances as to how satisfied an individual is with these circumstances of life (Cummins, 2007). The way an individual perceives himself greatly affects the way he handles himself when alone and when he has people around him. For one to have a high self-esteem an individual must be able to achieve their goals, meet their expectations, maintain their standards and address their concerns this is greatly affected when they realize they are infected or affected and cannot achieve these expectations. One's perception influence their morale, happiness and satisfaction in life. This study seeks to find out how counselling services influence the QOL of life of church members in selected churches in Nakuru. The study expects when a person access counselling services this have an influence on their QOL.

It usually refers to the degree to which a person's life is desirable or undesirable. QOL comprises a collection of interacting objective and subjective dimensions, which may change over time in response to life, health events and experiences. Quality of life can also be explained by asking questions such as, how much is your income? (This suggests objective aspects of QOL) and how satisfied are you with your income? (The question conveys the subjective aspects of QOL). The assessment of QOL as a measure of treatment outcomes has become popular in Medicine because the concept of QOL itself captures exactly the notion that the ultimate goal of medical intervention is to improve the quality of life of the patient (Olusina & Ohaeri, 2003).This study is concerned with the quality of life of a PLWHAS anything that makes a person feel fulfilled is a concern to this study.

While the health care system remains overstretched with increasing demand for clinical and palliative services, much of the burden of AIDS care in developing countries is now falling

onto households and communities (Taffa & Nyamongo, 2004). Sub-Saharan Africa has limited experience in assessing the impact of AIDS care and support programs on the quality of life among people living with HIV/AIDS (PLWHA), mainly due to lack of culturally validated measurement tools for health related quality of life (HRQOL) The demand for proper assessments of HRQOL becomes critical with increasing access for antiretroviral therapy and hence expected longevity of survival with HIV infection (Taffa & Nyamongo, 2004). Measurements of quality of life are a great concern to this study since the Kenyan government and the church have put in place counselling services to help improve the quality of life.

Through reflection on the sense of well-being and satisfaction experienced by people under their current life circumstances, the assessment of QOL aims to provide a comprehensive evaluation of the individual's well-being, which includes an assessment of their role functioning, community integration and personal adjustment (Olusina & Ohaeri 2003). This implies that HIV and AIDS does not only affect the physical well-being of PLWHA, but also the overall quality of life and the perceptions of various aspects of their lives and daily living.

2.5 Issues Influencing Quality of Life

There are many issues that influence the quality of life of people affected or infected by HIV/AIDS. These issues are social, physical, mental, emotional and economic in nature. As noted by Muraah & Kiarie, (2001) Patients and relatives are sometimes unable to pay hospital bills because of poverty; they also may find it difficult to afford a nutritious diet that the patient and the family require and purchase essential medicines. Both the family and other members of the community may lack the nursing skills required to manage HIV patients. Nursing of the patient may also take up a lot of time and the members of the family may be unable to continue with employment or other income generating activities These further drains the household income and greatly affects the quality of life of those infected and affected (Muraah & Kiarie, 2001). Care provision is very vital for those infected with HIV since the physical quality of their lives is greatly affected due to a low immunity that results in attacks by opportunistic illnesses.

Those infected often feel isolated and alone since HIV/AIDS scares people away from them (Willis, 2002). Managing one's health, visiting doctors and dealing with the changing working conditions and job skills loss occupies a lot of time thus often preventing people from spending time with others (Willis, 2002). PLWHAS experience fear because they don't

know what course the infection will take and they worry about the effects of the treatment. They also fear isolation through sexual rejection because of the fears of others concerning opportunistic infections, anticipating the partners and family inability to cope with the situation. The greatest concern however is about the possibility of physical deterioration or disability over time (Willis, 2002).PLWHAS face many fears when they realize they are infected to over- come these fears they need counselling so that they can cope with the pandemic

A common reaction when one is told they have HIV/AIDS is denial, anger and bitterness. For some being diagnosed with HIV positive results, result in a feeling of grief and shock, others feel numbness and complete absence of feelings. A person may deny positive results because he has always considered his lovers to be negative or has always been faithful to a partner. One may get angry because they got AIDS as a result of their own immorality or because their partner was unfaithful and therefore, it was not their fault. A person in denial or anger should be helped to accept the diagnosis and start living positively and face the facts that they are HIV positive (Sira, 2002). This study agrees with Sira, (2002) that PLWHAs go through many emotions such as anger, and denial once they realize they are infected they need counselling to help them cope.

Learning that one is HIV positive is frightening and very traumatizing. Once the diagnosis of being HIV positive is made, one goes through several stages. One experiences shock, fear, and anger and later gets into depression. Research shows that serious depression affects six out of 10 people living with HIV/AIDS (Gutman & Fullem,2009). The behavior of the affected persons changes leading to denial and bargaining. Some other behavior changes would include isolation and self-neglect, infecting others and suicidal tendencies (Magutu, 2008). Some people experience acute stress disorder after a HIV-positive diagnosis, or after the death of a significant other. The overwhelming anxiety that the person usually experiences can seriously disrupt his social or occupational functioning (Sue, Sue, & Sue, 2000). People often go through a lot of stress once they learn that they are affected or infected by HIV/AIDS this may lead one to change his behavior positively or negatively. The individual may need counselling to help them develop positive behavior.

Those infected and affected experience a lot of stress in their lives and because stress has a very negative effect on the immune system, increased stress often causes a decrease in the number of CD4 cells. It is, therefore, very important for HIV-infected individuals to learn

how to cope with stress. HIV-infected people should be encouraged to join support groups, to practice relaxation techniques, to visit friends, to talk to people, to obtain factual information about their condition from professional people and to ignore wild rumours and sensationalized anecdotal 'information' about AIDS. HIV-infected individuals should concentrate on positive living to promote health and well-being; they should think positive thoughts, not forget to see the funny side of things (even in their darkest moments), engage in enjoyable and life affirming activities and enjoy life to the fullest (Dyk, 2001). Dealing and coping with stress and seeking ways to reduce stress is very important to improve the quality of life. Those infected and affected need counselling to help them develop strategies that can help them cope.

Rejection by colleagues, friends and loved ones can cause loss of confidence and loss of social identity; leading to feelings of reduced self-worth. The inability to continue in a career or to participate in social, sexual and loving relationships also diminishes the person's self-esteem. The physical wasting and the loss of strength and bodily control contribute even more to lowering of self-esteem (Dyk, 2005). This person experiences a reduced quality in their lives because their social relationships are greatly affected by the low self-esteem and image.

2.6 The Access and Utilization of HIV/AIDS Counselling Services

In recent years, HIV testing and counseling (HTC) has been a major feature of the HIV response in Kenya. The country has adopted a number of strategies including provider initiated testing and counseling (PCT), outreach testing and counseling, home-based testing and counseling (HBT) as well as the integration of HTC in antenatal care, sexually transmitted infections (STI) and sexual and reproductive health services. According to the National AIDS Control Council of Kenya report on Kenya Aids Response progress (NASCOP, 2014) there has been dramatic progress in terms of the number of people getting tested for HIV. In 2000, there were just three voluntary counseling and testing (VCT) sites in Kenya; by 2010 there were over 4,000. This information is relevant to this study since it indicates there is an increase in access to counseling services and more people have utilized provided by the government and other stakeholders in the health sector.

As observed by Kenya National Bureau of statistics(KEBS,2015) in their Kenya Demographics and Health survey in 2014 statistics show in 2008, 860,000 people were being tested annually for HIV, by 2013; this had increased to 6.4 million. Though annual testing

rates have nearly doubled since 2008/2009; there remains a significant disparity between men and women. In 2014, 53% of women had tested for HIV in the past 12 months and received their results, alongside 45% of men. To address this, there has been a concerted effort to increase testing rates among Kenyan men with community-based testing programmes proving successful in particular. Like HTC coverage among the general population, testing rates among pregnant women have risen substantially. From 2009 to 2013, the percentage of pregnant women tested for HIV increased from 68% to 92% (NASCOP, 2014). Although those accessing HTC have greatly increased to 6.5 million in Kenya there is still a gap on access to counseling services shown by this statistics more women than men are said to be accessing counseling services. These statistics inform this study since they provided a basis for seeking to know the influence of counseling services on the quality of life of people infected or affected by HIV/AIDS.

People are becoming more aware of counselling services a study recently carried out in Nicaragua shows many people are now seeking counselling services unlike ten years ago when only a few had access to HIV test and getting tested was difficult. Fear of AIDS, and the stigma that came with being HIV-positive, also stopped people from discovering their status. “Nowadays people are more respectful of those who are HIV-positive, especially family members,” says Graciela Argüelles, a counsellors at Association Information and Counselling on sexually transmitted diseases, which is a non-profit organization sponsored by Department For International Development (DFID) since 2004 (Yanet, 2007). More people are well informed and have increased their knowledge on HIV/AIDS this has greatly reduced stigmatization and has led to more respect and understanding of those infected or affected by HIV/AIDS.

Kenya announced universal access to HIV treatment to all in 2003 only 6000 people living with HIV were accessing ART, but by 2013 this had increased to 596,000 adults and 60,000 children. This equates to 42% of adults who are in need of treatment receiving it, and 31% of children (UNAIDS, 2014). These statistics are relevant to this study since they show that Kenya has made strides in the provision of counselling services especially antiretroviral therapy. Kenya has worked on universal access for all individuals this has meant more people can access and utilize the services that have been brought as close as possible to people.

There is a need for more awareness of the importance of accessing and utilizing counseling services. A study was conducted by Irungu, Varkey and Patterson (2008) to determine the

extent of utilization of VCT, and to study the attitudes and preferences of the community regarding VCT in Nakuru sub County in Kenya. Results show that the majority of the studies participants (184 of 287; 64.1%) had never been tested for HIV; 77 (26.8%) had received VCT, and 26 (9.1%) had received HIV testing without counseling. A total of 219 (78.2%) of the 280 responding participants expressed readiness to have VCT. The majority of participants (216 of 296; 73%) preferred VCT, while 46 (15.5%) preferred testing without counselling. The majority (227; 76.7%) preferred couple testing and dedicated clinics and private doctors' offices as testing facilities. The choice of a nearby facility was ranked above the provision of anonymity by most participants (162 of 298; 54.4%; vice versa for 136 of 298; 45.6%). The study involved a total of 301 adults, aged 18-49. The results of the study also show that although VCT is one of the methods of controlling HIV/AIDS many people do not access VCT (Irungu, *et.al*, 2008). Although HIV/AIDS testing services have been established many people are yet to utilize the services. HIV/AIDS continues to be a major public health concern in Kenya, the issues surrounding acceptance and use of VCT need to be addressed. Enhancing community awareness of the benefits of early HIV diagnosis, providing couple-based VCT as an integral part of VCT and increasing access to VCT testing sites may increase utilization of VCT.

As access to ART and PMTCT programmes become a reality in much of Africa where HIV infection in women is disappointingly high many HIV-infected women would need better access to VCT if they are to benefit from these initiatives (UNAIDS, 2006). VCT would provide HIV-positive women with the means to enroll into treatment and care programmes as early as possible (WHO/UNAIDS 2007). The government has continued to provide PMTCT programmes.

Mother to child transmission of HIV is responsible for most HIV infections in children. A pregnant woman who is HIV infected is 30% to 40% likely to transmit HIV to her new born child. The baby can become infected during pregnancy, during labour and delivery or through breast milk. Most infected children acquire the infection from their mother at or around the time of birth. The number of children who are infected can be reduced through preventing transmission of HIV from infected pregnant women to their infants (PMTCT) services which include antiretroviral drugs such as azydothymidine (AZT) and nevirapine given during pregnancy or labour or both can reduce viral load in the mother and reduce by half the risk of her transmitting HIV to the new born child. Azydothymidine (AZT) is taken in the last few

weeks of pregnancy and during labour. Nevirapine is taken at the onset of labour and given to HIV exposed babies within three days after birth (NASCOP, 2005). This study agrees prevention of infection from mother to child is very important and everything possible should be done to ensure that a child is free of HIV infection. The government has put in place mechanism to ensure HIV positive mother can access these drugs mostly freely from government hospitals to help reduce viral loads and prevent transmitting HIV to the child.

Another PMTCT service is the use of modified obstetrical practices which reduce trauma and shorten exposure of the baby to the virus during labour and delivery. Practices include ensuring that a woman gives birth within four hours after the membranes rupture (the water breaks) avoiding routine episiotomy, avoiding prolonged labour, minimising the use of the vacuum or forceps delivery and choosing to use caesarean section (NASCOP,2005). Another PMTCT services includes the prophylaxis against opportunistic infections, treatments of HIV complications and antiretroviral therapy for eligible mothers, children and families (NASCOP, 2005).

The government has increased the number of people accessing HIV/AIDS testing (HTC) through encouraging the use of home based VCT. HIV counselors offer HTC services in clients' homes (Matovu *et al.* 2002; Were et al. 2006; Yoder *et al*. 2006). Home-based VCT eliminates the cost of transport to the test site (Wolff et al. 2005) and increases uptake especially among women, as they do not need to seek permission for VCT or money for transport to VCT sites from male partners (Matovu et al. 2005, Msuya et al. 2006, Thior *et al*. 2006). This approach can also reduce stigma associated with being seen at the VCT clinic (Yoder *et al*. 2006).This study agrees there is a need to improve the uptake of counselling and testing services for people. The government has put a lot of effort in bringing voluntary counselling and testing services as close as possible to people including going house to house to provide the services.

In a Zambian study of VCT acceptability of participants randomized to receive VCT either at the local clinic or at an optional location (i.e. home, local clinic or other venue of choice), 55.8% of participants allocated to an optional location took VCT, whereas only 11.8% of those allocated to the local clinic took the test. This shows a high percentage preferred the optional location as opposed to the clinic. Those who choose the alternative to the clinic choose to have their counselling and testing at home (Fylkesnes & Siziya 2004). In a study that assessed the uptake of home-based VCT provided alongside a population-based survey in

selected regions of Uganda 86% of participants received HIV test results and post-test counselling (83% of men and 88% of women); 93% chose to receive both at home. Home-based VCT reduced the cost in time and money to travel to a facility, and as one participant reported, 'no one can tell what is happening in your home so they cannot spread unnecessary rumors, but if they see you going to a health centre they begin to suspect that you might be sick and to ask you questions' (Yoder *et al.* 2006). The household members of HIV-positive persons often are also infected (Kabatesi *et al.* 2002), but unfortunately, are frequently unaware of their HIV status (Were *et al*. 2006). These studies show Home-based VCT can effectively reach many people and ensure people access services at the comfort of their homes. Home based HTC provides family members with an opportunity to learn their HIV status and gain access to appropriate HIV prevention, treatment and care services and increases the uptake of these services.

A significant part of church's ministry is counselling members so that they may cope with spiritual, social, psychological and physical challenges that they face on a day to day basis. The church guides the parishioners through the use of scriptures in solving their problems. It is through counselling that, the church attempts to provide encouragement and guidance for those who are facing losses, indecisions, or disappointments. Counselling stimulates personality growth; development and helps people cope effectively with the problems of living with inner conflicts and crippling emotions (Chacha& Bowers, 2005). The church provides hope, reconciliation, and the purpose for living by counselling those infected or affected by the HIV/ AIDS pandemic. It is in this regard that the work of Churches in Nakuru East Sub County is important to this study.

Counselling in HIV/AIDS has become a core element in a holistic model of health care in which psychological issues are recognized as integral to patient management. HIV and AIDS counselling has two general aims the prevention of HIV transmission and the support of those infected and affected by HIV. It is vital that HIV counseling should have these dual aims because the spread of HIV can be prevented by changes in behavior. One to one counseling has a particular contribution in that it enables frank discussion of sensitive aspects of patients' life and such discussion may be hampered in other settings by the patients concern for confidentiality or anxiety about a judgment response. Also when patients know that they have HIV they may suffer great psychological stress through fear of rejection, social stigma, disease progression and the uncertainties associated with future management of HIV

(Chippindale & French, 2001).This study agrees that counselling is very vital in disease management since it helps prevent infections, help in behavior change and help one cope with stress.

