

**Assessment of HIV/AIDS Behavior Change Messages used by
the Seventh-day Adventist (SDA) Church among its Young
People in Homa-Bay County**

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DECLARATION

Declaration by the Student

This research project is my original work and has not been presented for any study program in any university.

(Sign).....

Date

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Declaration by the Supervisor

This research project has been presented for examination with my approval as the university supervisor.

(Sign).....

Date

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DEDICATION

I dedicate this study to my dear husband, Nicky, for his support and encouragement throughout this program and to my babies, Chyzel and Kenzye for the inspiration.

ACKNOWLEDGEMENT

Conducting this research study has been a team effort and I would like to acknowledge members of that team. First and foremost, I thank God for giving me the strength to carry on even when things looked bleak. Secondly, I appreciate my dear husband, Nicky, for his financial and moral support. Special thanks go to my supervisor Dr. Sam Kamau for his patience and guidance throughout this journey. I register my appreciation to the SDA church, West Kenya Union and Kenya Lake Conference. Special recognition to Daniel Tirop, Pastor Benson Ogayo, Mrs. Esther Achiando and Kevin. I am also grateful to all the research assistance who helped me during data collection. I appreciate all those young people and the teachers who took part in the study. I also recognize Eric who helped in data analysis. May God bless you.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
HIV	Human Immunodeficiency virus: the virus that causes AIDS
SDA	Seventh-day Adventist
ADRA	Adventist Development and Relief Agency
PATH	Program for Appropriate Technology in Health
ABC	Stands for Abstinence, Being safe by being faithful to one partner and correct and consistent use of Condoms.
SAVE	Safe practice, Availability of medication, Voluntary counseling and testing and Empowerment through education
STI	Sexually transmitted infection
BCC	Behavior Change Communication
FBO	Faith-Based organizations
NGO	Non-governmental Organizations
PEPFAR	President's Emergency Plan for AIDS Relief
UNAIDS	Joint United Nations Program for HIV and AIDS
WHO	World Health Organization
MoHK	Ministry of Health Kenya
NACC	National Aids Control Council
UNICEF	United Nations Children's Fund
FHI	Family Health International

ABSTRACT

The Human Immunodeficiency Virus (HIV) continues to spread in most countries of the world including Kenya and the rate at which young people are being infected remain disturbingly high. Since HIV/AIDS has no cure yet, behavior change has been fronted as the most likely scientific basis for the reduction in HIV prevalence. There is need for concerted effort by all sectors including religious organizations to be able to curb this menace especially among the vulnerable young people. This study was an assessment of HIV/AIDS behavior change communication used by the Seventh-day Adventist (SDA) church among its young people in Homa Bay County. It was a descriptive survey. The researcher targeted young people in Homa Bay County who are members of the Seventh-day Adventist church. Out of the 648 SDA churches in Homa Bay County, 20 were randomly selected out of which 100 young people were randomly selected to be included in the sample. Key informants were purposively selected. Data was collected using a questionnaire and interview of key informants. SPSS (Statistical Package for the Social Sciences) and basic descriptive statistics were used for analysis and presentation of data respectively. The messages given by the SDA church regarding HIV/AIDS behavior change to its young people were mainly on how to take caution to causes of HIV/AIDS at 55%. These messages were mostly passed through young people group discussions at 34%. The reception of the HIV/AIDS behavior change communication by young people in the SDA church is moderate at 51%. But in spite of this level of awareness, young people in the SDA church still continue to be infected because of acting carelessly at 58%. This study concluded that the message of transmission of HIV/AIDS and preventive measures has been widely received by the young people in the SDA church.

Yet they continue to be infected because they lack negotiation skills for safe sex, decision-making skills to choose on the right thing even under peer pressure and the right attitude to avoid infection.

The study recommends that HIV/AIDS communication should target to develop such skills as negotiation, decision-making, critical and creative thinking as well as coping with stress and emotions among young people. The packaging should be more attractive and should involve young people in design and dissemination.

CHAPTER ONE: INTRODUCTION

1.0 Introduction

This study was intended to assess HIV/AIDS behavior change messages used by the Seventh-day Adventist (SDA) church among its young people in Homa Bay County. It critically analyzed HIV/AIDS behavior change information targeted at young people, how that information is packaged and passed to the young people and the results achieved and determine whether there is need to change the message, the packaging or method of presentation in order to achieve desirable results as far as HIV/AIDS infection is concerned.

1.1. Background to the Study

Scientists first identified the human immunodeficiency virus (HIV) as the cause of acquired immunodeficiency syndrome (AIDS) in 1983. Since then, the disease has spread relentlessly, causing one of the most devastating pandemics ever recorded in human history. Globally, it is recorded that almost 78 million people have been infected with the HIV virus and more than 39 million people have died due to AIDS-related causes since the pandemic began and millions more are newly infected with the virus each year. About 35 million people were living with HIV at the end of 2013. An estimated 0.8% of adults aged 15–49 years worldwide are living with HIV (UNAIDS, 2014).

Although the burden of the epidemic continues to vary considerably between countries and regions, Sub-Saharan Africa remains most severely affected, with 24.7 million people living with HIV in 2013, accounting for nearly 71% of the people living with HIV worldwide (WHO, 2014). In Kenya, the first case of HIV was detected in 1984, and by mid 1990s it was one of the major causes of mortality forcing the government to declare

AIDS as a national disaster in 1999. This led to concerted efforts to battle the pandemic in order to make a significant difference. Even though the country has over the years continued to significantly reduce the prevalence and impact of HIV, much still remains to be done. According to AVERT's 2012 statistics; Kenya had the 4th largest HIV epidemic in the world. An estimated 1.6 million people were living with HIV in 2013 with an adult (15-49 years) prevalence of 6% (MoHK 2014 HIV Estimates Report). Close to 101,560 new HIV infections occur annually (in 2013) in Kenya (NACC, 2014).

Globally, it is noted that nearly half of all new HIV infections occur in people under age 25. Africa has 1.8 million young people living with HIV, and AIDS related deaths are the leading cause of death among young people in the continent (NACC, 2014). The burden of HIV among young people worldwide is so high such that trends among young people shape the overall epidemic (www.popcouncil.org/hiv/aids). This has served as a fresh call for stakeholders to act on the rising numbers of infection and death among global and African young people. In Kenya similarly, cases of new rising infections among young people are on the rise. UNICEF 2013 statistics puts HIV prevalence among young people in Kenya at 2.2%, 1.7% for male and 2.8% for female. Approximately 29% of all new HIV infections in Kenya are among young people. 21% of all people living with HIV are aged between 15 and 24. 17% of all AIDS related deaths are among these young people. Young women aged 15 – 24 years post the highest number of HIV infections and contribute 21% of all new infections in Kenya, (NACC, 2014). HIV burden in Homa Bay County is the highest in the country with an overall prevalence rate of 25.7%. Of the 1,053,465 total population of the county, 159,970 people are living with HIV counting

for 15%. Out of the total number of people living with HIV in the county, 46,530 are young people (15-24 year) (NACC, 2014). Of all the 101,560 Kenyans infected with HIV in 2013, 15,003 were in Homa Bay county counting for about 15% (Kenya HIV Estimates Technical Report 2013).

From the above statistics, it is evident that much work still needs to be if Kenya is to continue in its path towards the goal of Zero new HIV infections by 2030. There should be a proactive involvement in creating awareness among the youth and helping them make healthy decisions regarding sexual activity so that they can protect themselves from HIV/AIDS. The launch of the 'All In' Global Campaign in Kenya by President Uhuru Kenyatta in February 2015, was aimed at providing impetus for a coordinated multi-sectoral response to reach adolescents and young people and accelerate the response to end new infections and AIDS related deaths. The 'All In ' Campaign, is a global initiative by UNAIDS, UNICEF and partners to fast track reductions in AIDS related deaths and new infections among adolescents and young people towards ending the HIV/AIDS epidemic by 2030. It is a new platform for action to drive better results for adolescents by encouraging strategic changes in policy and engaging more young people in the effort. During the launch, WHO Country Representative, Dr Custodia Mandlhate, called for a multisectoral approach and use of data to arrive at better decisions regarding young people and HIV/AIDS (www.unaids.org).

In this era of extraordinarily high HIV prevalence rates, interventions have relied on government, inter-governmental organizations, non-governmental organizations,

community-based organizations and religious organizations among others, to organize and deliver programs. Over the years, religious organizations have generated increasing interest as agents for preventing and mitigating the HIV/AIDS epidemic. They have been active in the fight against HIV/AIDS and their role in delivering information, encouraging open discussion, providing services, and changing behavior in order to reduce the impact of the HIV epidemic has been felt in many countries, for example in Uganda. Peter Okaalet in his article, *Role of Faith-based Organizations in the fight against HIV/AIDS in Africa*, posits that religious-based initiatives, when properly supported and coordinated, can be some of the most strategic vehicles through which to slow the spread of HIV and AIDS.

The Seventh-day Adventist church is one of the religious organizations that have taken a proactive role in the fight against HIV/AIDS. This has been done through programs that promote awareness and behavior change among its congregation and also providing care and support for people living with HIV/AIDS. The Adventist Aids International Ministries (AAIM) coordinates and promotes hundreds of HIV/AIDS church-based support programs for those living with the disease in sub-Saharan Africa (*adventist.org*). The Health and Youth Ministries department of the church equip young people with knowledge and information that help to model behavior and attitude. The church has a comprehensive children and youth program to meet the spiritual, social and lifestyle needs of its young people. It is against this background that this study sought to assess HIV/AIDS behavior change messages that the Seventh-day Adventist (SDA) church uses among its young people focusing on Homa Bay County.