Supportive counselling provides emotional and psychological support to PLWHAs (People Living with HIV/AIDS) and offers encouragement, hope and help clients cope with their situation. According to Bakusi, (2007) this form of counselling carried out several times assist the client cope with the different challenges that they might experience during the course of their illness. These challenges may arise from issues in their families, their work place, their social life and many other related areas. Some of the elements of supportive counselling are: helping clients identify sources of support; providing referrals to these services, providing counselling on survival skills and positive living (Bakusi, 2007).

Nutrition information is very vital for any person living with HIV. HIV and nutrition are so strongly linked; nutritional assistance is seen as an important part of the response to HIV. This may take the form of nutritional assessment, counseling, or food provision. Nutritional assessment helps HIV positive people receive appropriate treatment, care and nutritional support. Even in the poorest settings, according to the World Health Organization Screening for nutritional status and assessment of dietary intake should be included routinely in HIV treatment and care for adults and children (WHO, 2005).

The US, Department of Health and Human Services advises that, ideally, all people living with HIV should have access to the services of a registered dietician with expertise in HIV/AIDS (HRSA, 2004). A dietician can assess the patient's diet, lifestyle and nutritional status, and provide counseling and referrals as necessary. Nutritional counseling may include education on various topics, including: Healthy eating, achieving or maintaining a healthy body weight, managing lipid abnormalities and lipodystrophy, managing dietary complications related to antiretroviral treatment, managing symptoms that may affect food intake ,appropriate use of herbal and/or nutritional supplements, the role of exercise and food safety (important for preventing opportunistic infections) (HRSA, 2004). People infected and affected by HIV must be aware of nutrition information for effective management of their diet this is very crucial in improving the quality of their lives.

Providing food supplements to malnourished patients on antiretroviral treatment can increase programme success (WHO, 2005). Some programmes have been established to help people

living with HIV by providing a limited amount of food to those most in need. For example The United States President's emergency plan for AIDS Relief also known as PEPFAR funds such programmes. The fund supports provision of food, particularly for Orphans and vulnerable children born to HIV infected parents, HIV-positive pregnant and lactating women and malnourished adults in antiretroviral therapy and care programmes (PEPFAR, 2010). Many people living with HIV/AIDS have challenges with food since most of them maybe bedridden or have lost their jobs and are unable to fend for themselves they depend on well-wishers and relatives to provide meals and assist in any way for their lives to continue.

The government has continued to seek ways to reduce the spread of HIV especially among men. In 2008, Kenya implemented the voluntary medical male circumcision (VMMC) for HIV prevention programme. The programme aimed to circumcise 860,000 males aged 15-49 by 2013 to achieve universal coverage (80%).The number of VMMCs performed annually has increased dramatically, although by the end of 2013 only 670,000 VMMCs were performed, about 77% of the original target, with roughly 50% of Kenyan men aged 15-19 circumcised. Regions with the highest HIV prevalence among uncircumcised adult males - Nairobi (20.2%), Nyanza (17.3%), Rift Valley (7%) and Western (6.8%) were selected as priority regions for the implementation of VMMC (CDC,2012), 80% of all operations were conducted in the Nyanza region(NASCOP, 2014). In 2012, a new initiative was introduced to boost the number of men being circumcised annually. It involved handing out vouchers to men who had the procedure, which could be exchanged for money upon attending a follow-up appointment. They were also encouraged to bring a friend who was interested in becoming circumcised (IRIN, 2012). Upon the implementation of (VMMC) many men are changing their perception on circumsion and have embraced this to prevented HIV infections. The church facilitates also provide circumcision services to church members and the community. Counseling on HIV/AIDS related issues are also addressed before the operations and follow-up services are also available for clients.

2.7 Influence of HIV/AIDS Counselling Services on the Quality of life.

Counselling services help those who access counselling to plan for their future better. If the individual is HIV negative the result of testing motivates them to stay with a positive mind by avoiding risky behaviour or taking appropriate protective measures for example using condoms, keeping to one sexual partner or practising total abstinence (Muraah, & Kiarie 2001). After receiving counselling many people change their lifestyles and begin to protect

themselves and others. They also participate in the HIV/AIDS awareness campaigns that are essential to contain this pandemic. Some come out and lend their names to specific campaigns involved in the fight for HIV/AIDS control or live with the virus without revealing it to others but embrace and campaign HIV/AIDS causes (Muraah, & Kiarie 2001).

Counselling services help deal with feelings of guilt and overall anxiety which if not managed in time may result in self-destruction including suicide and depression. People with HIV/AIDS often experience depression because they feel that they have lost so much in life and that they have themselves to blame. Dyk (2005) suggests that the following factors also increase depression: the absence of a cure leads to feelings of powerlessness, knowing others who have died of AIDS; the loss of personal control over their lives and self-blame. Clinical depression is the most observed mental health disorder among HIV infected patients affecting up to 22% of patients. The prevalence may even be greater among substance abuse users (Komiti, Judd, Grech, et al, 2003). Depressive symptoms have been associated with risk behaviour, non adherence to medication and shortened survival. Although sadness and grief are normal responses to the many of the consequences of HIV infection, clinical depression is not. Failure to recognize depression may endanger both patients and others in the community. Patients with depression are at higher risk for comorbid psychiatric, alcohol and substance use related disorders particularly alcohol, cannabis and cocaine use. (Horberg, Silverberg, Hurley et, al, 2008) Depression continues to be one of the challenges faced by those infected and affected. Counselling services help patients to develop a positive state of mind towards themselves as human beings helping them to deal and cope with their depression and other challenges they may be experiencing.

People living with HIV are living longer and AIDS-related deaths are declining due to the lifesaving effects of antiretroviral therapy. Globally there were an estimated 34 million people living with HIV in 2010, and since 2005, AIDS-related deaths decreased from 2.2 million to 1.8 million in 2010. Around 2.5 million deaths are estimated to have been averted in low- and middle-income countries due to increased access to HIV treatment since 1995. Around 400 000 new HIV infections in children are estimated to have been averted since 1995 due to increased access to effective antiretroviral regimens in low- and middle income countries by 2010, almost half (48%) of all pregnant women living with HIV were able to access effective regimens to prevent their children from becoming infected with the virus(UNAIDS,2011).

Antiretroviral therapy (ART) has brought important benefits to HIV-infected patients, such as increased survival, better quality of life, significant reduction in the incidence of opportunistic infections and lower costs related to ambulatory care and hospitalization. The Kenyan government is committed to provide universal access to HIV testing and counselling for all. ART is the most effective intervention for prolonging survival in people with HIV, and when taken regularly, is associated with a 90% reduction in deaths caused by AIDS. According to the Ministry of Medical Services, ART is increasingly available in Kenya with more than 500 sites offering ART to about 190,000 adults by June, 2008 (KAIS, 2008).Counselling services offered in the Church provide open and free discussion about impending death, loneliness and powerlessness. Religious and spiritual counselling helps a HIV positive person to forgive and reconcile his feelings with those of others. In such a case belief in religion and spirituality gives hope for the future beyond earthly existence. This improves the patients' self-esteem and dignity.

Since their implementation VCT programmes have demonstrated the ability to promote safe sexual behaviour and provide care and support services among adults(Matovu, Kigozi, Nalugoda, Wabwire, Mangen & Gray, 2005). VCT has the following benefits it assists individuals to make better decisions about their sexual behaviours and reduce transmission risk; It provides prevention counselling which helps to reduce sex partners, increase condom use, reduce incidence of STIs, reduce Mother-to-Child Transmission of HIV (MTCT) and generally make people more aware of HIV/AIDS and take steps to avoid it. If people know they are HIV positive, they are more likely to adopt safer sex, reduce partners and risky sexual behaviour and so reduce transmission to others; It provides early access to care (opportunistic infections and TB), and support services therefore reducing ill health. It provides confidentiality and thus more people are able to come for testing. And the more people learn of the confidentiality available in VCT, the more this will create demand for the services. In the long term, the spread and use of VCT services will result in reduction of stigma, more clients will get HIV results hence HIV will become normalized, people will view it as an ordinary condition(Bakusi, 2007). This study agrees VCT programmes have been beneficial to people once they are accessed and utilized people get to know their status and make informed choices concerning their sexual relationships and their lifestyles this may lead to behaviour change. They also receive information and treatment that reduces transmission of the virus to others especially infants and improves the immunity in the body.

2.8 Perceptions and Attitudes of People towards HIV/AIDS Counselling Services

Though awareness of HIV and AIDS is comparatively high in Kenya, many people living with HIV face high levels of stigma and discrimination. This deters many people living with HIV, particularly vulnerable groups, from seeking vital HIV services (NASCOP, 2014). For example, many reports from Kenya have shown how pregnant women often do not test for HIV because they fear stigmatization from their family or healthcare workers (NASCOP, 2014). Accepting attitudes among the general population towards people living with HIV increased in Kenya between 2003 and 2009, rising from 27% to 33% among men, and from 39.4% to 47% among women. However, levels of stigma and discrimination remain too high to foster an environment for a more effective national HIV response (NASCOP, 2014). Those infected and affected still experience a level of stigma although due to increased awareness the levels have been reduced significantly there is still a need to do more on stigma reduction. All stakeholders have a responsibility to lead in stigma reduction.

A study carried out on knowledge, attitude, behavior and practice on Kenyan church leaders conducted by MAP International indicated that 60% of church leaders have received no counseling training on AIDS and STD's, 69% believe that the church lacks trained personnel to educate its people about AIDS and 96% believe that AIDS and sexuality should be taught in the churches. A further 53% identified lack of training as the biggest problem in counseling (Map International, 2000). This study agrees there is still a knowledge gap in the church concerning HIV/AIDS, more trainings should be conducted in the churches to increase people awareness levels this will help reduce discrimination and stigma in the church and community.

Rev Chege, of the Redemption World Crusaders Ministries, Before allowing weddings the church demanded health certificates and if one turned out positive we would tell them it was pointless to bless their union. Since they were about to die. Eventually, couples began producing fake health certificates or simply stopped coming to his church. Church leaders at the meeting committed themselves to training peers and congregants so as to change their attitudes to HIV/AIDS, promote responsible practices to help prevent transmission of the virus, encourage voluntary counseling and HIV testing, and educate children about HIV and AIDS (Plus News, 2009). Pastors and church leaders must come out strongly to help the church change their attitudes towards those infected and affected by HIV/AIDS, educate

members on responsible sexual behavior and inform them of available counselling services on HIV/AIDS.

During the same conference mentioned above Rev Canon Byamugisha of the Uganda Anglican Church emphasized Church leaders should know they are fighting a battle that can be won; they need to know that AIDS is preventable, manageable and defeat able. This is because we in the church have the means, the audience and the mandate to tackle the AIDS problem; moreover, we have God on our side. The perception of a person greatly affects the way he reacts to people infected and affected by the pandemic (Plus News, 2009).There is a need for church leaders to change their perception and attitude towards HIV/AIDS so that they can fight the pandemic effectively.

The involvement of religious leaders has been fundamental in bringing about change. Reverends, pastors, priests and community leaders have come together in a regional network to work collectively against HIV and AIDS. Also, by preaching against discrimination, they have encouraged more people to seek information and counselling. Churches and religious leaders are committed to the struggle against HIV and AIDS. Without them, we couldn't possibly have come this far acknowledges Yanet Lopez, the Nicaragua Ministry of Health's HIV and AIDS Regional program Coordinator (Yanet, 2007). Changing attitudes of religious leaders and counsellors is vital in increasing the uptake of HIV services.

Counsellors sometimes lack professional knowledge and skills this leaves them feeling inadequate to handle HIV positive people. Lack of competence leads to psychological stress and possibly burnout in medical staff. Counsellors may cope by distancing themselves from the reality of the situation. They become insensitive and cold towards patients. Alternatively they become too involved with patients, eventually finding they cannot cope and leave the job (Jackson, 2002).

HIV counsellors are trained people who provide pre and post-test counselling to clients who present for HIV test counselling and this involves giving accurate information about testing which will enable the clients to make informed decisions about testing (Adekeye, 2010, Hubley, 2002, UNAIDS, 2007). As part of their daily routine HIV counsellors come across the HIV infected and by training they are expected to promote acceptance, care and provide support systems. Dyk (2001) noted that as part of their routine HIV counsellors are expected to counter the negative attitude displayed by the society towards the HIV infected. Thus HIV

counsellors are positioned to help people undergo the HIV test by providing pre and post-test counselling. Counsellors have a role in providing pre and post counselling to individuals seeking HIV testing to know their status they also assist in changing the attitude of people towards HIV/AIDS. Counsellors also help promote acceptance, care and provide support for those affected and infected by HIV/AIDS.

2.9 Influence of Demographics on uptake of HIV/AIDS Counselling Services

A number of countries in the region have implemented national campaigns to encourage uptake of HIV testing. Botswana, Kenya, Uganda, Malawi and Rwanda are some of the countries that have conducted testing campaigns that increased the numbers of people tested in 2010. Overall, nearly 6 million people, aged over 15 years, received HIV testing and counseling in Kenya in 2010, an increase of over a million compared to 2009 figures (WHO, UNAIDS & UNICEF, 2011).Rwanda has also succeeded in improving the number of people receiving HIV testing and counseling, with 469 per 100,000 individuals over 15 years receiving this service in 2010, a total of 2.4 million individuals have received the services (WHO, UNAIDS & UNICEF, 2011). In South Africa, the number of people receiving HIV testing and counseling has significantly increased in recent years as a result of the governments national HIV testing campaign. However, whilst the estimated number of people receiving HIV testing and counseling in 2010 was more than 6.5 million, this is notably less than in 2009 when nearly 7 million people received testing and counseling (WHO, UNAIDS, UNICEF, 2011). This statistics are relevant to this study since they reflect the country response to the need for universal access to counselling services. The statistics also reflect the gradual success of the various countries involved in the fight against the pandemic.

The government has developed several strategies to ensure more people access counseling and testing. One of the 2010 targets set in Kenya's National HIV and AIDS Strategic Plan 2005/06 -2009/10 (KNASP II) was to test 2 million Kenyans for HIV annually (NASCOP,2010). In order to reach the target, international development organizations and the Kenyan government introduced a number of new initiatives. One such programme, launched in late 2009, aimed to provide door-to-door HIV testing and counseling for those living in remote areas with little access to health care (NASCOP, 2010). The government enhanced focus on testing has been reflected by the percentage of adults aged 15-49 years who report ever being tested for HIV. Increased testing rates have meant that record numbers

of Kenyans have been tested in recent years. In the year 2010, it is estimated that more than 5.7 million Kenyans aged 15 years and over received HIV testing and counseling (WHO,UNAIDS,UNICEF, 2011). This study agrees that testing has increased and more people are now aware of their HIV status and have also received basic counselling on how to deal with the pandemic.

According to the 2009 Kenya Demographic and Health Survey, 73.5 percent of women and 58.6 percent of men have been tested at least once (WHO, UNAIDS&UNICEF, 2010). Results show the female gender is more affected by HIVAIDS than the male gender. An estimated 1.5 million people are living with HIV, around 1.2 million children have been orphaned by AIDS and in 2009, 80,000 people died from AIDS related illnesses. Women were disproportionally affected by HIV in 2008/2009. HIV prevalence among women was twice as high as that for men at 8% and 4.3% respectively. This disparity was even greater in young women of the same age 15-24 who were four times more likely to become infected with HIV than men the same age. Kenyan women experienced high rates of violent sexual contact, which was thought to contribute to the higher prevalence of HIV. Adult HIV prevalence was greater in urban areas (8.4 percent) than rural areas (6.7 percent) of Kenya. However around 75% percent of people in Kenya live in rural areas the total number of people living with HIV is higher in rural area (1 million adults) than urban settings 500,000 adults (UNAIDS 2010). Kenya has developed different strategies to ensure the Kenyan population access counselling services, the government has increased the uptake of this services by going door to door to provide the services this is important to this study since this shows the efforts that have been made to increase universal access to counselling services.