1.2. Statement of the Problem

Most religious organizations have had to review their approach progressively in order to effectively address the HIV/AIDS crisis. Traditionally, the Seventh-day Adventist Church, like many other churches, had a strict approach to sexual issues among the young people by stressing complete abstinence, which was widely accepted and preached, but apparently with disastrous results (*Makahamadze and Sibanda 2008*). This was followed by a less strict stance towards ABC (Abstain, Be faithful and use Condoms) which was seen as compassionate attempt to prevent or reduce the negative consequences of detrimental sexual behavior among the young people (*Adventist AIDS International Ministries*).

Despite this seemingly pragmatic approach to dealing with these serious problems of sexuality and behavior change, and the use of ‘appropriate’ interventions, the church has not achieved much success in modeling young people’s behavior in line with its objectives as most of them still engage in risky sexual behavior which is evidenced by the high number of teenage pregnancies and HIV/AIDS infection rates among them. The concern is, if young people are so well informed, and in every sense over saturated with the extensive facts about HIV/AIDS, then why do they continue to put themselves at risks? Why are young people still getting infected? Isn’t HIV/AIDS knowledge by itself enough anymore? Then how else can the society and the church in specific make the threat more tangible, more real? What is it that works as far as HIV/AIDS behavior change communication is concerned?

Data lacks on success of communication strategies used by religious organizations to tackle HIV/AIDS behavior change among young people. For instance, it is not known why high levels of awareness about the consequences of risky sexual behavior do not translate to the desired behavior change, thus the need to critically look at HIV/AIDS behavior change messages used by the Seventh-day Adventist (SDA) church among its young people. A proper understanding is required in determining if and whether HIV/AIDS behavior change messages by the church are working or they are not. A critical analysis of how such information are packaged, passed and received by the young people and the response given is necessary in order to determine the challenges and whether there is need to change the approach.

1.3. Objectives of the Study

This section highlights the objectives of this study as follows:

- To establish HIV/AIDS behavior change messages used by the Seventh-day Adventist church among its young people in Homa Bay County.
- To identify communication tools used by the Seventh-day Adventist church to pass HIV/AIDS behavior change messages to its young people in Homa Bay County.
- To determine the reception of HIV/AIDS behavior change messages by the young people in the Seventh-day Adventist church in Homa Bay County.
- To establish why, in spite of the HIV/AIDS behavior change messages given by the Seventh-day Adventist church to its young people, more of them still continue to be infected by the HIV virus.

1.4. Research Questions

This research study will seek to answer the following research questions:

- What are the HIV/AIDS behavior change messages used by the Seventh-day Adventist church among its young people in Homa Bay County?
- What are the communication tools used by the Seventh-day Adventist church to pass HIV/AIDS behavior change messages to its young people in Homa Bay County?
- What is the reception of HIV/AIDS behavior change messages by the young people in the Seventh-day Adventist church in Homa Bay County?
- Why, in spite of the HIV/AIDS behavior change messages given by the Seventh-day Adventist church to its young people, more of them still continue to be infected by the HIV virus.

1.5. Significance of the Study

In June, 2011, Kenya joined the global community in embracing a set of ambitious goals for this millennium. They committed themselves to redouble efforts to halt and begin to reverse the spread of HIV by 2015 (Kenya AIDS Response Progress Report, 2014). In 2014, the Ministry of Health came up with a roadmap dubbed Kenya HIV Prevention Revolution Roadmap, aimed at steering the counties and the country at large to zero new infections by 2030 (MoHK, 2014). But with the current statistics showing HIV/AIDS prevalence still high in Kenya, much still remains to be done if these goals are to be achieved. Many agree that behavior change still remains the world's primary tool for achieving this goal and clarity is urgently required regarding the optimal communication means of producing needed behavior changes, hence this study.

The study findings will contribute to the body of knowledge in the area of HIV/AIDS behavior change communication among young people and by so doing reduce the rate of infections. The findings of this study will form an important platform for implementers and policy makers in religious organizations in general and the Seventh-day Adventist church in particular to come up with effective policies and communication strategies to tackle HIV/AIDS behavior change communication among young people and achieve desired results. The findings of this study would also be of great importance to the county government of Homa Bay as well as the national government of Kenya as it provides information useful in designing HIV/AIDS behavior change communication strategies for young people. The findings of this study would also be of value to communication consultants and health professionals who create and design HIV/AIDS campaigns and programs, as it will help them identify the most suitable communication strategies for communicating to young people. Last but not least, the study will be useful to other stakeholders such as non-governmental organizations since it will guide them on areas that need more resources and efforts in the fight against HIV/AIDS.

1.6. Scope and Limitation of the Study

This study was aimed at assessing HIV/AIDS behavior change messages used by the Seventh-day Adventist (SDA) church among its young people. It was conducted in Homa Bay County, Kenya, among the SDA church going young people of ages 15-24 years. The study focused on the messages given, the tools used and the response received from the young people. It also analyzed young people's feelings and attitude towards such communication. The research was conducted among young people from several sampled

SDA churches across Homa Bay County. Homa Bay County is one of the counties in Kenya that has a wide Seventh-day Adventist church following.

The limitation of this study is that it was conducted among the SDA-church going young people in Homa Bay County only and not the whole country. Time limitations could not allow the researcher to extend the research to the whole country. Although the region selected is one of the regions where the church has a larger membership, this limitation may affect generalization of the findings. Another limitation is that the stigma attached to behaviors such as pre-marital sex and HIV/AIDS especially in a church setting, may have influenced the participants' responses.

1.7. Definition of Terms

- HIV/AIDS Behavior change: Refers to abstinence from sex, correct and consistent use of condoms and faithfulness to one sexual partner
- Behavior change communication: An interactive process that helps to understand the target population, develop a focused strategy, and produce tailored messages which are delivered using a variety of communication channels to promote positive behavior.
- Leader of young people: Refers to a person in position of authority in the SDA church and is mandated by the church to supervise and coordinate activities of young people within the church.

Risky sexual behavior:	Behavior that increases ones risk of contracting sexually transmitted infections and experiencing unintended pregnancies.
Sexual debut:	First sexual intercourse.
Abstinence:	Postponing sexual intercourse until in marriage
Abstention:	The practice of restraining oneself from indulging in something. Deliberate self-denial
Detrimental:	Tending to cause harm or exceedingly harmful
Pragmatic:	Dealing with issues sensibly and realistically in a way that is based on practical rather than theoretical considerations.
Prevalence:	The percentage of population living with HIV/AIDS.
Teacher:	A person given the responsibility of teaching young people by the SDA church.
Young people	For the purpose of this study, I have used the term 'young people' which is defined as 'people between the ages of 10-24' (James Traore, 2001) but has restricted to ages 15-24.

CHAPTER TWO: LITERATURE REVIEW

2.0. Introduction

The scale of the HIV/AIDS epidemic has exceeded all expectations since its identification more than 30 years ago. Just as the spread of HIV has been greater than ever imagined, so has been its impact on social capital, population structure and economic growth. Therefore, responding to HIV/AIDS on a scale commensurate with the epidemic is a global imperative and nothing less than a sustained social mobilization is necessary to combat one of the most serious crises facing human development today (Peter Piot et al, 2001). Numerous studies have been conducted on the subject HIV/AIDS, in a bid to find a solution to the devastating impact of this menace. This chapter presents literature review that gives the current situation regarding the topic of study. Mugenda and Mugenda (1999) explains that literature review involves the systematic identification, location and analysis of documents containing information related to the research problem being investigated.

2.1. HIV/AIDS Still a Global Burden

According to World Health Organization, approximately 35 million people worldwide were living with HIV/AIDS in 2013. Out of this, an estimated 2.1 million individuals worldwide became newly infected with HIV in 2013. The vast majority of people living with HIV/AIDS were in low- and middle- income countries, particularly in Sub-Saharan Africa where 24.7 million people were living with HIV/AIDS in 2013. 71% of all people who are living with HIV in the world live in this region. HIV is the world's leading infectious killer. An estimated 39 million people have died since the first cases were reported in 1981 and 1.5 million people died of AIDS-related causes in 2013 (WHO

Global Statistics, AIDS.gov). Kaiser Family Foundation quoting UNAIDS, puts the number of people living with HIV/AIDS worldwide in 2014 at 36.9 million.

HIV/AIDS is one of the biggest challenges the world is facing today. Individuals, families and communities are badly affected by the epidemic. HIV/AIDS is currently killing young, economically productive people, bringing hardship to families, increasing expenditure on health care and adversely affecting country's development. It deprives the economy of qualified and productive labor force, restricts the tax base and raises demands for social services due to increased number of orphaned children and widows (UON HIV/AIDS Policy, 2003). The burden of care for those infected by HIV/AIDS fall on those related to them, family and children. Children orphaned by HIV/ AIDS are deprived not only of parental care but also of financial support and in most cases are forced to drop out of school. Such children have no hope of ever getting decent jobs and life even in the future. Children who grow up without parental or adult support and guidance in most cases end up being problematic in the society. The impact is felt by society at large. There is therefore an urgent need for all stakeholders to scale up prevention programs in an effort to reduce HIV incidence.