Statistics show that 2.5 million children under the age of 15 years are living with HIV/AIDS in the world, among these 90 % live in sub-Saharan Africa (UNAIDS, 2004). Mother to child transmission (MTCT) of HIV is responsible for more than 90% of pediatric HIV infection in sub-Saharan Africa. In breast feeding communities the risk of MTCT of HIV ranges from 20 to 45%. The Interventions in Prevention MTCT with Highly Active Anti Retroviral Therapy (HAART) can reduce MTCT below 2% (UN AIDS, (2004). Similarly VCT acceptance rate of 54% to 74% was reported in studies done in Zambia (72%), Zimbabwe (74%), Tanzania (54%) and Cote D'ivore (62%) (Freddy P *et.al* 2004). This study agrees there is a need to increase acceptability of PMTCT programmes so that mother to child transmission of the HIV virus can be reduced.

There are various factors that determine the uptake of counseling services. According to studies done in United States, Tanzania, Uganda, Vietnam and other developing countries factors that determine VCT acceptance include socio-demographic factors like age, educational status, marital status and religion. Individual cognitive and affective attributes such as knowledge on HIV/AIDS and benefits of HIV testing. Relational factors like fear of husband's reaction, divorce, violence, stigma and discrimination by community and service providers. Health service related factors such as type of diagnostic test, couple counseling, confidentiality and access to continuous medical care greatly influence the uptake of counselling services (Paulo, Amaha, Sileshi &Ayele, 2007) This study seeks to find out whether this factors actually affected the uptake of counselling services.

Education is one of the most effective tools in preventing HIV infections. More should be done to ensure people are educated on HIV related issues. An estimate from the global campaign for education suggest that if every child received a complete primary education around 700,000 new infection in young adults could be prevented every year (UNAIDS,2005). Education is particularly important for protecting girls against HIV infection. Schools can teach vital HIV prevention methods such as condom use, having fewer sexual partners and the importance of greater communication about HIV prevention between couples. Also girls who frequently attend school are more likely to be able to make decisions about their sexual lives more independently and are more likely to earn a higher income in the future (UNAIDS, 2005).

Those educated are seen to also have a low prevalence to HIV as compared to those not educated. According to the 2007 Kenya AIDS indicator survey women age 15-64 with higher educational levels have significantly lower HIV prevalence than those with less education. Those with primary education have a prevalence of 10% compared to 7% with secondary education and 4% with tertiary education. Prevalence among women who have never attended school is 7%. For men, there is also a decrease in HIV prevalence with higher levels of education but the differences are less pronounced and not statistically significant. This study is informed by these findings since education is vital when fighting against the HIV pandemic since those educated are aware of ways to prevent infections or to seek available counselling services.

HIV education and awareness is an important component of HIV prevention in Kenya. As indicate by the Government of Kenya (GOK, 2013) the Education Sector Policy on HIV and

AIDS 2013 aims to develop programmes to enhance HIV prevention, care and support for school pupils as well as education personnel (e.g. teachers). It emphasizes that strategies must be gender sensitive because women and girls are disproportionately affected by the epidemic. HIV and AIDS education has been part of the school curriculum in Kenya since 2003. However, the 2014 Demographic and Health Survey found that only 54% of young women and 64% of young men aged 15-24 had comprehensive knowledge about HIV prevention (KEBS, 2015).The provision of HIV and AIDS education does not necessarily equate to lower HIV prevalence. For example, the Kenya AIDS Indicator Survey 2012 reported almost no difference in HIV prevalence between those who had completed primary education (6%) and those who had completed secondary education (5.8%). In fact, the lowest HIV prevalence was among people without any schooling (3.6%). Moreover, HIV prevalence was higher among women than men across all education levels (NASCOP, 2012). In contrast, one study among participants from both secondary schools and universities found that while both had very high levels of knowledge, knowledge was significantly higher among university students. This shows that education delivered in the correct way can be an effective means to empower people to protect themselves from HIV (Mwamwenda, 2014). HIV/AIDS education continues to be an effective tool in dealing with HIV prevention; more knowledge will enable people to avoid situations that can lead to infections. Whether a person is infected or affected information will empower individuals to know how to cope with their status. Education should be gender fiend to reach everybody.

One's social economic status is said to have an influence on an individual utilization of counselling services. Both men and women are said to access services this is influenced by various demographics. According to a Demographic and Health Survey (DHS) data from 13 countries in sub-Saharan Africa used to describe the pattern of uptake of testing for HIV among sexually active participants. Univariate and multivariate logistic regression were used to analyze the associations between socio-demographic and behavioral characteristics and the uptake of testing. Across all countries, large differentials in uptake with respect to level of education were observed among both men and women, with uptake being greatest among those with higher level education. Overall, with respect to socio-demographic characteristics, the trends were remarkably similar across all countries analyzed, for both men and women (Ide, Simon, Geoffrey & Simon, 2012). Among women, a strong significant positive association between wealth quintile and knowing one's HIV status was observed. Those women in the richest quintile were more likely to know their HIV status than those in the

poorest quartile. Odds ratios were not calculated for Ethiopia as 81.1% of women who tested and received their result were in the richest wealth quintile. A similar trend was observed for men with respect to wealth index. Although statistically significant, the differentials in uptake were generally not as great as those for women. The odds of testing and receiving results were between 2.9 and 15.5 times greater among those in the richest quintile as compared to the poorest (Ide *et al*, 2012). This study sought to find out based on this research whether various demographic characteristics influence the uptake of counselling services.

Women and men both access counselling services although more women are reported to be seeking counselling services as compared to men. Gender has been found to be a significant predictor in the uptake of VCT (Sherr *et al*.2007) Adult men are more likely than their female counterparts to report psychological deterrents to utilization of VCT yet have been found to require reassurance of their HIV status more frequently(Sherr *et al*.2007). In a study conducted by (Liiyasu *et al.* 2006) the author concludes that gender is a factor when determining the willingness of participants to have VCT with only 57% of male respondents willing to have VCT in contrast to 83% of females. However there is little information on VCT uptake among men and also on the factors that influence it. It is not known whether factors that influence VCT uptake in general population are also operational in VCT uptake by men only (Bassett, Giddy, Nkerra, Wang, losina, Lu, Freedberg & Walensky, 2007). Men utilization of VCT is important because in many societies including those in Kenya men are the heads of their households and control decisions and resources that are essential for HIV prevention and care. As Kenya works to consolidate gains in HIV prevention it is vitally important that men are fully involved in HIV prevention and control strategies.

A study carried out in Amherst Regional High school in Canada among the adolescents through self-administered questionnaires between November 1996 and November 1999. Show counseling services can bring an influence in different genders. The results of the study indicate sexual activity was similar in 1996 and1999 for males and was seen to decrease slightly in females. Sexual health knowledge scores increased in both men and women, both for those who were sexually active and those who were not. For males overall, attitudes towards condoms remained the same from 1996 to 1999, but the attitude of sexually active men became less positive. Females in both groups showed more favorable attitudes. Females had significant increases in their perception of societal support for their use of condoms, while males indicated a decreased perception of such support. Use of condoms at last

intercourse increased significantly in females from 1996 to 1999, but was essentially unchanged in males. Females' use of oral contraceptives at last intercourse increased from 49 percent to 58 percent (Amaratunga, 2002). When people access counselling service, research has shown they change their attitudes mostly in a positive way and begin to show a change of behavior this may lead to a decrease of infection.

Based on the study at Amherst Regional High School in Canada the following conclusions were made: young women showed a change in sexual health attitudes and behaviors, Young men however did not show much in the way of change over the three year period. Although men showed an increase in knowledge, changes in attitude towards condoms and perception of societal support for their use were essentially the same; attitude to condoms in fact became less positive. This was reflected in the finding that male' condom use at last intercourse remained unchanged. Despite the efforts made to include both female and male student's needs in sexual health promotion messages in both school based and community programmes, young women responded more favorable to these message than the young men (Amaratunga, 2002). This shows different genders are influenced differently by counseling services, women receive and apply these services more positively than men.

HIV/AIDS can have a pervasive impact on the vocational development of individuals living with this disease. Many studies have found a high incidence of unemployment among people with HIV, with some reporting rates of unemployment at 50% or higher (Burns *et al*. 2006 and 2007); (Dray-Spira *et al*. 2006). Although initial studies related to HIV and employment tended to focus on employer needs and co-worker responses, there has been an increasing focus on the actual vocational development and work-related experiences of people with HIV/AIDS (Conyers, 2004; Timmons *et al*. 2004). Research indicates that many people with HIV/AIDS are able to achieve vocational goals with vocational rehabilitations services (Conyers, 2004a; Escovitz &Donegan, 2005). Despite these findings, many people with HIV/AIDS face significant barriers to achieving their vocational goals and need the skills and services that rehabilitation professionals have to offer.

Research on Social Economic Status and HIV/AIDS suggests that a person's socioeconomic standing may affect his or her likelihood of contracting HIV and developing AIDS. Furthermore, SES is a key factor in determining the quality of life for individuals after they are affected by the virus. Those with fewer resources are often left with limited treatment options. A lack of socioeconomic resources is linked to the practice of riskier health

behaviors, which can lead to the contraction of HIV. These behaviors include earlier initiation of sexual activity and less frequent use of condoms (Adler, 2006).Among women, lower social standing and the experience of life stress are associated with riskier sexual practices. This finding suggests that while ethnicity is a critical factor in the HIV/AIDS epidemic for women, social class is also an important risk factor in HIV infection (Ickovics, Beren, Grigorenko, Morill, and Druley & Rodin 2002). SES is a key factor in determining the quality of life of people who are infected with HIV. Many of those associated with risk sexual behavior are said to have low social economic resources most of them are willing to have sex without protection at a fee.

Unstable housing has been linked to risk for HIV infection, including HIV drug use and unsafe sexual behaviors (Andale, Cross, Stall, Harre, & Sumartojo, 2005). Individuals who are homeless or in unstable housing arrangements are significantly more likely to be infected with HIV compared to individuals in more stable housing environments (Culhane, Gollub, Kuhn, & Shpaner, 2001).Lack of socioeconomic resources is also associated with risk factors for neuropsychiatric dysfunction, such as exposure to environmental toxins and injuries. Many people in Kenya are said to be affected by poverty and many live below one dollar every day because of poverty many are also homeless or live in deplorable conditions because of instability many individuals are at the risk of getting infections because of exposure to risk behaviors and other environmental toxins.

HIV status often has a negative impact on socioeconomic status by constraining an individual's ability to work and earn income. Research indicates that up to 45 percent of people living with HIV are unemployed (Rabkin, McElhiney, Ferrando, Van Gorp, & Lin, 2004).The effects of HIV on physical and mental functioning can make maintaining regular employment difficult. Patients with HIV infection may also find that their work responsibilities compete with their health care needs. Individuals infected with HIV are often discriminated against in the workplace, leading to their termination or forced resignation (Dray-Spira, Lert, Marimoutou, Bouhnik, &Obadiah, 2003). People living with HIV often experience job related discrimination which may lead to termination or forced resignation. PLWHA may also find it hard to keep up with the working conditions because of their health this greatly affects their quality of life.

Social Economic status (SES) often determines access to HIV treatment. Individuals of low SES have delayed treatment initiation relative to more affluent patients, reducing their

chances of survival (Joy et al., 2008).Patients of lower SES with HIV have increased morbidity and mortality rates. Research suggests a correlation between low SES and earlier death from HIV/AIDS (Cunningham et al., 2005). Decreased access to health insurance and preventive services is a major contributor to health disparities between high- and low-SES individuals. Low-income individuals are not likely to have health coverage or receive optimal treatment and care for HIV/AIDS, such as Highly Active Antiretroviral Therapy (HAART) (Wood et al. 2002). This study agrees many people who have a low social economic status delay their access to counselling services reducing the quality of their lives.

2.10 Theoretical Framework

This study was informed by Caplans crisis theory of counselling and humanistic counselling theories that deal with those infected and affected by HIV/AIDS. These theories are useful to this study because the theories guide counselors on appropriate ways to help the people infected and affected by HIV/AIDS.

2.10.1 Caplans Crisis Theory

Gerald Caplans contributed most of the modern crisis intervention theory. Crisis Counselling is counselling offered to persons (clients) who are in distress, shock or who feel that they are in extremely difficult situations and therefore need counselling to help them deal with the crisis at hand. Crises arise when suddenly the client feels completely overwhelmed by an emotional challenge that they may be going through and they are faced with situations in which they are unable to make decisions about their next steps. Sometimes, this inability to make a decision may even include what they should do after they leave the counselling session. In the case of HIV/AIDS, the trigger that leads to crisis might be death of another person living with HIV/AIDS, diagnosis with HIV, emergence of a new symptom or failure of a treatment. A crisis is a subjective experience; what one person perceives as a crisis, another person may not. Crisis situations will thus require that the counsellor takes urgent interventions to address the issues at hand (Bakusi, 2007).

According to Wright (1993) People often cope with daily stresses and problems that they face. However when a problem occurs that is temporarily beyond a person's ability to cope and he or she is thrown off balance by the ensuing event, then the person experiences a crisis. Due to the critical nature of the crisis and its dangerous potential effects on a person, special counseling and intervention is needed for those who are experiencing a crisis so that positive growth may result.

Counselling is the “art and process of helping people overcome their problems and more positively, helping them grow mentally, emotionally and spiritually healthy (Meier, 1991). Crisis counseling differs from long term counseling in that crisis counseling is more emotionally intensive and has as a goal of emotional equilibrium rather than a goal of long term growth and working through long standing conflicts (Swihart & Richardson, 1997). Some per-requisite for a counselor to engage in crisis counseling include: caring genuinely for the person in crisis, understanding the definition and characteristic of crisis, and having the ability to diagnose whether a person seeking help is actually in crisis so that crisis intervention procedures can be utilized in critical situations. Crisis counseling theory is appropriate when dealing with HIV/AIDS since the pandemic is a crisis that involves a sense of loss of health, jobs, respect, and opportunities in the lives of those infected and affected by the pandemic. A person infected or affected by the pandemic begins to lose perspective, feel anxious and helpless, worthless and is often depressed (Swihart & Richardson, 1997).HIV/AIDS has continued to be a global challenge that its effects have had a global impact. HIV/AIDS is a crisis that has affected millions of people. The global problem has trickled down to all nations including Kenya which stands as the fourth most affected nation in sub-Saharan. A person infected by HIV/AIDS is in a serious crisis that will require counselling intervention since this person is fighting with various emotions, may also experience opportunistic illnesses; they may be struggling with various economic, social, physical, psychological and spiritual challenges. A person infected or affected by HIV/AIDS needs a lot of help to able to handle stigma and discrimination that goes on when people realize one is having these challenges. This study is informed by Crisis theory which is effective when used by counselors to help a person infected and affected by the pandemic.

2.10.2 Humanistic Counselling Theory

The humanistic counselling theory focuses on the genuineness, inherent worth and dignity of human beings. It advocates for freedom and provision of the individual with the opportunity to explore his/her potential for achievement, growth and satisfaction. The theory further maintains that individuals should have freedom to explore their subjective experiences; individuals should be aware of their inner feelings and be comfortable with them. Individuals have the capacity to solve their own problems and guide their own life and when individuals are in a positive environment; they grow in a constructive way and are relatively free from anxiety. Humanistic counselors accept the person for what they are, and do not make pre-judgments. They take into account all the problems and abilities of the client (KAPC, 2004).

Many people continue to live with HIV/AIDS longer because of available ARVS and counselling therapies that can help them deal with the various challenges that they have to deal with daily. This theory is appropriate when dealing with people affected or infected by HIV/AIDS because of their low self-esteem and the lack of ways to express their fears and pains they need care and support not judgment or condemnation. Humanistic theory has been adopted by this study as a relevant theory that informs that study and has been known to be effective when used by counselors.

2.11 Conceptual framework

The following figure shows the conceptual framework of the study. Figure 1 shows the proposition of the study on how provision of counselling services can change the lives of those infected or affected by the HIV/AIDS pandemic, from being psychologically unstable, to being stable and positive.

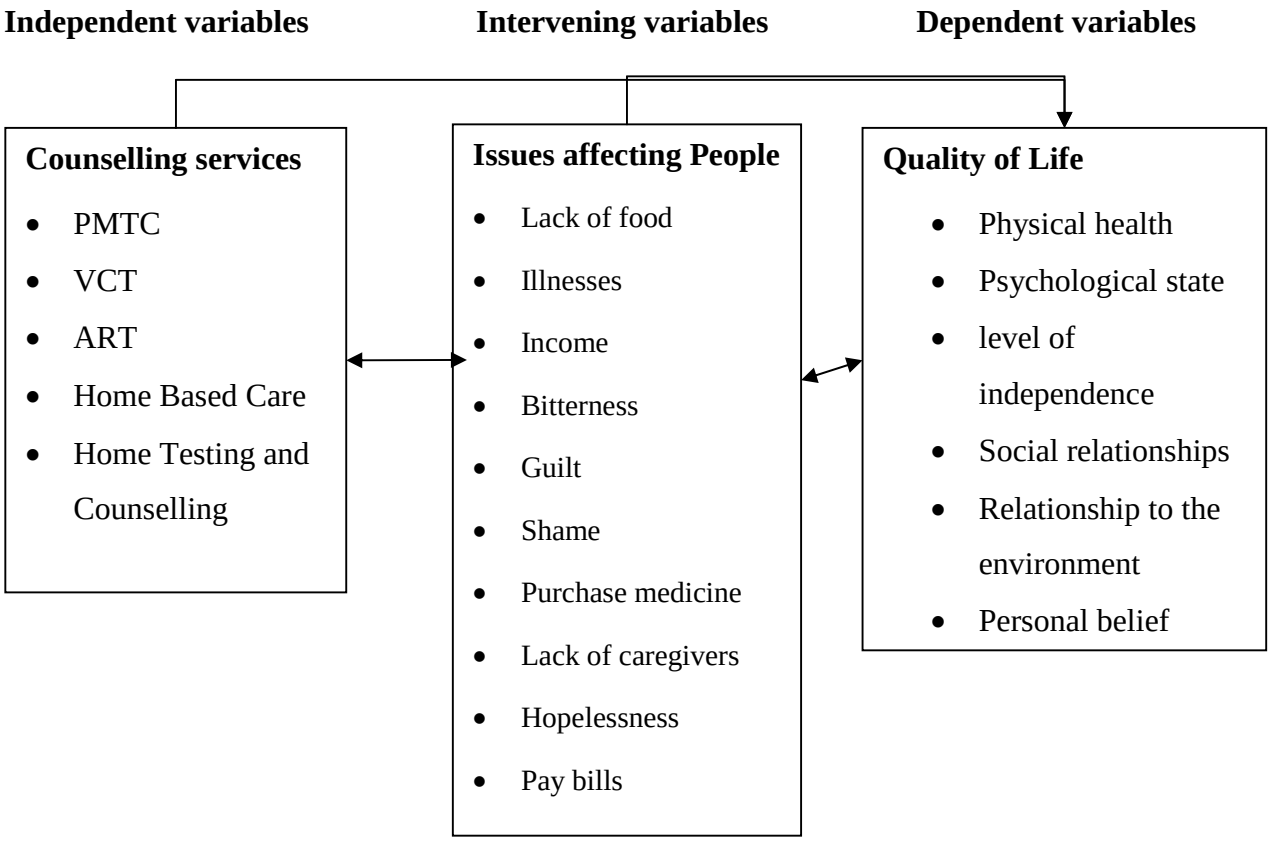

Figure1: Influence of Counselling Services

Those infected or affected by HIV/AIDS pandemic are greatly affected physically, emotionally, spiritually, psychological, socially and economically. They go through a very difficult time trying to come to terms with their HIV/AIDS status. Most are shocked that they are HIV positive or that they have AIDS or that their loved ones are sick. They experience intense emotional and bodily reactions to the devastating news, similar to shock after a physical trauma. Temporarily protection continues and denial sets in, this blocks appropriate behavior change and coping skills. Fury at being singled out for such a trauma as the situation begins to seem real, anger may be directed at the spouse, God and the opposite sex in general (Jackson, 2002). This may be followed by self-blame and often reduces their self-esteem. The challenges they encounter cause them to be absent from their work, heighten more illnesses that leave them in hospitals and bed ridden, malnutrition, stigmatized and poorer, because they may have to sell their property to get money to pay the extra costs of medication. When they receive counselling services, which includes Voluntary Counselling and Testing, Prevention of Mother to Child Transmission services, Home based care and Home Testing and Counselling they cope with the disease and the challenges of knowing their status. In the conceptual framework the extraneous variables (PMTC, VCT, ART, Home Based Care,

Home Testing and Counselling, Distigmatisation, counselling and awareness) are influenced by the independent variables (Nutritious diet, illnesses, income, physical exercise, shock, denial, depression, anger, displacement) and result into dependent variables improved physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment. Extraneous variables were studied alongside the independent variables. A person who is infected or affected by the pandemic has physical, psychological, spiritual and social concerns once they go through counselling and care they begin to change their behavior and cope with the rest of the community. The study sought to find out the influence of HIV/AIDS counselling services on the quality of life of church members in selected churches in Nakuru East Sub County. From the conceptual framework when people utilized counselling services their quality of life improves since they are now able to improve their physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of the environment.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research design, study location, population of the study, sampling procedure, sample size, instrumentation, pilot testing, validity, reliability, data collection, data organization and data analysis used in this study.

3.2 Research Design

Research design has been defined as a strategic framework that serves as a bridge between research questions and the execution or implementation of the research (Terre, Durkheim, & Desmond (2006). While Copper& Schinder (2003) state that it is a plan for meeting objectives and answering questions. This research adopted a causal comparative *ex post facto* research design that enabled the researcher to meet the objectives of the research and answer the research questions. According to Mugenda & Mugenda (2003) and Franenkel & Wallen (2000) causal comparative design is used to explore relationship between variables. This study sought to assess how provision of counselling services influence the quality of life. It also sought to find out how people access and utilize HIV/AIDS counselling services. This design was chosen because the researcher intended to assess the extent to which HIV/AIDS counselling services influenced the quality of life of church members, this influence has already happened and cannot be manipulated. The researcher studied the variables at their current state. This study focused on providing a picture of the situation and formed a basis for evaluation of the influence of HIV/AIDS counselling services.

3.3 Location of the Study

This study was conducted in Africa Inland Church, Presbyterian Church of East Africa and Catholic Church congregations in Nakuru East Sub County. According to 2002 government statistics, Nakuru East Sub County has an estimated population of 532,679, living on 974 square kilometres. This area is densely populated with migrants from different parts of the country. The Constituency is divided into four administrative areas: central (162,333), West (68,574), Lanet (99,209), Barut (202,063) and Lake Nakuru National Park (1,500). Nakuru East Sub County was chosen because the area has a high prevalence of HIV/AIDS. It was also thought that since Nakuru East Sub County is highly cosmopolitan the findings of this study could be generalised to all other parts of the country given the same terms of reference.

3.4 Population of the Study

The study targeted all Christians in Nakuru East Sub County. The accessible population of the study was Shabab Africa Inland Church, Nakuru West -Presbyterian Church of East Africa- and Christ the King Cathedral- Catholic Church. . These churches were chosen because they were the only churches that had established fully operational counselling services and had registered their counselling centres with the Government. The three accessible churches had an estimated population of 5,643 followers as indicated in Table 1.

Table 1: Distribution of Church Members in the three Churches.

Division	**Pastors**	**Men**	**Women**	**Youth**	**Counselors**	**Total**
Shabab AIC	1	141	359	200	2	703
Christ the King Catholic Church	4	360	2173	1592	5	4134
PCEA Nakuru West	2	203	434	164	3	806
Total	**7**	**704**	**2966**	**1956**	**10**	**5643**

Source of Statistics: Church Administrators 2013.

3.5 Sampling Procedures and Sample Size

The Churches were selected through purposive sampling based on the facts that they had established and running counselling services. The three churches selected were Shabab Africa Inland Church, Nakuru West -Presbyterian Church of East Africa- and Christ the King Cathedral- Catholic Church in Nakuru East Sub County. To take account of representation of all the Church members in the three churches, a sample was obtained using the coefficient of variation. According to Nassiuma (2000) coefficient of variation of at most 30% is acceptable in most surveys. This study took a coefficient of variation of 30% and a standard error of 0.02.

Nassiuma (2000) gives the formula:

$$n = \frac{NC^2}{C^2 + (N-1)e^2}$$

Where, n = sample size

N = population from which sample is obtained

C = covariance

e = standard error

$$\frac{n=(5643)(0.3)^2}{(0.3)^2 + (5642)\,(0.02)^2} == 225$$

Hence, this study involved 225 respondents drawn from three churches. The sample included pastors, women, men, youth and, counsellors. Three pastors and six counsellors in these churches were purposively selected and involved in the study based on their availability. The researcher used proportionate sampling to identify the number of respondents required per church. The youth, men and women in the study were selected through purposive sampling in order to select people with similar characteristics. The participants involved in the study were given numbered cards; those with odd numbers were picked randomly until the required number was reached. Table 2 presents the sample size of the study:

Table 2 Sample Size per Church

Church	**Pastor**	**Men**	**Women**	**Youth**	**Counselor**	**Total**
AIC Shabab	1	6	14	8	2	30
Christ the King Catholic Church	1	15	84	61	2	162
PCEA Nakuru West	1	8	16	7	2	33
Total	**3**	**27**	**114**	**75**	**6**	**225**

3.6 Research Instrumentation

The researcher used three sets of questionnaires for collection of data, namely questionnaire for pastors, church members and counselors. The questionnaires contained both closed ended and open-ended questions. The questionnaires had five sections, Section A: contained bio data information. Section B contained issues affecting the quality of life. Section C contained information on access and utilization of counselling services. Section D contained information on the influence of counselling services. Section E contained information on the attitude and perception of people towards counselling services and Section F contained information on the relationship between selected demographic characteristics and uptake of HIV/AIDS counselling services. The researcher visited the three churches and through the help of Church Elders and research assistants selected the respondents from the church members, counsellors and pastors.

3.6.1 Validity of instruments

Mugenda and Mugenda (2003) define validity as the degree to which results obtained from the analysis of collected data actually represents the phenomena under study. To improve on the appropriateness, meaningfulness and usefulness of the findings and inferences of the study the validity of the questionnaires were assessed by experts from the department of

Psychology, Counselling, and Educational Foundations to ensure they captured meaningful information like the content, construction and face validity of the questionnaires as intended by the researcher.

3.6.2 Reliability of Instruments

To ensure the reliability of the questionnaires a pilot study was conducted at Deliverance Church- Nakuru. This Church was used because it had a similar condition as the selected sample. The fact that Deliverance Church- Nakuru was not included in the study ensured that the subjects were not exposed to the test items before the study thereby enhancing objectivity. A counsellor and a pastor were requested to respond to the questionnaires. The pilot study included six men, six women and six youth at Deliverance Church- Nakuru. The reliability of the questionnaires was tested using Cronbach alpha reliability coefficient where the test yielded a value of 0.76 which was accepted and considered.

3.7 Ethical Considerations

The researcher sought permission to conduct research from Egerton University Graduate School and a research permit from the Government of Kenya through the National Council of Science and Technology that enable her carry out the research in Nakuru East Sub County.
The respondents' privacy and confidentiality was guaranteed by the researcher assuring the respondents that the information gathered was for research purposes only. The respondents were also assured of anonymity.

3.8 Data Collection Procedure

The researcher administered questionnaires to 225 participants in three churches with the assistance of the Church leaders and research assistants. The research instruments included personal data, questions on the influence, access and utilization of HIV/AIDS Counselling services. The researcher explained her interest in finding out the influence of HIV/AIDS counselling services on the quality of life of people in Nakuru East Sub County. The instruments were collected immediately after the respondents participated in the research.

3.9 Data Analysis

Descriptive statistics such as percentages and frequencies and inferential statistics such as chi-square, spearman's rho correlations, Linear by linear association and McNemar Bookers test were used to meaningfully describe the distribution of the scores and make inferences about the population. Data analysis was carried out using the statistical package for social science (SPSS) programme.

Table 3: Summary of the Data Analysis

Research Questions	**Independent Variable**	**Dependent variable**	**Statistical methods**
1. What are the issues that affect the quality of life of people receiving HIV/AIDS counselling services in selected churches in Nakuru East Sub County?	issues affecting PLWHAS	Quality of life	percentages, frequencies
2. Do people access and utilize HIV/AIDS counselling services to improve their quality of life in selected churches in Nakuru East Sub County?	Access and utilization of counselling services	Quality of life	percentages, frequencies
3.What is the attitude of people towards HIV/AIDS counselling services in selected churches in Nakuru East Sub County?	Attitude of people	Quality of life	percentages, frequencies
4. Does gender, age, education and social economic status influence the uptake of HIV/AIDS counseling services to improve the quality of life in selected churches in Nakuru East Sub County?	Demographic characteristics(gender, age, level of education)	Quality of life	Percentages and frequencies
5.What is the influence of HIV/AIDS counselling services on the quality of life in selected churches in Nakuru East Sub County?	influence of counselling services	Quality of life	percentages, frequencies chi-square linear by linear Mc Nemar Booker test

CHAPTER FOUR
RESULTS AND DISCUSSIONS

4.1 Introduction

The main purpose of this research was to assess the influence of HIV/AIDS counselling services on the quality of life of church members in Nakuru East Sub County. This chapter presents the findings of the research which was collected through questionnaires. This chapter also gives a summary of demographic and background characteristics of Pastors, counselors and church members. The data is analyzed and presented using frequencies and percentages.

4.2 The Demographic characteristic of the sample

The research was conducted in three churches namely Christ the King Catholic Cathedral, Africa Inland Church – Shabab, Presbyterian Church of East Africa – Nakuru West. The study involved six counsellors, three pastors and 207 Church members. This section gives a summary of the demographic distribution, background characteristics: gender, marital status, of the Pastors, counsellors and church members.

Table 4: Demographic characteristics of the research participants

Characteristics	**Respondents**	**Gender**	**frequency**	**percentages**
	Pastors	Male	3	100.0
Gender	Counselors	Male	3	50.0
		Female	3	50.0
	Church members	Men	48	23.9
		Youth	49	21.5
		Women	101	54.6
Marital status	Pastors	Married	2	66.7
		Single	1	33.3
	Counselors	Single	3	50.0
		Married	3	50.0
	Church members	Married	27	12.9
		Single	171	86.2
	Total		**207**	**100.0**

Results in table 4 indicated that 3 pastors, 6 counselors, 48 men, 101 women and 49 youth respond to the questionnaire. The total number of respondents was 207 out of the expected 225 this shows 92% of all questionnaires were received from respondents. Those involved in the study were married and single people aged 20 years and above.