The HIV/AIDS menace can slowly but surely reverse the gains that have been made in economic and social development. Governments cannot fight this battle alone and other organizations on the ground like churches have to provide the type of leadership and direction that will lead to a real change in people's attitude and behavior.

2.2. Impact of HIV/AIDS on Young People

While HIV/AIDS has always been considered an epidemic of young people due to the nature in which it spreads, current trends indicate that things are moving from bad to worse with the projected numbers of people living with HIV/AIDS in hard hit countries rising steadily. According to the Henry J. Kaiser Family Foundation HIV/AIDS Policy Fact Sheet, HIV/AIDS prevalence among young people is already high in many countries around the world, and young people continue to make up a significant proportion of new infections. More than a third (38%) of all people living with HIV/AIDS worldwide are under the age of 25. Teens and young adults between the ages of 15 and 24 represent almost a third of all people living with HIV/AIDS in the world, they also account for approximately 30% of new HIV infections (among those 15 and over) (UNAIDS, 2014).

Several factors make the young people particularly vulnerable to HIV/AIDS. These include their age, biological and emotional development and their financial dependence. Surveys indicate that although many more young people across the world have now heard about the HIV/AIDS epidemic, awareness is not universal and many are still unaware of how to protect themselves or harbor misconceptions about HIV transmission. Also, many sexually active young people at risk for HIV do not perceive themselves to be at risk, even those in countries with very high prevalence. Moreover, most young people living with HIV do not know they are infected. Many young people in Sub-Saharan Africa are vulnerable due to poverty, ranging from lack of access to education, economic opportunities, and health-related services (H.J.K.F. Foundation HIV/AIDS Fact Sheet).

The high HIV/AIDS prevalence among young people is seen to be resulting from increasing sexual permissiveness and associated promiscuity in the society today. At particular risk are young people entering puberty at increasingly younger ages, when they are especially vulnerable to peer pressure and a barrage of media and peer messages that treat casual sex among young people as acceptable and normal. At this tender age, they often do not settle with one partner nor do they use condoms regularly. They are also more likely than any other age group to experiment with drugs, including injection drugs, which further increases their risk of HIV (UNAIDS) . The very nature of young peoples' relationships increases their risk of HIV infection. Young people may enter a series of short-term sexual relationships and because they are faithful to their current partner, they do not consider themselves at risk of HIV infection and rarely use condoms. They assume that partners are HIV negative until suspected otherwise and when trust within the partnership is broken, they often terminate that relationship and look for another intimate partner immediately rather than adopting risk-reducing methods such as using condoms (Longfield et al, 2002) or abstaining.

Obiero et al (2000) explains that, previous studies conducted in Kenya show that in spite of young people having information and awareness of HIV/AIDS, many were still engaging in risky sexual behavior. Ochako et al (2011) says that, in Kenya the response to HIV/AIDS pandemic relies on preventive strategies where information on modes of transmission are provided to enable people identify and avoid risky behavior that could expose them to infection. Having accurate HIV/AIDS knowledge about transmission and prevention is important for avoiding HIV infection. Global HIV Prevention Working Group (2003) pointed out that effective approaches for young people include life skills

based education that promotes the adoption of healthy behaviors such as taking greater responsibility for their own lives, making healthy and informed choices and having the stamina to resist negative peer pressures.

2.3. HIV/AIDS Prevention Models

There are two main HIV/AIDS prevention approaches, ABC and SAVE that are being used in the fight against the scourge. The ABC, (Abstain, Be faithful and use a Condom) has been used for decades now. The ABC approach for preventing the sexual transmission of HIV/AIDS has been adopted by many governments and non-governmental organizations since the term was first introduced in 1992. It is often credited for Uganda's success in drastically reducing the rate of infection in the 1990s. According to UNAIDS (2004), ABC stands for Abstinence, Being safe by being faithful to one partner and correct and consistent use of Condoms.

The President's Emergency Plan for AIDS Relief (PEPFAR), America's initiative to combat the global HIV/AIDS epidemic, follows an ABC strategy that emphasizes abstinence for young people including delay of sexual debut and abstinence till marriage, being tested for HIV and being faithful in marriage and monogamous relationships and correct and consistent use of condoms for those who practice high risk sexual behavior. Even though ABC has been adopted and promoted around the world, certain countries that have been promoting it as a national strategy have expressed doubt about its effectiveness. For instance, in Namibia, women groups criticized the ABC approach claiming that it does not take into consideration context, where women inequality often means they cannot abstain, practice marital fidelity or demand use of condom, (The Body, 2006, Cultural Practices in Namibia Hinder Prevention Group).

In response to these concerns, UNAIDS called for a move towards a more comprehensive approach to HIV prevention which reflects the inequality between men and women. Suggestions to expand the ABC approach to include social and economic factors, especially women rights have been forwarded by some organizations.

The SAVE approach is propagated by Inerela+, an international network of religious leaders, lay and ordained, women and men living with or personally affected by HIV. It was formally launched in August, 2008 at the International AIDS Conference in Mexico. This approach is promoted by Inerela+ as a reaction to the shortcomings of the ABC approach.

The acronym SAVE stands for:

- S- Refers to safer practices covering all different modes of transmission like safe blood transfusion and the use of condoms. Abstinence remains the most effective mode of avoiding exposure to STIs.
- A- Refers to available medication-ARTS, treatment of associated infections and provision of good nutrition and clean water.
- V- Refers to voluntary counselling and testing
- E- Refers to empowerment through education

2.4. HIV/AIDS Behavior Change Communication

The late Dr. Jonathan Mann, former Executive Director, World Health Organization/Global Program on AID rightly put it “At the moment, education and communication are the only weapons we have against HIV/AIDS”.

Family Health International (FHI) describes Behavior change communication(BCC) as an interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviors; promote and sustain individual, community and societal behavior change; and maintain appropriate behaviors. It is used to support individuals' ability to adopt and maintain a new positive behavior. It aims at increasing knowledge, stimulating dialogue and could ensure that people are given accurate and timely information about HIV and AIDS in their preferred language or medium (Exchange, 2008).

Communication strategies play a key role in addressing the social and structural barriers to the adoption of healthy behaviors. Through targeted communication strategies aimed at changing individual and community health behaviors (i.e., behavior change communication), public health practitioners have made impressive strides in reducing disease and improving family health outcome (Population Council, 2001). Given the importance of HIV/AIDS prevention and care, mainly due to absence of cure, employing effective communication strategies become pivotal in controlling the pandemic. Consequently, evaluating and redefining approaches to communicating relevant messages to different populations and the public at large has become a critical aspect of HIV/AIDS prevention and care (*Collins O. Airhihenbuwa, et al, 2000*).

Young people, in their teens and early twenties are naturally curious about sex and sexuality and often want to know more than they are told in the home or at school (*Devin,*

1995), and can be exposed to a wide range of attitudes and beliefs that relate to sex and sexuality. They get information about sex and sexuality from a wide range of sources including each other, media, books, as well as the internet which in most cases are contradictory leaving them even more confused. For instance, health messages emphasize the risks and dangers associated with sexual activities among young people, but some media messages promote the idea that being sexually active makes a person more attractive and mature. This being the case therefore, any HIV prevention efforts by all players must confront several challenges, especially of perception within young people (*Global HIV Prevention Working Group, 2008*).

FHI, Institute of HIV/AIDS (2002) explains that before individuals and communities can reduce their level of risk or change their behaviors, they must first understand basic facts about HIV/AIDS, adopt key attitudes, learn a set of skills and be given access to appropriate products and services. They must also perceive their environment as supporting behavior change and the maintenance of safe behaviors. They also must trust the source of information, as *Rogers (2003)*, points out, a change agent must have a connection with clients and must be seen as “credible” and someone people can “trust,” which is vital during the communication process.

With an effective curative drug still elusive, efforts to reduce risk behavior is obviously the only feasible way to curb the epidemic (*Global HIV Prevention Group, 2008*). Thus, efforts by various sectors in this area should be seen to be producing desirable results. Appropriate and effective communication is central to the success of interventions to

reduce the risk of HIV infection by promoting behavior change. Behavior change communication employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation. Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioral objectives (FHI). Interpersonal communication is most effective in influencing the behavior of an individual or a small group of people because of a number of reasons. First, the message is delivered by a person who belongs to that particular group and that has the advantage of opinion leader influence. Secondly, the content of the message is harmonized with the local culture, traditions, norms and values. Thirdly, this type of communication is more successful in addressing the sensitive issue of sexual behavior.

Since in most parts of the world, HIV is primarily a sexually transmitted infection (STI), development of a supportive environment requires national and community-wide discussion of relationships, sex and sexuality, risk, risk settings, risk behaviors and cultural practices that may increase the likelihood of HIV transmission. A supportive environment is also one that deals, at the national and community levels, with stigma, fear and discrimination, as well as with policy and law. All players, including religious organizations must ensure that they use effective communication strategies in order to achieve the aim of changing behavior and consequently reducing infections. UNAIDS Penn State Project (1999) identifies five interrelated domains of context that should be focus for comprehensive communication strategy for HIV/AIDS prevention, care and supports as follows:

1. Government Policy: The role of policy and law in supporting or hindering intervention efforts.
2. Social-economic status: Collective and individual income that may allow or prevent adequate interventions.
3. Culture Positive: Unique or negative characteristics that may promote or hinder prevention practices.
4. Gender Relations: Status of women in relation to men in society and community and the influence on sexual negotiations and decision making.
5. Spirituality: The role of spiritual or religious values in promoting or hindering the translation of preventive messages into positive health actions.

2.5. The Seventh-day Adventist Church (SDA) and the Fight Against HIV/AIDS

Kenya can be described as a religious society given that over 70 percent of the population subscribes to Christian beliefs and over 20 percent to the Islamic faith, with the rest belonging to other religions. (*www.onislam.net*). The Anglican and Roman Catholic Churches are the most established Christian denominations. Other well established African religions and denominations include the African Inland Church (AIC), Seventh Day Adventists (SDA), and the Presbyterian Church of East Africa (PCEA) (*Kenya information Guide*). The teachings of religious leaders and organizations are therefore immensely influential.

Religious organizations have over the years become more aggressive about discussing issues of HIV/AIDS with their congregation. In 2001 the All Africa Conference of Churches released a statement which claimed that it is “long overdue for churches to get

more involved and intensify their responses to the epidemic.” The activities of the church currently have dismissed the earlier perception. In many minds, the stereotype of a religious organization was that of a conservative moral group that disapproved of any form of sexual behavior outside of marriage, as well as what was seen as the "only solution" to HIV infection, i.e., condoms. Today we have convincing examples of initiatives by religious organizations in HIV/AIDS prevention that have had major impact (Edward C. Green, 2001).

Religion plays a very important role in people’s lives, shaping their world view. Religious organizations and belief remain today the lifeblood of society’s moral ethos. Not only does religion teach virtue, it catalyzes moral action. As such, religion plays an essential societal role warranting special consideration. Through their influence, religious organizations have the ability to construct and reconstruct people’s views on HIV/AIDS which will affect their very interaction with the disease and people living with HIV/AIDS on a daily basis (*Consultancy Africa Intelligence, Justin Du Toit*). As a matter of fact, there is no other institution that is strategically positioned to tackle the HIV/AIDS pandemic the way the church would, its strengths including, compassionate ministry, grassroots structure, a holistic approach and the behavior change message(*Rev Francis MkandaWire: Role of Churches in a World Living with HIV/AIDS*). The churches have strong associational infrastructure at the national and local levels which helps in coordination of their activities. Such an advantage is particularly vital in rural areas, as many AIDS-related NGOs are concentrated in cities and towns, whereas religious groups often have a strong presence in rural areas. These grassroots activities have made

religious organizations a more present and permanent fixture in ordinary life, especially in rural areas. In addition, in many cases religious leaders command a good deal of respect and trust from much of the congregation. Their flock perceives their actions as less politically driven and selfish than those projects of government leaders.

Uganda is considered as the country that has had the most dramatic decline in HIV/AIDS infection rates. HIV prevalence declined from 21.1% to 6.1% among pregnant women between 1991 and 2000 (Uganda Ministry of Health, 2001). In 1987, the major religious organizations in the country, Catholic, Anglican, Muslim, became significantly involved in HIV/AIDS prevention, with World Health Organization Global Program on AIDS (WHO/GPA) funding, through the Ministry of Health. By 1992, HIV infections rates were still so high that USAID also decided to allocate some of its funds for faith-based organizations (FBOs) to work in prevention, but on the FBO's own terms. The FBOs said that they wished to promote "fidelity" and "abstinence" rather than condoms. Although at the time, many thought the approach would have few if any measurable results, it was strongly favored by President Museveni. President Museveni is credited as one of the most activist African head of state in addressing the HIV/AIDS crisis. He openly and convincingly stated his standpoint in his speech to the First AIDS Congress in East and Central Africa. By 1991, Uganda had began experiencing a downward trend in both STI and HIV infection rates. Numerous studies after 1993 documenting behavioral change, showed that reduction in the number of sexual partners (which could be causally related to the "fidelity" message), and delay of sexual debut among youth (which seemed to be related to the 'abstinence' message), were the major forms of behavioral change that

occurred in Uganda, more than increased condom use. Condom ever-use was at about 20% nationally. The proportion of Ugandans who reported one or more non-regular sexual partners was between 6-8.7%. And about 20-25% of those surveyed age 15-49 reported complete abstinence in the past year, most of this was attributed to the youth delaying first sexual experience (Uganda MoH 2001).

Another country that stands out in its progress in battling HIV/AIDS epidemic in sub-Saharan Africa is Senegal. According to UNAIDS, Senegal currently has one of the lowest HIV seroprevalence rates in sub-Saharan Africa. As in Uganda, in Senegal religious organizations became actively involved in HIV/AIDS prevention from early in the epidemic. A conservative Muslim organization, Jamra, approached the national AIDS program in 1989 to discuss prevention strategies. The government conducted a survey of Muslim and Christian leaders to better define a role for them in HIV/AIDS mitigation. The survey found that religious leaders needed and wanted more information about HIV/AIDS, so that they in turn could educate those in the respective religious communities. According to UNAIDS:

In response, educational materials were designed to meet the needs of religious leaders. They focused in part on testimonials from people living with AIDS—the human face of the epidemic, often hidden where prevalence remains low. Training sessions about HIV were organized for Imams and teachers of Arabic, and brochures were produced to help them disseminate information. AIDS became a regular topic in Friday sermons in mosques throughout Senegal, and senior religious figures addressed the issue on television and radio.

From the above examples, it is evident that the role of religious organizations in mitigating the spread and impact of HIV pandemic is very crucial. Currently, many of these religious organizations are doing a lot to create awareness and reduce the HIV

prevalence and its devastating effect in Kenya. Their approach is to put emphasis (sometimes sole emphasis) on what is referred to as primary behavior change i.e, abstinence, “delay” and fidelity.

The Seventh-day Adventist Church is a Protestant Christian denomination that was founded in the 1860s in the USA. The name of the ‘Seventh-day’ indicates its two main distinctive characteristics: Sabbath observance on the seventh day (i.e., Saturday) and an expectation that the end of the world is drawing near. Other distinguishing characteristics include adherence to the teachings of Ellen G. White (who is regarded as a prophet), and various dietary observances rooted in Jewish law. The worldwide Seventh-day Adventist church is managed by the head office, called the General Conference based in Maryland, United States.

In Kenya, the Seventh-day Adventist church was introduced in 1906 by two missionaries sent by the General Conference. These were Carscallen Arthur Assa Grandville, a Canadian-born missionary, administrator and linguist, and Pastor Peter Nyambo, a Malawian who had gone to study in England. The two pitched camp near Lake Victoria region and highlands of Kisii where they began to spread the gospel. Today, the Seventh-day church has spread throughout the country with a membership nearing 1 million (*Dictionary of African Christian biography, www.eau.adventist.org*). The General Conference has 13 sub-entities which oversee the church’s work in various portions of the world. These sub-entities are called Divisions and are further divided into Union Conferences and Union Missions which are divided into local conferences and fields. In

Kenya, there are two union conferences; East Union Conference and West Union Conference. They are under The East-Central Africa Division (www.ecd.adventist.org).

The Seventh-day Adventist church has been on the fore front in the fight against HIV/AIDS. Neal C Wilson (the General Conference SDA president in the 1990s) said, “The Christ-like response to AIDS must be personal—compassionate, helpful, and redemptive.” In November 2003, during the church’s East-Central Africa Division (ECD) regional workshop on HIV, the church gave a statement of commitment to the fight (dubbed the Nairobi Declaration), *“Given the extreme nature of the emergency situation we acknowledge our responsibility to our Church members and the community. It is our mandate to engage in multiple Christian responses to the HIV/AIDS problem, and call upon our people to unite in prayer and action asking God to guide us in loving and caring ministries. We realize that we have the source of power to move the mountains because we have faith in God. We have Love - a powerful tool for service. We are committed to be the Heart, the Feet, and the Hands of Christ in responding to this call.”* (World Council of Churches: Church Statements on HIV/AIDS 2001-2005)

The Seventh-day Adventist church developed a profound approach to nurturing and empowering its young members. This is done through a worldwide youth ministries department organized in terms of age-groups; Adventurers is a club for children ages 6 to 9. Pathfinders club is for young people ages 10 to 15. The Ambassador Group strives to meet the spiritual, social and lifestyle needs of those from 16 into their 20s. The Adventist Youth Society links youth of ages 16-31+ on every continent of the globe. More than half of Adventists worldwide are between the ages of 16 and 40. The Seventh-

day Adventist church teaches its young people a biblical view of human sexuality in an intentional and culturally sensitive manner. Emphasis is placed on appreciating and understanding the human body and its functions, upholding sexual chastity, and developing skills for decision-making and communication about sexual behavior. The Church is committed to conveying the truth that the misuse of one's own sexuality is contrary to God's ideal (*Adventist.org, official website of the SDA church*).

The issue of HIV/AIDS is addressed through school and church curricular which provides information regarding sexuality in general and HIV/AIDS in particular, for the youth groups (*Health and Temperance Department, General Conference of Seventh-day Adventists*). The school curricular is for schools run by the SDA church. Such HIV/AIDS and behavior change education programs are integrated into the already existing system of clubs; Adventurer, Pathfinder, Ambassador and Youth. The activities of these clubs, in most cases through camps and congresses, are coordinated by the Health and Youth Ministries department which is also responsible for creating resource materials (*gcyouthministries.org*). During these sessions, the young people are taught HIV/AIDS behavior change issues among other spiritual and social issues.