4.3 Issues that affect the quality of life

The first objective of the study was to investigate the issues that affect the quality of life of people. The table below represents our finding

Table 5: Issues Affecting Quality of Life

Issues	Church Members					Counselors					Pastors				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
	Percentages					Percentages					Percentages				
lack of food	16	27	21	30	6	33	17	17	17	17	33	33	33	0	0
Denial/Anger	37	24	18	13	8	17	17	50	17	0	67	0	33	0	0
Bitterness	33	30	17	13	7	33	33	33	0	0	67	33	0	0	0
Guilt	46	16	19	12	8	17	50	33	0	0	33	0	33	33	0
Shame	49	18	14	11	8	33	17	50	0	0	33	0	33	0	33
Hopelessness	39	19	12	22	8	0	0	17	50	33	33	33	33	0	0
Regret	49	20	13	12	6	17	50	33	0	0	67	33	0	0	0
Unable to pay bills	16	42	19	18	6	17	17	50	17	0	67	33	0	0	0
Unable to purchase medicine	21	33	23	15	8	33	17	50	0	0	67	33	0	0	0
Lack of caregivers	30	23	19	16	12	33	17	33	17	0	67	33	0	0	0

Key

1. Always
2. Frequently
3. Less Frequently
4. Occasionally
5. Never

The findings indicate that 30% of Church members and 33% of counselors and 67% of the Pastors said that those infected and affected by HIV/AIDS occasionally and always lacked food (Table 5). This suggests that food is a major problem especially to those living with HIV because they have lost their jobs or they are bedridden and unable to fend for themselves. As a result, they depend on well-wishers or caregivers to provide food.

People infected and affected by HIV/AIDS always experience many emotions when they learn their status or that of their loved ones. These includes: denial and anger, as observed by 37% of church members and 67% of pastors, bitterness as observed by 33%of church members and 67% of pastors and 67% of the counselors . Guilt according to 46% of church members, 50% of counselors showed that guilt is frequently experienced although the pastors had a different opinion 33% said guilt is always experienced. Similarly 49% of church members and 50% of the counselors said infected and affected people always feel ashamed,

Another emotion commonly experienced is hopelessness 39% of church members indicated that hopelessness is always experienced while 50% of the counselors said hopelessness is occasionally experienced and 67% of the counselors felt that hopelessness is always and frequently experienced. This shows that many people felt hopeless when they realize they are infected because they tended to feel like death is inevitable and since they are not sure how the infection will take its course.

According to 49% of church members and 67% of pastors regret is always experienced, while 50% of counselors indicated that regret is frequently observed. A good percentage of the respondents said regret was always and frequently observed among PLWHAS this suggest they regret actions that may have led to infections. People are frequently unable to pay hospital bills according to 42% of church members and 67% of Pastors while 50% of counselors felt the inability to pay hospital bills occasionally happen. This suggests some PLWHAS may find it a challenge to pay hospital bills especially for those who are greatly affected by poverty and have had the illness for long. Some people may also have lost their jobs because of absenteeism as a result of opportunistic illness that attack the body because of low immunity occasionally or they may lose jobs because of discrimination.

Those infected or affected by HIVAIDS frequently face challenges when purchasing medicine according to30% of church members and 67% of pastors while 50% of counselors said the purchase of medicine is occasionally a challenge. This suggests that most people who

are infected are also affected by poverty and are frequently unable to purchase drugs. The counsellors refer these clients to the comprehensive care unit in the Provincial hospital where there is free access to ARVS.

Findings from the study show that 30% of church members, 67% of pastors and 67% of counselors agreed that there is always and frequent a lack of caregivers. Many of those living with HIV also lack people to take care of them especially when one has already lost a spouse or has very young children. Some of the children have had to drop out of school to take care of sick parents. Well-wishers may also try to help but because of lack of nursing skills they may withdraw their assistance because of the demands of the disease. From these findings we can conclude that there are various issues that affect the quality of life of people infected and affected by HIV/AIDS. The church and the government can come out and try to address these issues to improve the quality of life.

These findings agree with Muraah and Kiarie, (2001) who notes that there are many issues that affect the quality of life of people affected or infected by HIV/AIDS. These issues are social, physical, mental, emotional and economic in nature. Patients and relatives are sometimes unable to pay hospital bills because of poverty; they also may find it difficult to afford a nutritious diet that the patient and the family require and purchase essential medicines. Both the family and other members of the community may lack the nursing skills required to manage HIV patients. Nursing of the patient may also take up a lot of time and the members of the family may be unable to continue with employment or other income generating activities. This further drains the household income and greatly affects the quality of life of those infected and affected

Table 6: Methods Church members use when handling various issues

Issues	Church members					Counselors					Pastors				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
	Percentages					Percentages					Percentages				
Lack of Food	48	19	10	11	12	17	17	67	0	0	0	33	0	0	67
Inability to purchase medicine	25	26	16	13	20	17	17	67	0	0	33	67	0	0	0
lack of employment	16	20	22	27	15	0	0	17	33	50	0	0	100	0	0
Bitterness	19	15	16	43	8	0	0	0	100	0	0	0	100	0	0
Shame	20	25	14	33	8	0	0	0	100	0	0	0	100	0	0
Guilt	13	14	9	64	1	0	0	0	100	0	0	0	100	0	0
Hopelessness	13	11	6	65	5	0	0	50	50	0	33	0	33	0	33
Lack of caregivers	21	18	13	27	20	0	17	33	17	33	0	0	67	0	33
Unable to pay bills	24	20	21	13	22	17	83	0	0	0	33	0	0	0	67

KEY

1. Confronted
2. Sympathized
3. Did nothing
4. Counseled
5. Referred

When faced with people infected and affected by HIV/AIDS there are various approaches that people use to respond to the pandemic. The findings of the study show 48% of Church members, confront those who experience lack of food, 26% sympathize with those who are unable to purchase medicine. When church members encountered those who lack employment they provided counselling as indicated by 27%. People who experience

bitterness in their lives were also counseled by 43%. As indicated by 33% they took time to counsel those who experience guilt. People who experienced hopelessness were counseled by 65%. Most of the time those infected lack caregivers they also received counselling from 27% church members. Many people have a challenge and are unable to pay hospital bills as indicated by 24% they counseled them. From the church members responses the most common method used in dealing with the various issues was counselling, followed by confrontation and sympathy.

Counselors responses show that 67% did nothing for those who experience a lack of food, 67% did nothing for those who are unable to purchase medicine. According to 50% of counsellors they refer those who lack employment, 100% counseled those who experience bitterness in their lives, 100% take time to counsel those who experience guilt, 100% take time to counsel those who experience shame, 50% counseled and 50% did nothing to those who experience hopelessness, 33% either did nothing or referred those who have a challenge with caregivers and 67% did nothing towards those unable to pay hospital bills. When people infected or affected by HIV/AIDS visit the counseling centres one struggle they are facing is lack of food the counselors face a challenge since the churches do not offer nutrious meals frequently they either sympathize or refer this clients to places they can get food. Since counselors do not have money to assist needy clients they are left with the option of sympathizing or referring these clients to Provincial General Hospital where medicine is free or prices are subsidized. Many people who visit the centers are unemployed some have recently lost their jobs due to their absenteeism from the work place, the counselors counsel them on how they can start income generating projects to sustain themselves. People who are infected or affected by HIV/AIDS go through many emotions such bitterness, shame, guilt, hopelessness and lack of care givers, counselors responds to these emotions by counselling, referring and confronting these emotions.

The results from Pastor's responses indicate that 67% did nothing for those who lacked food, employment and caregivers, 67% sympathized with those who were unable to purchase medicine and referred those unable to pay hospital bills, 100% did nothing to those who experience bitterness, guilt and shame, 100% counseled, did nothing and referred those who experience hopelessness. From the pastors responses we found out that they did nothing concerning most of the issues facing people who are infected or affected by HIV/AIDS.

The results of this study show most people responded to the issues faced by those infected or affected by HIV/AIDS by confronting, sympathizing or doing nothing however some used counselling to help those infected and affected by HIV/AIDS. Counselling was one of the methods that were commonly administered when dealing with various issues faced by people infected or affected by HIV/AIDS. Counselling provided emotional and psychological support to PLWHAs and offers encouragement, hope and help clients cope with their situation. According to Bakusi, (2007) this form of counselling carried out several times assist the client cope with the different challenges that they might experience during the course of their illness. These challenges may arise from issues in their families, their work place, their social life and many other related areas. Some of the elements of supportive counselling are: helping clients identify sources of support; providing referrals to these services, providing counselling on survival skills and positive living.

4.4 Accessibility and Utilization of HIV/AIDS Counselling Services

The second objective was to find out whether people access and utilize HIV/AIDS counselling services to improve their quality of life.

Table 7: Visits to the Centre for Counselling

Visits	Church Member Percentages	Pastors Percentages	Counselors Percentages
Daily	16	33	83
Weekly	20	67	0
Twice a week	17	0	0
Problem arise	46	0	17

The results show that although the counselling centres were opened daily 46% of the people indicated that the counselling centres are visited when a problem arises. The pastors responses show that although the counselling centres are opened daily 67% of the people indicated the counselling centres are visited once per week. As observed by 83% of the counselors, clients who visit the clinic every day are taken through HIV pretest and posttest counselling since the government has put in place a policy where the provider initiate testing of all people attending the hospital especially the pregnant women to help the patients know their HIV status and provide PMTC services.

HIV testing and counseling is now offered routinely as part of clinical evaluation in health facilities. The Government provides counseling services through voluntary counseling and testing centers (VCT), antenatal clinics, TB clinics, and Home-based care counseling and testing which is a new approach that involves the provision of HTC services to all family members in the convenience of the home (KAIS, 2008).

The results also agree with Yanet, (2007) who says that people are becoming more aware of counselling services, a study recently carried out in Nicaragua shows that many people are now seeking counselling services unlike ten years ago when only a few had access to HIV test and getting tested was difficult. Fear of AIDS, and the stigma that comes with being HIV-positive, also stopped people from discovering their status. "Nowadays people have learned to respect those who are HIV-positive, especially family members," says Graciela Argüelles, a counsellors at Association Information and Counselling on sexually transmitted diseases, which is a non-profit organization sponsored by DFID (Department For International Development) since 2004.T he following methods have been used to create awareness on available counselling services.

Table 8: Methods used to Create Awareness

Methods	**Church members**					**Counselors**					**Pastors**				
	1	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
	Percentages					**Percentages**					**Percentages**				
Mouth	32	28	18	16	6	0	83	17	0	0	0	100	0	0	0
Brochures	12	34	23	18	12	33	33	0	17	17	33	0	0	67	0
Radio or TV	26	30	22	14	9	0	33	50	17	0	33	0	67	0	0
Church announcement	18	29	21	22	10	0	33	50	17	0	33	0	67	0	0
Free medical camps	44	22	17	11	6	0	33	33	17	17	33	67	0	0	0
Medical services	42	29	17	10	3	17	17	50	0	0	33	67	0	0	0

KEY

1. Always
2. Frequently
3. Less frequently
4. Occasionally
5. Never

The results from table 8 indicate the following methods are used to inform people about available services. According to 32% of church members' word of mouth is always used, 83% of counselors and 100% of Pastors said word of mouth is frequently used to create awareness. This suggests that people get information concerning the availability of counselling services offered by the church through word of mouth.

Brochures are also used to create awareness of available counselling services as noted by 34% of church members and 67% of counselors noted that brochures are frequently and always used while 67% of pastors said brochures are occasionally used to create awareness .As noted by 30% of church members' radio announcements are frequently used to create awareness, 50% of counsellors indicated radio is less frequently used and 67% of pastors indicated that radio is less frequently used. Based on the results we can suggest that radio announcements are rarely used to create awareness. Church announcements are also used to announce the availability of counselling services, according to 29% of church members church announcements were frequently used, 50%of the counsellors felt church announcements were less frequently used from this findings we can conclude that church announcements are rarely used since only 29% of church members indicated that church announcements are made concerning the available counselling services.

When provided medical camps and services are avenues that can be used to inform the church and the community of available counselling services, according to 44% of church members medical camps are always used to create awareness while 67% of the counselors felt that medical camps are frequently and less frequently used. As observed by 67% of pastors medical camps are frequently used. Results from 42% of church members, indicate medical services are always used, 50% of counselors indicated that medical services are frequently and less frequently used to create awareness and 67% of pastors said medical services are used to inform people of available counselling services.

4.5 Attitude of People towards Counselling Services

The third objective was to find out the attitude of people towards counselling services in selected churches in Nakuru County.

Table 9: Attitudes of Church Members towards Counselling Services

Attitudes towards counselling services	1	2	3	4	5
	Percentages				
Need for more training	8	15	18	22	37
Need to offer more services	20	43	12	16	9
Pray with the sick	25	16	43	9	7
Visit the sick	24	14	44	12	7
Help patients write their wills	24	24	19	22	11
Touch the sick	25	17	36	13	9
You should have known before you had the Affair.	22	22	25	15	17

Key

1. Rare
2. Frequently
3. Never
4. Sometimes
5. always

Results from table 9 indicate that 37% of the church members felt there was a need for more training on how to handle people who are infected and affected. There is also a need to provide more services to help those affected or infected as observed by 43% of church members. As noted by 43% of church members they are never afraid to pray with people who are infected or affected by HIV/AIDS. According to 44% of the church members they are never afraid to visit those who are infected or affected. According to 24% of the church members they rarely and frequent help people write their wills. Findings from the study reveal 36% of church members felt they can never touch a person who is infected with HIV/AIDS. Similarly 25% of the church members never feel like telling someone "you should h

Table 10: Pastors Attitude towards Counselling Services

Attitudes towards counselling	**1**	**2**	**3**
	Percentages	Percentages	Percentages
Wastage of time	67	33	0
Your problem is nothing	67	0	33
Need for someone more qualified	33	0	67
Just go and wait for your death	67	33	0
I cannot pray for a sinner like you	33	67	0
You will make me sick	0	100	0
You must not mix with other people	0	100	0
Lack of adequate training	33	67	0
Lack of sufficient time	0	0	100
Lack of funds to establish counseling services	0	0	100

Key

1. Rare
2. Never
3. Sometimes

As pastors interact with clients sometimes they may experience various emotions 67% of the pastors said they rarely felt the clients were wasting their lives. They take people's problem seriously and they rarely feel that those problems are nothing. Sometimes the client's burdens are too heavy and they feel there is a need for a more qualified person to handle client. Pastors do not fear that they will be made sick by the clients. They never tell the clients not to mix with other people. As pastors get involved with the clients sometimes they feel they do not have adequate time to deal with all the emerging issues.

Table 11: Counsellors' Attitudes towards Counselling Services

Attitudes towards counselling services	**Always** Percentages	**Often** Percentages	**Occasionally** Percentages	**Never** Percentages
I feel emotionally drained in my work	0	0	83	17
My work is stressful	0	0	100	0
My work is very rewarding	67	0	17	0
My work environment is very stressful	33	50	17	0
I learn something new in my work everyday	50	33	17	0
I feel isolated in my work	0	0	17	83
I have problems communicating with my clients	0	0	17	83
I have confidence in my counselling skills	17	0	67	17
I can help my clients	50	0	50	0

According to 83% of counselors they occasionally feel emotionally drained in their work. Their work is occasionally very stressful. Counselors always find their work very rewarding according to 67%. They never feel isolated in their work environment as indicated by 83%. According to 50% they learn something new in their work every day. They never have problems communicating with their clients as indicate by 83%. They occasionally have confidence in their counselling skills as indicated by 67%. They find themselves able to help their clients most of the time. Counselors indicated they have a positive attitude towards counselling.

These findings agree that HIV counsellors are trained people who provide pre and posttest counselling to clients who present for HIV test counselling and this involves giving accurate information about testing which will enable the clients to make informed decisions about testing (Adekeye, 2010, Hubley, 2002 & UNAIDS, 2007). As part of their daily routine HIV counsellors come across the HIV infected and by training they are expected to promote acceptance, care and provide support systems. Dyk (2001) noted that as part of their routine HIV counsellors are expected to counter the negative attitude displayed by the society

towards the HIV infected. Thus HIV counsellors are positioned to help people undergo the HIV test by providing pre and posttest counselling.