2.6. Theoretical Framework

In order to change behavior effectively, communication strategists need to understand the way people behave and why they do so and thus communication intended to affect behavior should be grounded in a sound theory such that the resulting framework is flexible enough for application in regional and cultural contexts (*Collins O. Airhihenbuwa et al, 2000*). According to Ann Pollock of the Harvard Graduate School of

Education and Julia Coffman and M. Elena Lopez of Harvard Family Research Project, designing communication that are more effective at changing behavior require keeping in mind the factors that influence behavior. Communication interventions are more effective when they are based on research that tell what factors influence a person's decision to perform a specific behavior or the ways in which an existing behavior can be channeled towards more desirable behavior.

This study will be based on the following two theories:

- Theory of reasoned action
- Social learning theory

2.6.1. Theory of Reasoned Action

Theory of reasoned action, put forward by Martin Fishbein and Icek Ajzen (Fishbein and Ajzen, 1975). It predicts an individual behavior by examining attitudes, beliefs, and behavioral intentions as well as observed and expressed acts. It is based on the idea that the most immediate determinant of a person's behavior is his/her behavioral intentions. Intention is a joint function of one's positive and negative feelings leading him/her to perform or not to perform the particular function. Behavioral intent reflects the level of commitment that an individual has to undertake a desired behavior and the likelihood that an individual will perform the desired behavior. Behavior is influenced by personal attitudes and perceived social pressure/norms, Servaes (2008). This theory highlights intentions by focusing on attitudes towards risk reduction, response to social norms and behavioral intentions vis-à-vis risky behaviors.

An individual is more motivated to perform a behavior that will result in an outcome that is highly valued. When one does not believe that an act will lead to a specific outcome or the outcome is not valued, the individual will be less motivated to perform a behavior. (Blue, C.L., 1995). Because of the specific nature of the theory, it offers an approach for understanding and predicting behavior change intentions. When an appropriate strategy has been used to convey HIV/AIDS behavior change message to young people, they are expected to respond by changing their behavior positively, consequently avoiding infection and remaining HIV negative. Such communication must therefore seek to enable the young people to appreciate and see value in the outcome. Being HIV negative is should be seen by young people as valuable. This theory assumes that individuals are rational in their decision-making process. Therefore, communication going to young people should be designed to influence their attitudes, beliefs and behavioral intentions thus influence their decision-making in favor of positive behavior.

If a person perceives that the outcome from performing a behavior is positive, she/he will have a positive attitude towards performing that behavior. The opposite can also be stated if the behavior is thought to be negative. If relevant others see performing the behavior as positive and the individual is motivated to meet the expectations of relevant others, then a positive behavior is expected. If relevant others see the behavior as negative and the individual wants to meet the expectations of these "others", then the experience is likely to be a negative behavior for the individual. Consequently, in line with this theory, HIV/AIDS behavior change communication targeting young people ought to be approved and applauded by significant others in the society. Most young people would like to be

seen to be doing the right thing by those they look up to in the society. The purposes of the theory of reasoned action include:

1. To identify how and where to target strategies for changing behavior.
2. To explain virtually any human behavior such as why a person engages in premarital sexual intercourse.

2.6.2. Social Learning Theory

Social learning theory was developed by Albert Bandura in 1977 (Bandura, 1986). It postulates that an individual's behavior is the result of the interaction among cognition, behavior, environment and physiology. That people learn from one another via observation, imitation and modeling. The theory assumes that the individual interacts constantly with their social environment and that they influence and are influenced by their social milieu- friends, family, co-workers etc. Central to this theory is the premise that "behavior is a result of a three-way reciprocal interaction between personal factors, that is their own feeling and reactions, and environmental influences like thought, advices and feelings of significant others (Servaes, 2002).

Bandura (1994) points out that to achieve self directed change, people need to be given not only reason to alter risky habits but also behavioral means, resources and social support to do so.

The two primary domains widely used in HIV/AIDS programs are modeling (imitation of behavior of a role model) and self-efficacy (one's perceived ability to adopt a recommended behavior). According to Heidi D. et al, (2014), Social learning theory

integrates a large number of concepts into an overall framework for understanding human functioning. These include:

1. **Observational learning/modeling.** People learn through observation. This process is also described as vicarious learning or modeling because learning is a result of watching the behavior and consequences of models in the environment. Observational learning is dependent upon the availability of models.
2. **Outcome Expectations.** Outcome expectations reflect individuals' beliefs about what consequences are most likely to ensue if particular behaviors are performed. For instance, young people may believe that if they engage in premarital sex then they will be applauded and admired by their peers. Outcome expectations are important because they shape the decisions people make about what actions to take and which behaviors to suppress. The frequency of a behavior should increase when the outcomes expected are valued, whereas behaviors associated with unfavorable or irrelevant outcomes will be avoided.
3. **Perceived Self-efficacy.** Self-efficacy reflects individuals' beliefs about whether they can achieve a given level of successful at a particular task (Bandura, 1997). It refers to a person's belief in his/her ability to effect change, which determines what course of action that person will choose, how long it will be sustained in the face of resistance. People are more likely to engage in certain behaviors when they believe they are capable of executing those behaviors successfully, (Ormond, 1999). The virtue of self efficacy may be effective only if the actors are confident of their ability to act. People look up to models similar to them solving problems successfully which help them develop a stronger belief in their own abilities.

Young people with greater self-efficacy are more confident and display positive behavior in relation to HIV/AIDS behavior change when compared to their peers with lower self-efficacy. For instance, they will consciously strive to keep away from risky sexual behavior that would expose them to HIV infection. Self-efficacy is viewed as a product of individuals' own past performances, the observation and verbal persuasion of others in the environment, and individuals' on-going physiological state (Bandura, 1997).

Religious organizations and the Seventh-day Adventist church must aim to provide role models to their young people if their HIV/AIDS behavior change communication are to yield positive results. Church leaders should walk the talk and thus can be emulated by young people.

CHAPTER THREE: METHODOLOGY

3.0. Introduction

This chapter presents the methodology that was used in the study. It also explains the research design, the area of study, the target population, sampling, data collection techniques, data analysis procedures and data presentation procedures. In order to achieve any meaningful solution to a practical or theoretical problem in any field of study, the research process must be conducted courteously. Kent et al, (1978) says that research is a systematic quest for knowledge that is characterized by disciplined enquiry.

3.1. Research Design

This study which was qualitative in nature used a descriptive survey design that guided the researcher in getting factual data on HIV/AIDS behavior change communication used by the Seventh-day Adventist church among young people in Homa Bay County. Descriptive research design was considered appropriate because of two reasons. First, it helps elicit most complete sample from individuals presumed to have experienced the phenomena under study, and second, it relies on an individual's self-report of their knowledge and attitudes. This method revealed the current status of information being given, the way the information is delivered and the response of the young people towards the communication on HIV/AIDS behavior change.

Data was collected using questionnaires administered to the young people who are members of the Seventh-day Adventist church in Homa Bay County. The researcher used research assistants who distributed the questionnaires to young people in the sampled churches and collected them once they had been completed. More data was collected by interviewing key informants who are teachers and leaders of young people in the SDA church. The interviews were conducted face to face by the researcher.

3.2. Area of Study

The study was conducted among the Seventh-day Adventist church going young people in Homa Bay County, Kenya. Homa Bay County, located in the former Nyanza Province along the south shore of Lake Victoria, covers an area of 3,183.3 sq km. According to the Kenya National Housing and Population Census conducted in 2009, Homa Bay County had an estimated population of 963,794 persons (462,454 males and 501,340 females). This population was projected to be 1,119,769 by 2015. Because of proximity to Lake Victoria, The livelihoods of most residents depend on fisheries and rain-fed small-scale farming, practices that are highly vulnerable to environmental degradation and the effects of climate change. Coupled with rapid population growth that has placed enormous pressure on natural and environmental resources such as fisheries and land, most residents are exposed to poverty.

Traditionally, Luos (who are major residents in Homa Bay County) did not circumcise their males as an initiation rite into adulthood instead boys used to have their lower front teeth removed. Today, modern culture has diminished this practice and male circumcision, though slowly, is taking root. This has also in recent times been advocated for as a means to curb the spread of HIV/AIDS. The custom of wife inheritance, which allows a man's relatives to inherit his wife in case of his death, is slowly fading away. This practice had been for a long time one of the major factors fueling the spread of HIV/AIDS among the Luo community (County data sheet). From the above geographical, economic and cultural factors, Homa Bay County residents can be classified as a vulnerable population, i.e people whose context increase their vulnerability to HIV risk. According to HIV Estimates Report Kenya 2014, Homa Bay County has

the highest HIV prevalence at 25.7 percent with about 160,000 people living with HIV. This means that 15% of the total population is living with HIV. The report indicates that there are about 12,700 new infections yearly. Kenya HIV County Profiles report indicates that 46,530 young people (15-24 years) in Homa Bay County are living with HIV and about 53,884 others need to know their status as they could be living with HIV. In 2014 alone, there were 2,381 new infections among this group.

Christianity is the dominant religion in Homa Bay County and Seventh-day Adventist church has a big following in the county.

3.3. Target Population

Babbie (1973) defines population as the aggregation of elements from which sample is actually selected. Mugenda Mugenda (2003) defines population as a complete set of individuals, cases or objects with some common observable characteristics. The target population is a complete set of individuals that have common characteristics to which the researcher is studying. The researcher targeted young people who are members of the Seventh-day Adventist church. According to SDA church (West Kenya Union) statistics, there are about 130,100 SDA members in Homa Bay County of which more than half are categorized as young people. Homa Bay County is under Kenya Lake and Ranen Conferences of the West Kenya Union, which is according to the SDA church subdivisions.

Young people in the SDA church constitute the very active group in the SDA church. They actively take part in church activities through the clubs that are organized according

to ages, giving a vibrant face of the church. The Parthfinders club in particular appeals to even young people who are not members of the SDA church. Young people in the SDA church even though exist in the same environment as other young people in Homa Bay County should, by virtue of being trained in the church, be able to resist risky sexual behaviors that lead to HIV infection.

The study will also include key informants who are leaders and teachers of young people at the conference and church levels. They are tasked with the roles of formulating policies and designing communication that go out to the young people as well as coordinating classes and learning sessions. The researcher intended to get their view on what works as far as HIV/AIDS behavior change messages are concerned.

3.4. Sampling

A sample is a sub-set of the whole population. The samples of the study are thus drawn from the population but the results of the study will apply to the whole population. The sample is investigated and its characteristics generalized to the entire population. A sample is identified through a process called sampling. Sampling, according to Kendall and Kendall (2002), is the process of systematically selecting representative elements of the population. When selected elements are examined closely, it is assumed their analysis will reveal useful information about the population as a whole. This process is time saving and cost effective.

This study employed both random and purposive sampling methods. The SDA churches to be included in the sample were randomly selected. A list of all the 648 churches in

Homa Bay County was done in alphabetical order and 20 churches selected randomly by including every 30th name in the list. Five young people from each of the 20 churches were then randomly picked to be included in the sample giving a total of 100 young people. (Lindlof and Taylor, 2002) explains that random sampling is a sampling procedure in which every element of the population has an equal and independent chance of being selected.

Purposive sampling was used to identify teachers and leaders to be included in the sample. Two youth leaders at conference and Union levels, and three teachers from the churches were purposively selected. Purposive sampling is a type of non-probability sampling in which the researcher consciously selects certain elements of subjects for inclusion in a study in order to ensure that the elements will have certain characteristics relevant to the study. It is a form of sampling in which the selection of the sample is based on the judgment of the researcher as to which subjects best for the criteria of the study (Lindloff and Taylor, 2002)

3.5. Data Collection Methods and Tools

During this study, the researcher employed the use of the following data collection methods:

Questionnaires: The researcher used questionnaires to collect data from the young people. The questionnaires had a combination of close and open ended questions and this had the advantage of allowing the respondents to explain their opinion as well as giving the researcher easy time when quantifying the data. Two research assistants were used to

administer the questionnaires to the participants. The research assistants distributed the questionnaires to the participants after seeking for informed consent. They then collected the questionnaires after the participants had filled them.

Questionnaire as a method of data collection, allows large amount of information can be collected from a large number of people within a short period and at a relatively cost effective way. It also allows the researcher and the research assistants to carry out data collection without effects on validity and reliability as well as allowing the researcher to easily and quickly quantify data. The disadvantages of using questionnaire is that there is no way of telling how truthful a respondent is, how much thought they've put into answering the questions and whether they've thought out the questions within the full context of the situation. People also read differently into each question and therefore reply based on their own interpretation.

Interview: The researcher carried out a face to face interview of the sampled leaders and teachers of young people. Using an interview guide, the researcher was able to get information that helped in answering the research questions effectively. The researcher took notes during the interview and captured all the issues discussed. Face to face interviews have a distinct advantage of enabling the researcher to establish rapport with potential participants and therefore gain their cooperation. These interviews yield highest response rates in survey research. They also allow the researcher to clarify ambiguous answers and when appropriate seek follow-up information. Its disadvantages include being time consuming and expensive (Leedy and Ormrod, 2001).

3.6. Data Presentation and Analysis

Qualitative and quantitative data collected was coded, analyzed and presented as frequency distribution tables, bar graph and pie chart and narrations, from which inferences, recommendation and conclusions were made.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.0. Introduction

In this chapter, analyzed data is presented using frequency distribution tables, bar graph, pie chart, narrations and discussions for qualitative description and summarized according to common themes. The analysis is based on the study objectives and research questions.

4.1. Background Information of the Respondents

The tables below give background information of the respondents.

Gender	Frequency	Percent
Male	44	46.8
Female	48	51.1
Missing	2	2.1
Total	94	100

Table 4.1: The Frequency statistics of the respondents' gender

Age	Frequency	Percent
15-19 years	32	34.1
20-24 years	61	64.8
Missing	1	1.1
Total	94	100

Table 4.2: The Frequency statistics of the respondents' age

Education Level	Frequency	Percent
Primary education	10	10.6
Secondary education	31	33.0
College education	29	30.9
University education	24	25.5
Total	94	100.0

Table 4.3: The Frequency statistics of the respondents' education level

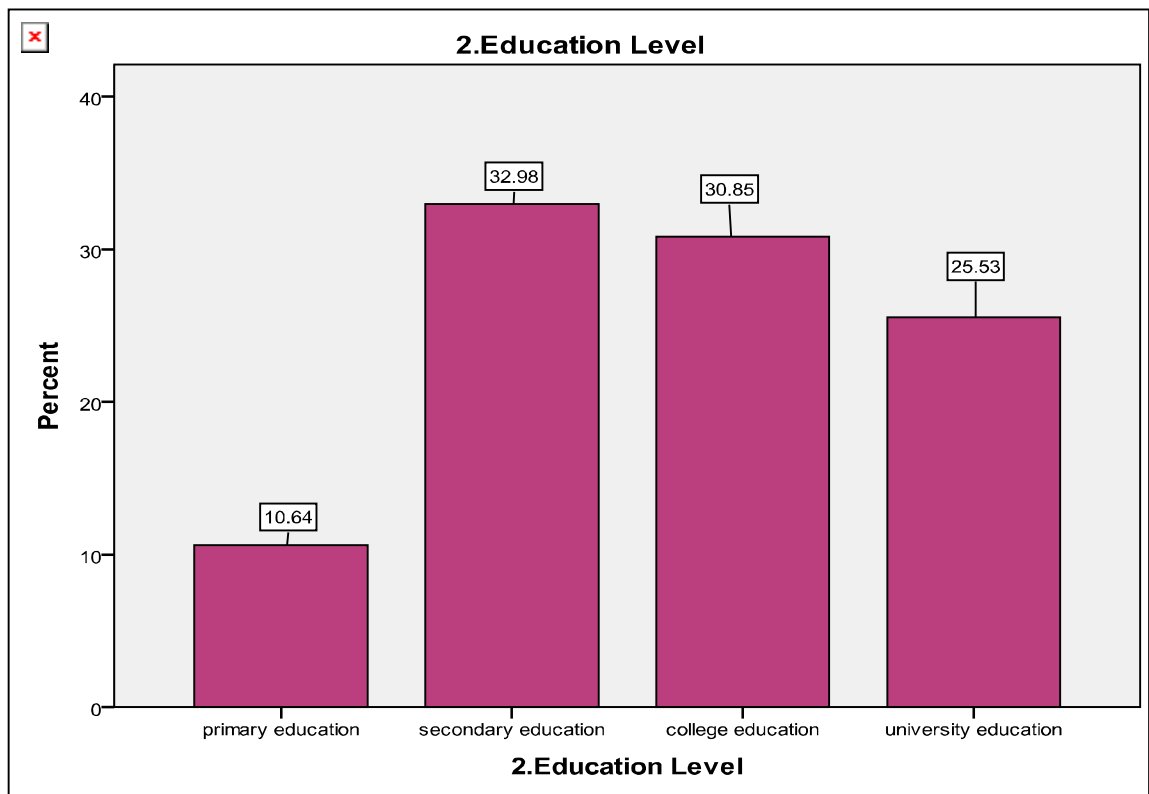


Figure 4.1: The Frequency statistics of the respondents' education level

From the findings, it was established that the majority of the respondents were female at 51% while the minority were male at 46%. Most (65%) of the respondents were in the age range of 15 to 19 years while the remaining (34%) were in 20 to 24 years age bracket. Majority of the respondents had attained secondary and post-secondary

education, secondary education were at 33%, followed by college education at 30.9%, then university education at 25.5%, and finally the primary education level at only 10.6%.

4.2. Discussion of the Research Findings Based on the Research Questions

The data collected was analyzed based on the research questions as presented in chapter one. The researcher analyzed responses from the respondents on the respective questions.

4.2.1. What are the HIV/AIDS behavior change messages used by the Seventh-day Adventist church among its young people in Homa Bay County?

Information learnt and received	Responses	
	Frequency	Percent
No Cure	41	39.4
No Stigma	6	5.8
Caution to causes	57	54.8
Total	104	100.0

Table 4.4: HIV/AIDS behavior change messages used by the Seventh-day Adventist church among its young people in Homa Bay County

The findings indicate that 39.4% of the respondents had received information that HIV/AIDS has no cure, 54.8 of the responded had received information on how to be cautious to the causes of HIV/AIDS to avoid being infected, while 5.8% had received information on how to avoid stigma on those already affected. From the findings, it is established that the SDA church teaches the young people messages about HIV/AIDS not being curable, and lays emphasis on the causes or ways of transmission of HIV infection in order to enlighten them against getting infected. The church also teaches the young people to avoid stigmatizing those living with HIV among them.

The table below shows the HIV/AIDS behavior change messages young people in the Seventh-day Adventist church would like to be taught.