4.6 Uptake of HIVAIDS Counselling Services by Gender, Age, Social Economic Status and Education

The fourth objective was to find out whether there is a difference in the uptake of HIV/AIDS counselling services by gender, age, education and social economic status to improve the quality of life of church members in selected churches in Nakuru East Sub- County**.**

Table 12: Difference in Uptake of HIV/AIDS Counselling by Various Demographics

Respondents	**Variables**	**Ages**	**Gender**	**Education**	**Occupation**	**Marital**
		Percentages				
Church members	Always	35	21	32	31	31
	Frequently	24	32	33	29	23
	Less frequently	12	24	19	23	18
	Occasionally	21	12	7	9	18
	Never	8	11	9	9	1
Counselors	Always	17	0	17	17	0
	Frequently	0	17	50	50	0
	Less frequently	50	33	0	0	17
	Occasionally	0	33	0	0	50
	Never	33	17	33	33	33
Pastors	Always	0	0	33	33	0
	Frequently	0	0	0	0	0
	Less frequently	67	0	0	67	0
	Occasionally	0	67	0	0	33
	Never	33	33	67	0	67

Results from table 12 indicate 35% of church members show people's age always influence people to seek counselling services. According to 50% of the counselors and 67% of pastors they felt that age less frequently influence utilization of counselling services. Based on these results 35% of church members felt age influences utilization of counselling services. The

35% are less than half and therefore represent a very small percentage. While 50% of the counselors and 67% of the pastor felt people ages do not influence access to counselling services.

People from different gender are frequently influenced to seek counselling services according to 32% of church members. As observed by 66% of counselors and 67% of pastors gender occasionally and less frequently influence the utilization of counselling services. Based on the findings gender frequently and occasionally influence the utilization of counselling services other researchers have shown and suggested that women access counseling services more than men. Women seek services more frequently than men because they often seek antenatal services from hospitals and because of the provider initiated services they are counseled to utilize counselling services if they test positive or are affected in one way or another.

The levels of education always influence people to seek counselling as indicated by 33% of church members and 66% of counselors while 67% of the pastors felt the level of education does not influence utilization of counselling services. From these findings we can suggest that education has a level of influence on people which guides them to see counselling services. The marital status of people always influences how they seek counselling services as indicated by 31% of the church members, while 50% of the counselors indicate marital status influence utilization of counselling services and 67% of the pastors said marital status does not influence how people utilize counselling services. From these findings we can suggest marital status has some influence on access to counselling services as noted by church members and counsellors.

Table 13: Correlation of various Demographics with HIV/AIDS Counselling Services

Demographics	Correlation	Counseling services								
		1	2	3	4	5	6	7	8	9
Age group	Correlation Coefficient	.196**	-.039							
	Sig. (2-tailed)	.006	.590							
	Sig. (2-tailed)	.384	.250	.096	.049					
Marital status	Correlation Coefficient	-.025	.156*	-.076	-.025	.075				
	Sig. (2-tailed)	.731	.029	.290	.736	.305				
	Sig. (2-tailed)	.623	.527	.452	.245	.373	.001			
Gender	Correlation Coefficient	.077	.078	-.002	.023	-.054	.345**	.496**		
	Sig. (2-tailed)	.283	.281	.977	.755	.461	.000	.000		
Education	Correlation Coefficient	.005	.056	-.062	.140	-.005	.272**	.238**	.252**	
	Sig. (2-tailed)	.950	.440	.393	.053	.940	.000	.001	.000	
Social Economic status	Correlation Coefficient	.063	.032	-.114	.105	-.002	.276**	.252**	.338**	.527**
	Sig. (2-tailed)	.384	.658	.113	.146	.981	.000	.000	.000	.000

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Key

1. Voluntary Counselling and Testing
2. Prevention of mother to child transmission
3. Home based care
4. Resource Centre- Library
5. Nutritious meals
6. Individual counselling
7. Group counselling
8. Referral
9. Training (seminars)

As observed from Table 13 there was an observed weak positive correlation coefficient of 0.196 between the age group the respondents belonged and their access to counseling services. The observed significance was 0.01 which was less than 0.05 and therefore statistically significant. Based on this it was inferred that the group in which the PLWAs

belonged could be used to predict their access to counseling services. All other variables yielded correlation coefficients that were not significant with regard to access to counselling and quality and therefore it was concluded that these correlation did not have statistical influence on target variables.

There was observed correlation coefficient of 0.180 between the levels of education in relation to access to counselling services at significant level of 0.05. These shows the levels of education always influence people to seek counselling. Influence of marital status showed a positive correlation of 0.144 at a significant level of 0.05. This indicates marital status may influence access to counselling services. Influence of gender had a positive correlation coefficient of 0.345 on access to counselling services at a significant level of 0.01. People from different gender are frequently influenced to seek counselling services. More women than men are said to access counselling services since they seek more reproductive related services. Marital status was seen to have a positive correlation coefficient of 0.276 at a significant level of 0.01.

Table 14: Age Groups that Frequently Go for Counselling

Age (Years)	Church Members percentages	Counselors percentages	Pastors percentages
20 - 24	29	0	33
25 - 29	49	67	33
30 - 34	13	0	33
35 - 39	6	33	0
40 - 44	1	0	0
45 and above	1	0	0

Results from Table 14 show people who are between the ages of 25 to 29 are the ones who frequently seek counselling services.

Table 15: Level of Education of Clients Visiting Centre

	Church Members	Counselors	Pastors
		Percentages	
Illiterate	9	0	0
Primary	6	0	0
Secondary	25	0	33
College/ higher Education	59	100	67

Results from Table 15 indicate the majority of people who seek counselling services are educated especially those with college or higher education.

Table 16: Difference in visit between Genders

Visits by gender	Church Members	Counselors	Pastors
	Percentages	Percentages	Percentages
Yes	52	67	100
No	28	33	0
Don't Know	19	0	0

Results from Table 16 show there is a difference in visits made by different genders. As indicated by 52% of church members, 67% of counselors and 100% of pastors. This study results agree with the findings of Sherr *et al.* (2007) that gender has been found to be a significant predictor in the uptake of VCT. Adult men are more likely than their female counterparts to report psychological deterrents to utilization of VCT yet have been found to require reassurance of their HIV status more frequently (Sherr *et al*.2007). In a study conducted by Liiyasu *et, al* (2006) the author concluded that gender is a factor when determining the willingness of participants to have VCT with only 57% of male respondents willing to have VCT in contrast to 83% of females. However there is little information on VCT uptake among men and also on the factors that influence it. It is not known whether factors that influence VCT uptake in general population are also operational in VCT uptake by men only (Bassett, Giddy, Nkerra, Wang, losina, Lu, Freedberg& Walensky, 2007).

Table 17: Occupation of clients visiting centre

Occupation	Church Members Percentages	Counselors Percentages	Pastors Percentages
Employed	47	100	33
Unemployed	53	0	67

Results from the study as presented in table 17 shows both those employed and those not employed visit counselling centres. Although those unemployed are the majority according to 53% of church members and 67% of pastors. Many studies have found a high incidence of unemployment among people with HIV, with some reporting rates of unemployment at 50% or higher (Burns et al. 2006 & Dray-Spira et al. 2006). Although initial studies related to HIV and employment tended to focus on employer needs and co-worker responses, there has been an increasing focus on the actual vocational development and work-related experiences of people with HIV/AIDS (Conyers, 2004a and 2004b)

Table 18: Marital Status of clients who visit centre

Marital status	Church Members Percentages	Counselors Percentages	Pastors Percentages
Married	50	33	33
Single	41	67	67
Widowed	1	0	0
Divorced/Separated	7	0	0

As observed by 50% of church members, clients seeking counselling services are married. According to 67% of the counselors and pastors those seeking counselling services are mostly single. From the results we can conclude both single people and married people seek counselling services.

The results of the study show that people are always influenced by their age to seek counselling services. Occasionally gender influences these decisions. More women than men visit the center for counselling services since women seek more counselling services than men. The level of education may influence the access and utilization of counselling services. The fact that one is married or not does not influence the decision a person makes concerning counselling services. Most of the people who visit the centers for counselling services are 20years and above. Most of the people who seek counselling services like VCT are college

students and form four leavers because they are eager to know their HIV/AIDS status. These findings agree with UNAIDS, (2010) which states Kenya is home to one of the world's harshest HIV and AIDS epidemics. Results show the female gender is more affected by HIV/AIDS than the male gender. An estimated 1.5 million people are living with HIV; around 1.2 million children have been orphaned by AIDS, in 2009, 80,000 people died from AIDS related illnesses. Women are disproportionally affected by HIV in 2008/2009 HIV prevalence among women was twice as high as that for men at 8% and 4.3% respectively. This disparity is even greater in young women of the same age 15-24 who are four times more likely to become infected with HIV than men the same age.

4.7 Influence of HIV/AIDS Counselling Services on the Quality of life

The fifth objective was to find out the influence of HIV/AIDS counselling services on the quality of life in selected churches in Nakuru East Sub County. To establish the influence of access to counselling services on the quality of life, a cross tabulation was carried out between the two variables. The results are presented in Table 19

Table19 Distributions of means and standard deviations of transformed QOL scores

	Physical domain	**Psychological domain**	**Social domain**	**Environment domain**	**Beliefs domain**	**Independent domain**
Mean	60.71	59.8810	63.1667	47.1667	77.7857	79.0000
Std. Deviation	17.913	19.35068	25.80406	15.52797	22.31650	15.32645

Forty two patients with HIV were interviewed using whoqol questionnaire. The outcome indicated the mean QOL scores are the highest in the independent domain (79.0) which measures the individual's level of independence when making serious decisions that affect their quality of life of life is high. Beliefs of patients also affect their quality of life as indicated by a mean score of (77.8). The patients also scored highly in the social domain (63.2) indicating social relationships influence the quality of their life. Support from friend and relatives, their perceptions on how satisfied they are with their relationships and how satisfied they are with their sex lives greatly affects their quality of life. The provision of care and support is largely influenced by the prevailing cultural norms amongst people concerned

who are burned with the task of providing care for those who are ill. The patients scored in the physical domain (60.7), psychological domain (59.9) many affected are affected psychological and experience constant worry, stress and anxiety contribute to poor qol and the lowest score were (47.2) on the environment domain this scores indicated the PLWHAS are not happy with the conditions of their environments they may not be feeling safe and their environment may not be health. A person's quality of life is affected by the level of independence one has when making their day to day decisions, their religious beliefs because of the challenges they are facing on a day to day. Their social interaction, the physical conditions of their bodies. They are also concerned with the things that affect their psychological wellbeing and the environment they live in.

To find out the relationship between counselling services and quality of life the following hypothesis was tested. Hypothesis Ho_1 stated that there is no statistically significant relationship between HIVAIDS counselling services and the quality of life of church members who are infected by HIV/AIDS in Nakuru East Sub County

A significance test for the hypothesis was conducted to help make conclusions whether the influence was statistically significant or not. The findings are presented in Table 20

Table 20: Influence of counselling services on quality of life

Statistics used	**Value**	**df**	**Asymp.sig. (2sided)**
Pearson chi square	16.941	4	.002
Likelihood Ratio	14.434	4	.006
Linear by Linear Association	.013	1	.909
McNemar-Booker Test	19.036	3	000
N of valid cases	207		

Pearson chi square test of significance yielded a 2 tailed significance of $\alpha = 0.002$ which was less than the set $\alpha = 0.05$ and therefore statistically significant. It was therefore inferred that access to counselling services predicted improved quality of life among those infected and affected by HIV/AIDS. However, linear by linear association test were not significant and

therefore a non-parametric confirmatory test was conducted. This was done by means of a Chi-square test between access to counselling services and quality of life. The findings are presented in Table 21

Table 21: Relationship between access to counselling services and quality of life

Access to counselling and QOL	**Counselling Services**	**Quality of life**
Chi-square	1.387	140.431
Df	2	2
Asymp.sig	.000	.000

Table 22 shows a significance level of $\alpha = 0.00$ which is less than $\alpha = 0.05$ and therefore statistically significant. It was inferred therefore that the more those affected and infected access counselling services, the better the quality of their lives become.

CHAPTER FIVE
SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter focused on a summary of the study, conclusions that have been made of the study, the implications of the study and recommendations of the study also, a brief highlight has been made on areas that further research can be undertaken.

5.2 Summary of Findings

i. The first objective of the study was to determine the issues that affect the quality of life of church members receiving HIV/AIDS counselling services in selected churches in Nakuru East Sub County. This objective was addressed through the research question what issues influence the quality of life of church members receiving HIVAIDS counselling services in selected churches in Nakuru East Sub County. The study found out many people infected and affected by HIV/AIDS experience various issues which include lack of food since those infected are sometimes unable to fend for themselves while those affected spend a considerable amount of time trying to assist the sick. People also experience various emotions including denial, guilt, shame, hopelessness and regret when they realizes that they are infected or affected by HIV/AIDS this greatly affects their quality of life. When one is HIV positive they experience many opportunistic illnesses which require frequent medication and sometimes hospitalization this poses a great challenge since there are bills to be paid and purchases of medicine to be made. Those infected sometimes lack caregivers since many relatives and friends may not be willing to associate with infected person. Those who accept to nurse the sick may be unable to continue with employment or income generating projects this further drains the household income and greatly affects the quality of life.. The results of the study show counselling is one of the methods commonly used to address these issues. The other methods include confrontation, sympathy, doing nothing concerning the issues and making referrals. Among the church members the most common method was counselling. The counsellors responded to the issues through counselling, referring and confronting. The pastors mostly did nothing when issues were present but occasionally made referrals.

ii. The second objective was to determine the access and utilization of HIV/AIDS counselling services to improve the quality of life in selected churches in Nakuru East

Sub County. This objective was addressed through a research question, "Do church members access and utilize HIVAIDS counselling services to improve the quality of life in selected churches in Nakuru East Sub County?" The study findings show that many people access and utilize the counselling services although they are not necessarily church members. Once people utilize counselling services there are significant changes in their lifestyles. The numbers visiting the centre are not large although more people are becoming aware of available counselling services offered in the church premises. The provider initiated counselling and testing has greatly increased the utilization of the counselling services. There is a need to create awareness of available counselling services. The following methods were used to create awareness in the church and surrounding communities word of mouth, brochures, radio or TV, church announcement, free medical camps and medical services. The following counselling services are offered in the counselling centres. Voluntary counselling and testing, Home based care, group counselling, individual counselling, referral, training, PMTC, resource centre and nutritious meals. The quality of the counselling services offered are good although there are challenges when providing this services especially the provision of nutritious meals is generally poor because of lack of funds and home based care lacks personnel to visit the sick in their homes.

iii. The third objective was to determine the perception and attitude of church members towards HIV/AIDS counselling services in Nakuru Sub County. This objective was addressed by the research question "What is the perception and attitude of church members towards HIV/AIDS counselling services in Nakuru Sub County?" The findings of the study show after receiving more information about HIV/AIDS church members have positive attitude towards people who are infected or affected by the pandemic. People are now able to pray and spend time with those who are sick without fear, they are more willing to visit them and even touch them without fearing that they will be infected or that they are wasting time.. People try to be less judgmental towards the infected and do not feel those infected should have known sexual affairs could leave one infected. Although counselors occasionally feel drained by the counselling cases they have to handle they still find counselling rewarding, they never feel isolated and find there is still something new to learn as they assist their clients. They always find themselves able to help their clients.

iv. The fourth objective was to determine the influence of gender, age, education and social economic status on the uptake of HIV/AIDS counselling services by church members in selected churches in Nakuru East Sub County. This objective was addressed through the research question "Does gender, age, education and socio economic status influence the uptake of HIV/AIDS counselling services in Nakuru Sub County?" Demographic characteristics sometime influence the uptake of HIV/AIDS counselling services. The study findings were that church members are occasionally influenced by their gender to seek counselling services. More women than men seek counselling services since they mostly seek other services like antenatal and post natal care. The level of education and the marital status sometimes influences the utilization of counselling services. The married and unmarried, employed and unemployed utilize counselling services

v. The fifth objective of the study was to determine the influence of HIV/AIDS counselling services to improve the quality of life in selected churches in Nakuru East Sub County through a research question is there a significant relationship between HIV/AIDS counselling services and quality of life of church members in selected churches in Nakuru East Sub County. The study revealed that when people access and utilize counselling positively they experience changes in their lives and improve their physical state, psychological wellbeing, level of independence in making decisions that concern their day to day activities, their social relationships, personal beliefs and their relationship to salient features of the environment. People who are infected or affected begin to have a positive self-perception in the community this helps them to interact actively in the community. They are able to cope with their HIV/AIDS status and various challenges they encounter. A person who is infected by HIV/AIDS is occasionally affected by opportunistic illnesses when faced by these illnesses they readily seek medical attention and accept to start using ARVs.