Topical Issues young people would like to be taught	Responses	
	Frequency	Percent
Causes and Effects	69	73.4
Therapy	25	26.6
Total	94	100

Table 4.5: Table showing HIV/AIDS behavior change topical issues that young people in the Seventh-day Adventist church would like to be taught

Comparing the results of table 4.4 and table 4.5, the young people in the SDA church to continue with the messages on how young people can keep themselves from getting infected by being cautious to ways of transmission. They also would like to be taught the impact of HIV/AIDS on their lives in case one is infected. They would also like the SDA church to include in their messages how those already infected can manage the disease.

4.2.2. What are the communication tools used by the Seventh-day Adventist church to pass HIV/AIDS behavior change messages to its young people in Homa Bay County?

How HIV/AIDS messages are passed	Responses	
	Frequency	Percent
Books and magazine	35	23.3
Young people group discussion	51	34.0
Teaching through peers	30	20.0
Lectures from experts	32	21.3
Others	2	1.3
Total	150	100

Table 4.6: Tools used to pass HIV/AIDS behavior change messages by the Seventh-day Adventist church among its young people in Homa Bay County

The findings show that the highest number of respondents had received the HIV/AIDS behavior change information through young people group discussion at 34%. This is followed by 23.3% of the respondents who said they had received the information through books and magazines. 21.3% of the respondents had received it through lectures from experts on HIV/AIDS issues. Only 1.3% of the respondents indicated to have received the information through other tools like internet. This therefore implies that the SDA church employs the use of group discussion in most cases to pass HIV/AIDS behavior change communication. Literature materials as well as lectures by experts are also widely used.

The table below shows the respondents views on how they would like to be given HIV/AIDS behavior change messages.

How young people would like to be taught HIV/AIDS behavior change messages	Responses	
	Frequency	Percent
Through group discussion	43	45.7
Seminars and training	35	37.2
Visiting the already sick	6	6.4
Reading books	9	9.6
Through private session	1	1.1
Total	94	100

Table 4.7: How Seventh-day Adventist young people in Homa Bay County would like to be taught HIV/AIDS behavior change messages by the Seventh-day Adventist church

Comparing the results from table 4.6 and 4.7, it is evident that young people in the SDA church would wish that the church continue teaching them through group discussion as most respondents preferred it. That mode of communication is leading with a percentage of 34% and 47% respectively. During group discussion, peers tend to feel relaxed and share information, leading to a greater learning and uptake.

The findings indicate that teachers and leaders of young people in the SDA church have some level of formal training on HIV/AIDS. This is important as it equips them to be able to come up with the appropriate HIV/AIDS behavior change messages for young people and also employ the right tools to disseminate such messages for effective results. The two leaders interviewed have medical backgrounds, one being a nurse while the other is a trained community health worker. Organizations such as ADRA (Adventist Disaster Relief Association) conduct seminars and train church community workers, Training of Trainers (TOT) program where individuals are trained by the conferences and

these individuals in turn go to the community and train interested local church members who then are able to teach and counsel individuals and groups in the local churches as well as the community. The three teachers interviewed have all gone through the TOT program. The church also partners with Non-Governmental organizations working in the region to fight HIV/AIDS and its effects, for example Path International, who provide training on HIV/AIDS issues. However, the findings also indicate that most of these trained teachers are concentrated in upper clubs (young people from the ages of 9 onwards) i.e the Pathfinders, Ambassadors and Youth clubs while the Adventurers and Eager-beaver clubs (8 years and below) are run by mothers or old ladies who have no training pertaining to HIV/AIDS issues. These lower clubs are therefore never taught or exposed to information regarding HIV/AIDS behavior change.

The findings show that SDA church is well aware that its young people engage in risky sexual behavior that put them at risk of contracting the HIV virus. These young people in the church behave almost similarly to their counterparts who are not SDA members only that most of them do their things secretly. The result is evident from the many pregnancies and HIV infections among them. The respondents cited the following factors as contributing to young peoples' vulnerability:

Lack of strong foundational teaching; Issues of HIV/AIDS behavior change are not strongly taught to children right from lower ages/clubs in the SDA church, thus children do not grow up with strong knowledge base on how to protect themselves. Such children

become vulnerable and may end up being infected at very tender age even by their peers born with the disease.

Reluctance in the part of parents to offer guidance to young people; Parents leave their children in the hands of the school and church teachers to offer guidance and to train them on moral and social issues. Most parents are shy to discuss issues of sexuality with their children and hope that somehow they'll get to know what is right. Since the church strongly condemn immorality, for instance if a girl gets pregnant before marriage she is removed from church membership and has to go through rebaptism before she can be allowed back, most of the parents are more concerned about their daughters getting pregnant (which is seen as evidence of immoral behavior) and opt to take their young girls, as young as 9 years, for family planning. These girls are given contraceptives (the three months jab mostly preferred) and with that assurance, they continue to engage in risky sexual behavior without fear. Young girls act carelessly knowing that the issue of pregnancy has been taken care of, but naïve to the fact that they may get infected due to unprotected sex.

Peer pressure among young people forces them to do that which their peers are doing or what they watch and listen to from the media and internet. Young people are easily influenced by their fellow and always tend to copy what appears 'appealing' from their peers. Having a boyfriend/girlfriend is the inn thing and engaging in sex is the norm among young people today, thus the message of abstinence do not mean much to them. Peer pressure among young girls make them desire to live expensive lifestyles that they

cannot afford and thus resort to getting handouts from older men in exchange for sex, thus exposing themselves to HIV infection. The rate of HIV infection among these young people has also been fuelled immensely by love triangles that normally exist where the young girls date older men for money while at the same time dating young boys who are their age-mates.

Adverse poverty, unemployment and early parental role left to young orphan (children headed families), may lead, especially girls, to seek financial assistance from men in the society who may end up infecting them. The respondents indicated that some of the young people have also been exposed to HIV/AIDS infection while taking care of their infected parents. With no knowledge of protecting themselves while taking care of their sick parents, young people have been vulnerable to HIV/AIDS infection.

The findings show that young people in the SDA church are more or less similar to those outside behavior and character as well as in terms of the challenges and pressures they face and therefore HIV/AIDS behavior change messages targeting them should tackle the very issues that exist in the secular world. They exist in the same environment as their counterparts and are influenced by similar factors. That said, young people in the SDA church are expected to respond differently when faced with 'temptations' that could expose them to HIV infection given their church training on morality. The church teachings emphasize strict abstinence as premarital sex (fornication) against biblical teachings. Young people are expected to abstain till marriage. To appear to be living by

the set standards, many young people engage risky sexual behaviors in secret, mostly when they are away from home, in schools and colleges.

The findings indicate that HIV/AIDS behavior change messages are crucial. In addition to that, young people should be taught decision making skills and attitude change. The communication must emphasize that HIV/AIDS has no cure, but is preventable through positive behavior change. That young people must learn to say no to irresponsible sexual behaviors and make right judgment when under peer pressure. They should be taught that a healthy looking person could be HIV positive and so their judgment should never be based on appearance. The messages should include the various ways through which one can keep himself/herself from being infected; abstinence, being faithful and use of condoms. The respondents, however, cited that the key message of the church to the young people is abstinence but acknowledge that it is important to be real to the situation on the ground and teach other forms of protection that young people can adopt, because complete abstinence is a mirage for most of them. Young people should also be taught to use technology and the internet responsibly, watching and listening to things that build them positively.

From the findings, HIV/AIDS behavior change messages should be packaged in a way that is appealing to young people. Interesting books and magazines with contents that young people relate with should be used. For instance, testimonies that portray real life situations and words of counsel from fellow young people that they can identify with should be included. Use of films and young people participating in plays and songs that

have moral lessons regarding HIV/AIDS behavior change as well as peer group discussions. Young people ought to be involved in planning and designing of communication that is intended for them so that their needs and preferences are captured. The respondents indicated that this has not been the case in the SDA church since in most cases teachers and leaders of young people are aged and mature and do not understand what appeals to young people neither do they involve them in the process. Most teachings are given through lecture or sermon method and in most cases young people ‘switch off’ from such sessions but they added that this is currently being handled by the TOT program being implemented. Available literature are strict on biblical approach to sexuality and does not give room for modification given the current context and young people feel such literature do not apply to their life situations. Fellow young people who are reactive and are living positively with the virus can be used to pass the HIV/AIDS behavior change message to them and paint a real picture of the situation.

It is also evident from the findings that although camporees, congresses and retreats provide good opportunities for young people to interact positively and learn from one another, sometimes the occasions are misused and some young people engage in the very immoral and risky sexual behaviors. Therefore guidance and supervision must be provided to young people during such events.

4.2.3. What is the reception of HIV/AIDS behavior change messages by young people in the Seventh-day Adventist church in Homa Bay County?

Level of reception	Frequency	Percent
Very high	9	9.6
High	18	19.1
Moderate	48	51.1
Low	10	10.6
Very low	6	6.4
I don't know	2	2.1
Missing	1	1.1
Total	94	100.0

Table 4.8: The level of reception of the behavior change messages

The findings indicate that there is a moderate satisfaction level to the HIV/AIDS behavior change communication given by the SDA church to its young people. 51% of the respondents indicated that they are moderately satisfied, 19.1% indicated high satisfaction, followed by 9.6% who had very high satisfaction, then 6% indicated very low satisfaction, and finally 2% could not rate their level of satisfaction. 1% of the respondents indicated that they had not received any information on HIV/AIDS behavior change being discussed in church, hence could not rate their level of satisfaction.