5.3 Conclusions

From the study findings the following conclusions were made:

i. People who are affected and infected by HIV/AIDS experience many challenges and are greatly affected by various issues including lack of food especially nutritious food that can help their bodies, sometimes they are unable to purchase medicine and pay hospital bills, they lack employment and sometimes lose jobs due to dismissals, they also face many emotions like bitterness, shame, guilt and hopelessness. People need to

be helped to address these issues. The study found out that counseling was one of the methods commonly administered when dealing with various issues faced by people infected or affected by HIV/AIDS. The study revealed that counselling centres are open daily and because of provider initiated testing more people receive HIV/AIDS testing, although most people visit the centre when problems arise. The study revealed that most churches still need to create awareness. Although people pass information verbally about the availability of counselling services in the church. More brochures need to be circulated, the use of media through radio or Television should also be used and free medical camps can be used once in a while.

ii. The attitude of church members, pastors and counsellors towards counselling services is positive which shows that currently there is more awareness about HIV/AIDS and this has helped change people's attitude.

iii. Occasionally gender influences decision to seek counselling. More women than men visit the centres for counselling services since women seek more reproductive services than men. The level of education does not always influence the access and utilization of counselling services. The fact that one is married or not does not influence the decision a person makes concerning counselling services. Most of the people who visit the centres for counselling services are between the ages of 18 to 47. People mostly access counselling services because they want to know their status, maintain a close relationship with their partners and also to avoid family conflicts. The highest numbers of people who visit counseling centers like VCT are College students and form four leavers as they are eager to know their HIV/AIDS status.

iv. There is some difference in the uptake of HIV/AIDS counselling services by gender, age, education, marital status, and social economic status. The results of the study show that people are sometimes influenced by their gender, age, education, marital status and social economic status to seek counselling services.

v. Counseling services have a positive influence on the quality of life. When people receive counseling services with a positive attitude a significant change is evident in their lives.

5.4 Implications of the findings

i. People who are infected and affected have many issues that needed to be addressed to help improve the quality of their lives.

ii. Policy makers should involve professionals in developing more and appropriate programmes to help improve the quality of life of those infected and affected to improve their quality of life.

iii. The church and the government have a critical role in supporting those infected and affected to improve the quality of their lives. All sectors are necessary in the fight against the HIV/AIDS pandemic. For holistic care and improvement of quality of life. Those infected and affected should not fight alone but together as a nation we can support each other in ways that can improve quality of life.

iv. Counselling services have been seen to have an influence on the quality of life of those who access and utilize the services. The Government and the Church have established and implemented HIV/AIDS counselling services. However current efforts are not reaching all as a result not all people infected and affected utilize these services. More awareness and prevention initiatives need to be developed and undertaken.

5.5 Recommendations

i. This study recommends that counselling services need to be improved to be able to address effectively the various issues and challenges faced by those infected and affected.

ii. This study recommends the scaling up of awareness campaigns of available counselling services through reminding the church members the need to access the counseling services, the use of public meetings to inform members of the community of available counselling services, use of support groups to discuss pass relevant information and mass media to bridge the gap between awareness and intake of services.

iii. The study recommends provision of more funds to boost more services like nutritious meals, and even projects development and establishment which can be used to create employment and generate income for struggling households. The Government should also develop policies and strategies that can enhance and improve the counseling services being provided. The Kenyan government needs to work to develop sustainable methods of funding to sustain and scale up existing prevention efforts.

iv. However, in order to get more people in Kenya to test for HIV, as well as an increase in the provision of HIV services, a number of social, cultural and legal barriers need to be overcome which prevent many people, particular those belonging to key affected groups from accessing them.

v. The study recommends that the church and the Government should continue to address and help church members and the community to change their attitudes and perceptions towards people infected and affected this will help reduce stigmatization and improve the quality of life of these people.

vi. This study recommends the need to consider various demographics when developing and implementing policies, strategies and programmes related to HIV/AIDS since these demographics have an influence on the uptake of counselling services.

5.6 Suggestions for Further Research

i. Issues surrounding acceptance and use of Voluntary Counselling testing centres.

ii. Preparedness and effectiveness of Counselors to handle HIV/AIDS affected and infected people.

iii. The impact of HIV/AIDS related trauma on caregivers who handle those infected to the point of death.

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APPENDICES

APPENDIX A: QUESTIONNAIRE FOR PASTORS

This questionnaire is intended to assess the influence of HIV/AIDS counselling services on the quality of life of people in selected churches in Nakuru County. Please answer the questions as truly as you can. All information will be treated confidentially. Kindly do not put or indicate your name in the questionnaire. Tick or comment briefly where applicable.

Section A: Bio data

Please kindly provide the following information. The information gathered will be kept strictly confidential and will only be used for the research and not for any other reason.

1 a) Name of your Church……..

b) Date …….

c) Gender Male ( ) Female ( )

d) What is your age bracket? Tick () where applicable

i) 20-24 ( ) ii) 25-29 ( ) ii) 30-34( ) iv) 35- 39 ( )

v) 40-44 ( ) vi) 45-49 ( ) vii) 50 and above ( )

2 a) How long have you been in this Church ……?

b) How long have you been a pastor/Priest…….?

3. Current status

Married ( ) ii) Single adult ( ) iii) Youth ( ) iv) Separated ( )

Widow ( ) vi) Widower ( )

Section B: Issues Affecting Quality Of life

4. The table below contains issues that affect the quality of life of people infected or affected by HIV /AIDS. How frequent were these issues observed among the infected and affected people in the past two years?

Issue	**Always**	**Frequently**	**Less frequently**	**Occasionally**	**Never**
Lack of food					
Unable to pay hospital bills					
Satisfaction current life circumstances					
Unable to purchase medicine					
Lack of caregivers to provide nursing					
Lack of employment/ income					
Denial					
Anger					
Bitterness					
Guilt					
Shame					
Regret					
Discrimination					
Lack of love					
Fear					
Hopelessness					
Despair					

5. How did you deal with the above Issues?

Did nothing	**Confronted**	**Sympathized**	**Counseled**	**Provided**	**Referred**
Lack of food/nutritious diet					
Unable to pay hospital bills					
Unable to purchase medicine					
Lack of caregivers to provide nursing					
Satisfaction current life circumstances					
Lack of employment/ income					
Regret					
Discrimination					
Lack of love					
Fear					
Hopelessness					
Poverty					
Despair					

Section C: Access and Utilization of Counselling Services

6. The following factors influence people to go or not to go for counselling services kindly select the appropriate answer

Factors	**Always**	**Frequently**	**Rare**	**Never**
Their Knowledge of HIV/AIDS				
Understanding the benefits of HIV testing				
Fear of a spouse reaction				
Fear of divorce				
Fear of violence				
Fear of stigmatization and discrimination				
Fear of type of test to be used				
Fear of couple counselling				
Access to medical care				
Confidentiality (counsellors keeping secrets)				

7. In the last three months how many people came to the centre for counselling

i) Every day…… ii) Every week…… iii) Every Month…

8. The following are commonly used methods to create awareness of the availability of a counselling centre select the frequency by which a method attracts people to come for counselling services

Advertisement	**Always**	**Frequently**	**Less frequently**	**Occasionally**	**Never**
Word of mouth					
Church Announcements					
Use of brochures					
Free medical camps in the community					
Medical services/maternity					
Radio/ TV					

Section D: The Influence of Counselling Services

9. Are the following counselling services offered in your Church?

Services	**Sometimes**	**Always**	**Never**
Voluntary Counselling and Testing (VCT)			
PMTC (Prevention of Mother to child transmission)			
Home based care			
Resource Centre (Library)			
Nutritious meals			
Individual Counselling			
Group Counselling			
Referral (sending a patient to a specific Doctor)			
Training (seminars)			

10. What is your assessment of the following counselling services offered in your Church?

Services	**Poor**	**Fair**	**Good**	**V.Good**	**Excellent**
Voluntary Counselling and Testing (VCT)					
Home based care					
Resource Centre (Library)					
Nutritious meals					
Individual Counselling					
Group Counselling					
Referral (sending a patient to specific Doctor)					
Training (seminars)					

11. In the last three months have you undertaken any of the following Counselling services?

Counselling services	**Yes**	**No**	**Don't Know**
Counseled youth on sex and marriage			
Counseled couples on faithfulness in marriage			
Cared for people living with AIDS			
Cared for orphans and vulnerable children			
Held behavior change seminars			
Provide Counselling to individuals			
Carried out home based care programme			
Provided Drugs(ARVs)			
Build a counselling centre			

12. After providing HIVAIDS counselling services in the Church do you see these changes in the lives of people?

Changes	**Yes**	**No**	**Sometimes**
Improved sexual behavior			
Positive self esteem			
Positive perception and attitudes of self in the community			
Coping with HIV/AIDS			
Use of ARVS			

Section E: Attitudes of People towards Counselling Services

13. The following are emotions experienced by people towards counselling services please select them according to their frequency in your life?

Emotions/Feelings	**Rare**	**Frequently**	**Never**	**Sometimes**	**Always**
I need more training.					
I need to offer more services.					
I am afraid to pray with people who are infected and affected.					
I am afraid to visit sick people.					
I can help someone write their will.					
I cannot touch a person with HIV/AIDS.					
You should have known before you had the affair.					

14. Which age groups frequently go for Counselling?

i) 20-24 ( ) ii) 25-29 ( ) ii) 30-34( ) iv) 35- 39 ( )

v) 40-44 ( ) vi) 45-49 ( ) vii) 50 and above ( )

Section F: Influence of Demographic characteristics and Counselling services

15. Do the following characteristics influence people to access and utilize counselling services

Characteristic	**Always**	**Frequently**	**Less frequently**	**Occasionally**	**Never**
Age					
Gender					
Level of Education					
Occupation/ Status					
Marital status					

16. What influences this age group to seek for counseling?

……

17. What is the common level of education of those attending counselling services?

i) Illiterate ( ) ii) Primary ( ) iii) Secondary ( ) iv) College ( )

18. Is there a difference in visits made to the centre by men or women?

i) Yes () ii) No () iii) I don't know ()

19. Explain your answer to the question above?

……

20. From your assessment most of the clients who visit the centre are

i) Employed ii) Unemployed

21. What is the marital status of most of the clients who attend the counselling?

i) Married ( ) ii) Single ( ) iii) Widowed ( ) iv) Divorced/ separated ( )

22. If you rate the counselling services offered in your church can you say it is

i) Excellent ( ) ii) Good ( ) iii) Average ( ) iv) Poor ( )

23. How can HIVAIDS counselling services be improved?

APPENDIX B: QUESTIONNAIRE FOR COUNSELLORS

This questionnaire is intended to assess the influence of HIV/AIDS counselling services on the quality of life of people in selected churches of Nakuru County. Please answer the questions as truly as you can. All information will be treated confidentially.

Section A: Biodata

Please kindly provide the following information. The information gathered will be kept strictly confidential and will only be used for the research and not for any other reason

1) a. Name of your Church……..

   b. Gender Male ( ) Female ( )

2) What is your age bracket?

   i) 20-24 ( ) ii) 25-29 ( ) ii) 30-34( ) iv) 35- 39 ( )

   v) 40-44 ( ) vi) 45-49 ( ) vii) 50 and above ( )

3 How long have you been a counselor…….?

4. Current status?

   i) Married ( ) ii) Single adult ( ) iii) Youth ( ) iv) Separated ( )

   v) Widow ( ) vi) Widower ( )

Section B: Issues Affecting the Quality of Life

5. The table below contains issues that affect the quality of life of people infected or affected by HIV /AIDS. How frequent were these issues observed among the infected and affected people in the past two years?

Issue	**Always**	**Frequently**	**Less frequently**	**Occasionally**	**Never**
Lack of food					
Unable to pay hospital bills					
Unable to purchase medicine					
Lack of caregivers to provide nursing					
Satisfaction of current life circumstances					
Lack of employment/ income					
Denial					
Anger					
Bitterness					
Guilt					
Shame					
Regret					
Discrimination					
Lack of love					
Fear					
Hopelessness					
Despair					

6. How did you deal with the above Issues?

	Did nothing	Confronted	Sympathized	Counseled	Referred
Lack of food/nutritious diet					
Unable to pay hospital bills					
Unable to purchase medicine					
Lack of caregivers to provide nursing					
Lack of employment/ income					
Satisfaction of current life circumstances					
Regret					
Discrimination					
Lack of love					
Fear					
Hopelessness					
Poverty					
Despair					

Section C: Access and Utilization of Counselling Services

7. The following factors influence people to go or not to go for counselling services kindly select the appropriate answer

Factors	**Always**	**Frequently**	**Rare**	**Never**
Knowledge on HIV/AIDS				
Understanding the benefits of HIV testing				
Fear of a spouse reaction				
Fear of divorce				
Fear of Violence				
Fear of Stigmatization and discrimination				
Fear of type of test to be used				
Fear of couple counselling				
Access to medical care				
Confidentiality (counsellors keeping secrets)				

8. The following are commonly used methods to create awareness of the availability of a counselling centre select the frequency by which a method attracts people to come for counselling services

Advertisement	**Always**	**Frequently**	**Less frequently**	**Occasionally**	**Never**
Word of mouth					
Church Announcements					
Use of brochures					
Free medical camps in the community					
Medical services/maternity					
Radio/ TV					

9. Which method attracts more people to come for counselling services?

10. What counselling services are offered in your Church?

Section D: The Influence of Counselling Services

11. In the last three months have you offered these counselling services?

Key: 1. Yes 2. No 3. Don't Know

a. Counseled youth on sex and marriage	1	2	3
b. Counseled couples on faithfulness in marriage	1	2	3
c. Counseled couples on faithfulness in marriage	1	2	3
d. Cared for people living with AIDS	1	2	3
e. Cared for orphans and vulnerable children	1	2	3
f. Held behavior change seminars	1	2	3
g. Provide Counselling to individuals	1	2	3
h. Carried out home based care programme	1	2	3
i. Provided Drugs (ARVs)	1	2	3
j. Build a counselling centre	1	2	3

12. Do you see the following changes after providing HIV/AIDS counselling services in the Church?

Changes	**Yes**	**No**	**Sometimes**
Improved sexual behavior			
Positive self esteem			
Positive perception and attitudes of self in the community			
Coping with HIV/AIDS			
Use of ARVS			

Section E: Attitudes of People towards Counselling Services

13. Counselors experience various attitudes when providing counselling services kindly select the options that describe your attitudes

I feel emotionally drained by my work

Always ( ) often ( ) occasionally ( ) never ( )

My work is very stressful

Always ( ) often ( ) occasionally ( ) never ( )

My work is very rewarding

Always ( ) often ( ) occasionally ( ) never( )

My work environment is very stressful

Always ( ) often ( ) occasionally ( ) never ( )

I learn something new in my work every day

Always ( ) often ( ) occasionally ( ) never ( )

I feel isolated in my work

Always ( ) often ( ) occasionally ( ) never ( )

I have problems communicating with my clients

Always ( ) often ( ) occasionally ( ) never ( )

I have no confidence in my counselling skills

Always ( ) often ( ) occasionally ( ) never ( )

I can help my clients

Always ( ) often ( ) occasionally ( ) never ( )

10 What is your attitude towards counselling services?

Negative ( ) Positive () Undecided ( )

Section F: Influence of selected Demographic Characteristics and uptake of HIV/AIDS counselling services

14. Do the following characteristics influence people to access and utilize counselling services.

Key: 1. Always 2. Frequently 3.Less frequently 4. Occasionally 5 Never

Age	1	2	3	4	5
Gender	1	2	3	4	5
Level of Education	1	2	3	4	5
Occupation/ Status	1	2	3	4	5
Marital status	1	2	3	4	5

15. From your experience in counselling which age groups frequently come for Counselling?

16. What influences this age group to come for counselling services?

…….

17. What is the common level of education of those attending counselling services?

18. Is there a difference in visits made to the centre by men or women?

19. Explain your answer to the question above?

……

20. From your assessment most of the clients who visit the centre are

i) Employed ii) Unemployed

21. What is the marital status of most of the clients who attend the counselling?

i) Married ( ) ii) Single ( ) iii) Widowed ( ) iv) Divorced/separated ( )

22. If you rate the counselling services you offer can you say it is

i) Excellent ( ) ii) Good ( ) iii) Average ( ) iv) Poor ( )

23. How can HIVAIDS counselling services be improved?

APPENDIX C: QUESTIONNAIRE FOR CHURCH MEMBERS

The following questionnaire is intended to help assess the influence of HIV/AIDS counselling services on the quality of life in selected churches in Nakuru County, Kenya. Please fill these questions as truly and honestly as possible. All information on this questionnaire will be treated as strictly confidential. Kindly do not put your name on the questionnaire. Tick or comment briefly where applicable.

Section A: Biodata

Please kindly provide the following information. The information gathered will be kept strictly confidential and will only be used for the research and not for any other reason

1 a) Name of your Church……

2. Gender: Male ( ) Female ( )

3. Current status?

i) Married ( ) ii) Single adult ( ) iii) Youth ( ) iv) Separated ( ) v) Widow ( ) vii) Widower ( )

4. Which group do you belong?

Men ( ) ii) Youth ( ) iii) Women ( )

Section B: Issues Affecting the Quality of life.

5. The table below contains issues that affect the quality of life of people infected or affected by HIV /AIDS. How frequent were these issues observed among the infected and affected people in the past two years?

Issue	**Always**	**Frequently**	**Less frequently**	**Occasionally**	**Never**
Lack of food					
Unable to pay hospital bills					
Unable to purchase medicine					
Lack of caregivers to provide nursing					
Lack of employment/ income					
Satisfaction of current life circumstances					
Denial					
Anger					
Bitterness					
Guilt					
Shame					
Regret					
Discrimination					
Lack of love					
Fear					
Hopelessness					
Despair					

6. How did you deal with the above Issues?

Issue	**Confronted**	**Sympathized**	**Did nothing**	**Counseled**	**Referred**
Lack of food/nutritious diet					
Unable to pay hospital bills					
Unable to purchase medicine					
Satisfaction of current life circumstances					
Lack of caregivers to provide nursing					
Lack of employment/ income					
Regret					
Discrimination					
Lack of love					
Fear					
Hopelessness					
Poverty					
Despair					

Section C: Access and Utilization of Counselling Services

7. The following factors influence people to go or not to go for counselling services kindly select the appropriate answer

Factor	**Always**	**Frequently**	**Rare**	**Never**
Their Knowledge of HIV/AIDS				
Understanding the benefits of HIV testing				
Fear of a spouse reaction				
Fear of divorce				
Violence				
Fear of Stigmatization and discrimination				
Fear of type of test to be used				
Fear of couple counselling				
Access to medical care				
Confidentiality (counsellors keeping secrets)				

8. How frequent do people visit the centre for counselling services?

i) Every day ( ) ii) Once a week ( ) iii) Twice a week ( )

iv) When a problem arises ( )

9. The following are commonly used methods to create awareness of the availability of a counselling centre select the frequency by which a method attracts people to come for counselling services

Advertisement	**Always**	**Frequently**	**Less frequently**	**Occasionally**	**Never**
Word of mouth					
Church Announcements					
Use of brochures					
Free medical camps in the community					
Medical services/maternity					
Radio/ TV					

Section D: The Influence of Counselling Services

10. Are the following counselling services offered in your Church?

Services	**Sometimes**	**Always**	**Never**
Voluntary Counselling and Testing (VCT)			
PMTC (Prevention of Mother to child transmission)			
Home based care			
Resource Centre (Library)			
Nutritious meals			
Individual Counselling			
Group Counselling			
Referral (sending a patient to a specific Doctor)			
Training (seminars)			

11.After providing HIVAIDS counselling services in the Church do you see these changes in the lives of people?

Changes	**Yes**	**No**	**Sometimes**
Improved sexual behavior			
Positive self esteem			
Positive perception and attitudes of self in the community			
Coping with HIV/AIDS			
Use of ARVS			

12. What is your assessment of the following counselling services offered in your Church?

Services	**Poor**	**Fair**	**Good**	**V.Good**	**Excellent**
Voluntary Counselling and Testing (VCT)					
Home based care					
Resource Centre (Library)					
Nutritious meals					
Individual Counselling					
Group Counselling					
Referral (sending a patient to specific Doctor)					
Training (seminars)					

13. In the last three months have you undertaken any of the following Counselling services?

Counselling services	**Yes**	**No**	**Don't Know**
Counseled youth on sex and marriage			
Counseled couples on faithfulness in marriage			
Cared for people living with AIDS			
Cared for orphans and vulnerable children			
Held behavior change seminars			
Provide Counselling to individuals			
Carried out home based care programme			
Provided Drugs(ARVs)			
Build a counselling centre			

Section E: Attitudes of People to Counselling Services

14. The following are emotions experienced by people towards counselling services please select them according to their frequency in your life?

Emotions/Feelings	**Rare**	**Frequently**	**Never**	**Sometimes**	**Always**
I need more training.					
I need to offer more services.					
I am afraid to pray with people who are infected and affected.					
I am afraid to visit sick people.					
I can help someone write their will.					
I cannot touch a person with HIV/AIDS.					
You should have known before you had the affair.					

Section F: Influence of Demographic characteristics and Counselling services

16. Do the following characteristics influence people to access and utilize counselling services

Characteristic	**Always**	**Frequently**	**Less frequently**	**Occasionally**	**Never**
Age					
Gender					
Level of Education					
Occupation/ Status					
Marital status					

17. Which age groups frequently goes for Counselling?

i) 20-24 ( ) ii) 25-29 ( ) ii) 30-34( ) iv) 35- 39 ( )

v) 40-44 ( ) vi) 45-49 ( ) vii) 50 and above ( )

18. What influences this age group to seek for counseling?

……
….

……
…..

19. What is the common level of education of those attending counselling services?

i) Illiterate ( ) ii) Primary ( ) iii) Secondary ( ) iv) College ( )

20. Is there a difference in visits made to the centre by men or women?

i) Yes () ii) No () iii) I don't know ()

21. Explain your answer to the question above?

……
…….

22. From your assessment most of the clients who visit the centre are

i) Employed ii) Unemployed

23 What is the marital status of most of the clients who attend the counselling?

i) Married ( ) ii) Single ( ) iii) Widowed ( ) iv) Divorced/ separated ( )

24. How can HIVAIDS counselling services be improved?

APPENDIX D: QOL ASSESSMENT QUESTIONNAIRE FOR PEOPLE LIVING WITH HIV/AIDS (WHOQOL)

The following questions ask how you feel about your quality of life, health or other areas of your life. Please choose the answer that appears most appropriate if your are unsure about which response to give to a question the first response you think of is often the best one

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last four weeks.

	Very poor	Poor	Neither poor or good	good	Very good
1. How would you rate your quality of life	1	2	3	4	5

	Very dissatisfied	Dissatisfied	Neither dissatisfied nor satisfied	Satisfied	Very satisfied
2. How satisfied are you with your health.	1	2	3	4	5

The following questions ask how much you have experienced certain things in the last four weeks.

	Not at all	A little	A moderate amount	Very much	Extreme amount
3. To what extend do you feel that physical pain prevents you from doing what you need to do?	5	4	3	2	1
4. How much do you need medical treatment to function in your daily life	5	4	3	2	1
5. How much do you enjoy life	1	2	3	4	5
6. To what extend do you feel your life to be meaningful	1	2	3	4	5
7. How well are you able to concentrate	1	2	3	4	5
8. How safe do you feel in your daily	1	2	3	4	5

life					
9. How health is your physical environment	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

	Not all	A little	Moderately	Mostly	Completely
10. Do you have enough energy for everyday life?	1	2	3	4	5
11. Are you able to accept you bodily appearance	1	2	3	4	5
12. Do you have enough money to meet your needs?	1	2	3	4	5
13. How available to you is the information that you need in your day to day life	1	2	3	4	5
14. To what extend do you have the opportunity for leisure activities	1	2	3	4	5

	Very poor	Poor	Neither dissatisfied or satisfied	Satisfied	Very Satisfied
15. How well are you able to get around					

	Very dissatisfied	Dissatisfied	Neither dissatisfied or satisfied	Satisfied	Very Satisfied
16. How satisfied are with your sleep	1	2	3	4	5
17. How satisfied are with your ability to perform your	1	2	3	4	5

daily living activites					
18. How satisfied are you with your capacity for work	1	2	3	4	5
19. How satisfied are you with yourself	1	2	3	4	5
20. How satisfied are you with your personalrelations hips	1	2	3	4	5
21. How satisfied are you with your sex life	1	2	3	4	5
22. How satisfied are you with the support you get from friends	1	2	3	4	5
23. How satisfied are you with your transport	1	2	3	4	5
24. How satisfied are you with the living conditions of your living place	1	2	3	4	5

The following questions refers to how often you have felt or experienced certain things in the last four weeks

	Never	Seldom	Quite often	Very often	Always
25. How often do you have negative feelings such as despair, anxiety, depression	5	4	3	2	1

26. How much confidence do you have in yourself	1	2	3	4	5
27. How positive do you feel about the future?					
28. How much are you bothered by any limitations in performing everyday living activities	1	2	3	4	5

29. To what extent do you have difficulty in performing your routine activities	1	2	3	4	5

	Not at all	A little	A moderate amount	Very much	A extreme amount
30.To what extend to your personal beliefs give you the strength to face difficulty	1	2	3	4	5

31.To your personal beliefs give meaning to your life	1	2	3	4	5

32.To what extent do you feel your life be meaningful	1	2	3	4	5

33.To what extent do your personal beliefs help you to understand difficulties in life	1	2	3	4	5

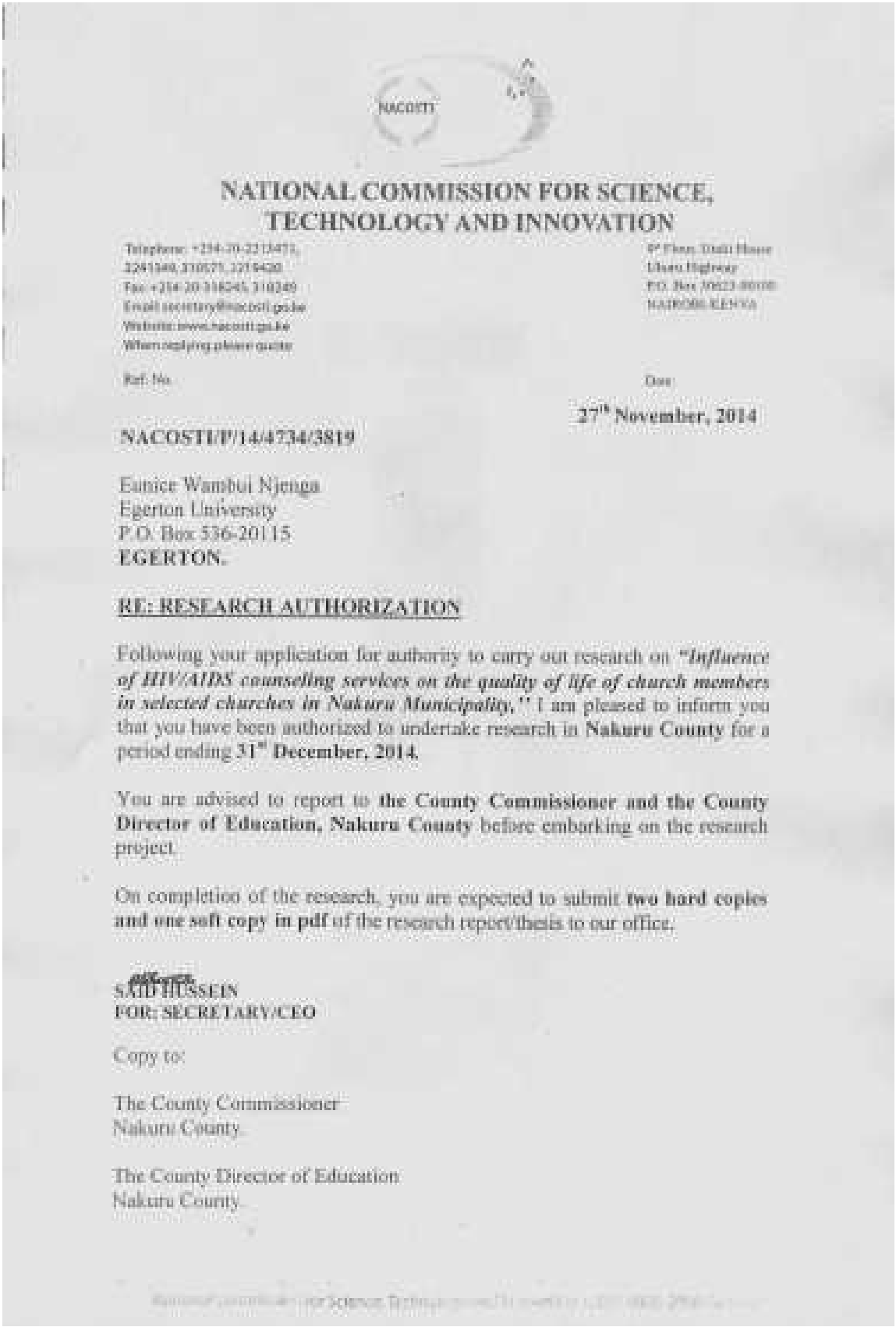
APPENDIX E:PUBLICATIONS

The Perception and Attitude of Church members towards HIV/AIDS Counseling Services in Selected Churches in Nakuru East Sub County – International Journal of Innovative Research & Studies

The Influence of HIV/AIDS counselling services on the quality of life in selected churches in Nakuru Municipality. Journal of Education and Practice vol 5, no 30 (2004)

Influence of Gender, Age, Education and Socio-Economic Status on the uptake of HIV/AIDS Counseling Services by Church Members in selected Churches in Nakuru County. Kabarak University Journal of Research and Innovation - in the process

APPENDIX F: RESEARCH APPROVAL – NACOSTI



NACOSTI

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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2241349,310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:

27th November, 2014

NACOSTI/P/14/4734/3819

Eunice Wambui Njenga
Egerton University
P.O. Box 536-20115
EGERTON.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Influence of HIV/AIDS counseling services on the quality of life of church members in selected churches in Nakuru Municipality,"*** I am pleased to inform you that you have been authorized to undertake research in **Nakuru County** for a period ending **31st December, 2014.**

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

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

SAID HUSSEIN
FOR: SECRETARY/CEO

Copy to:

The County Commissioner
Nakuru County.

The County Director of Education
Nakuru County.

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

NACOST

National Commission for Science Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No. A 3757

CONDITIONS: see back page

THIS IS TO CERTIFY THAT:

MS. EUNICE WAMBUI NJENGA

of EGERTON UNIVERSITY, 14201-20100 NAKURU, has been permitted to conduct research in Nakuru County

on the topic: INFLUENCE OF HIV/AIDS COUNSELING SERVICES ON THE QUALITY OF LIFE OF CHURCH MEMBERS IN SELECTED CHURCHES IN NAKURU MUNICIPALITY

for the period ending: 31st December,2014

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