The pie chart below also illustrates the respondents' level of satisfaction to HIV/AIDS behavior change communication by the church.

13. a) Are you satisfied with how awareness is being carried out on HIV/AIDS and behavior change among the young people in the SDA church?

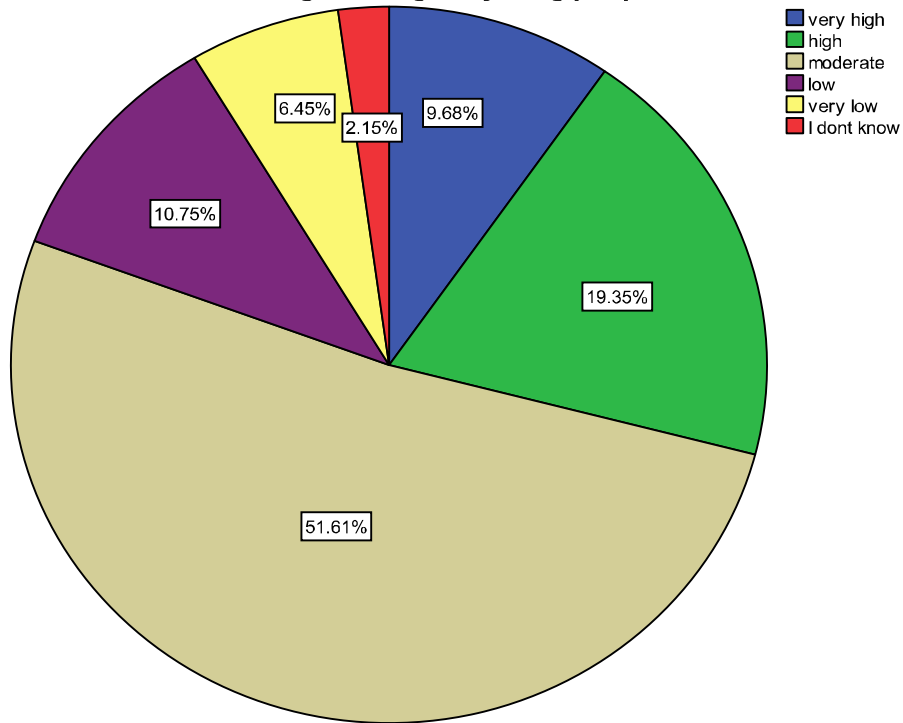


Figure 4.2: Pie chart showing the level of satisfaction with HIV/AIDS awareness in SDA church

The researcher carried out a cross tabulation to find out if there is any relationship between the respondents' level of education and their level of reception of the HIV/AIDS behavior change messages.

		13. a) Are you satisfied with how awareness is being carried out on HIV/AIDS and behavior change among the young people in the SDA church?						Total
		very high	high	moderate	low	very low	I dont know	
2.Education Level	primary education	0 .0%	1 11.1%	6 66.7%	1 11.1%	1 11.1%	0 .0%	9 100.0%
	secondary education	1 3.2%	5 16.1%	15 48.4%	6 19.4%	3 9.7%	1 3.2%	31 100.0%
	college education	7 24.1%	6 20.7%	11 37.9%	2 6.9%	2 6.9%	1 3.4%	29 100.0%
	university education	1 4.2%	6 25.0%	16 66.7%	1 4.2%	0 .0%	0 .0%	24 100.0%
Total		9 9.7%	18 19.4%	48 51.6%	10 10.8%	6 6.5%	2 2.2%	93 100.0%

Table 4.9: The correlation between the level of education and the level of reception of the HIV/AIDS behavior change messages

From the cross tabulation, it can be concluded that there is no relationship between the respondents level of education and extent of satisfaction with HIV/AIDS behavior change communication being given by the SDA church.

The findings indicate that there are several changes in the society today that have greatly influenced HIV/AIDSs infection trends among young people. Young people receive information on sex and sexuality from many different sources that in most cases leave them confused. This poses a great challenge to the church in its mission to create awareness among its young people. The respondents cited example like advancement in technology and the use of internet through smart phone, tablets, computers, laptops.

Availability of smart phones enables even young people from remote rural areas to access internet where they access pornographic literature exposing them to information on sex at very tender age, this gives them the urge to put in practice what they see and watch making it hard for them to abstain. Such information is shared among them while in school and most of them strive to follow the current trends. Also most radio and television channels that young people watch or listen to have programs that tend to glorify sex thus influencing young people to engage in risky sexual behavior just to have experience. The result is that young people in the church do not appreciate much the church teaching on sexuality and HIV/AIDS behavior change.

The advent of smart mobile phone has seen application come with soft copies of bible, lesson book, hymn book all package in a smart phone or tablets and young people choose to carry their smart device to church instead of the hard copies of these crucial spiritual literatures. These smart devices too are configure to social sites like WhatsApp, Facebook, twitter, YouTube among others and young people when in church may be distracted by messages sent to them or view contents from these social sites. This may make them loose out on important spiritual messages meant to equip them to fight temptations that may expose them to HIV/AIDs.

The respondents also cited the less contact time the parents and the church leaders have with young people. The education system today is such that a lot of time is spent in school away from home and the church, especially for those in boarding school and colleges. There is very little time that the church has to mold its young people by

instilling in them biblical principles of morality while a lot of time is spent in schools where young people relate and interact with their peers sharing and influencing one another negatively. Similarly, there is less contact time between the parents and the young people and thus parents also end up not teaching them how to behave. Some of the teachers who spend more time with the young people and who ought to offer guidance sometime abuse their innocence by coercing them into sex or forcefully through rape.

The findings show that laws that allow administration of family planning contraceptives by medical personnel to teenage girls in most cases do them more harm than good. The law allows young girls to use family planning contraceptives even as early as 14 years and this has encouraged reckless behavior among young people since pregnancy is no longer a worry. Some non-governmental organizations have also provided health facilities with abortion drugs and encourage health workers to conduct safe abortion to girls who want the same. They reason that such safe abortions prevent girls dying when carrying out unsafe abortion. This has also contributed to some level of carelessness as girls can easily abort once they realize they have conceived. Young people view having early pregnancy as a greater mistake and burden than contracting HIV/AIDs as it is seen as immediate evidence that one has been engaging in immoral behavior and may lead to one dropping out of school or college. Once the issue of pregnancy has been taken care of, young people choose to engage in unprotected sex ignoring protected sex or abstinence.

The findings indicate that the SDA church has set appropriate a program that is intended to mitigate such factors. It aims to offer a strong foundation for the family, different clubs in the church and the teachers in the church in order to reach the young people effectively. This ensures that parents and teachers take up their roles so that knowledge of HIV/AIDs is built from the early stages of a child's development to continually equip them for teenage hood and youth stages when they are at risk. The church concentrates on strengthening the family unit with the hope that children raised from a morally upright family tend to live morally upright lives.

To be able to make an impact in the lives of its young people within the short time that it has with them, the SDA church has created activity filled programs with activities that interest young people. Such programs include vocational bible study (VBS), Pathfinder camporees, youth congress and student retreats, where young people are taught spiritual, social and moral issues. They interact with their peers in a free but spiritual context that enables them to form strong moral principles. The local churches also organize programs for young people during holidays and eves of festivities like Christmas and new-year including 'Keshas' , singing concerts, beach cleaning activities, peer group discussions, outreach activities among others. During these times, young people socialize positively and share information on sexuality and HIV/AIDs behavior change, learning that their bodies are the temple of God. The TOT Program is geared towards providing experienced professionals to act as catalysts for HIV/AIDS behavior change in such forums. The mode of transmission used in most cases are young people group discussion, lectures or sermons by the teachers or through books and magazines that the young people are given

to read. The TOT program has ensured that there is adequate number of teachers within the church to be able to effectively deliver the HIV/AIDS behavior change message to young people. The training also equips the teachers with knowledge and skills that are necessary for delivery of the message depending on the age group.

The SDA church has a defined young people training system based on age. Young people are organized in age-groups and belong to clubs where age appropriate content is taught to them. The Eager Beaver club is for children below 6 years, 6-9 years belong to Adventurers club, 10-15 years belong to Pathfinders club, 16-24 years belong to Ambassador Club while Adventist Youth Society is for young people between the ages of 16 into their 30s. The respondents indicated that it is within these clubs that young people learn HIV/AIDS behavior change messages. Behavior change messages are taught based on biblical principles on morality but also in response to increasing HIV/AIDS infection among young people, HIV/AIDS behavior change has been given more prominence. The messages are more pragmatic and allows for other means of protection against the HIV virus other than abstinence. Those who cannot abstain are urged to be faithful to one partner whom they know their status or to consistently use condom. The main messages going out to the young people is that HIV/AIDs has no cure, but can be prevented through positive behavior change and abstinence from risky sexual behavior. To enable the young people achieve this, the church teaches them to develop strong personal principles that will enable them make decisions to resist pressure to engage in such risky sexual behaviors.

The findings further indicate that the SDA church is partnering with ADRA (Adventist Development and Relief Agency) and other Non-governmental organizations such as Path (Program for Appropriate Technology in Health), Medicines San Frontiers, among others in order to be able to reach its young people effectively. Such organizations help in provision of learning materials as well as in training of teachers. They also empower the community economically in an effort to reduce vulnerability.

4.2.4. Why, in spite of the HIV/AIDS behavior change messages given by the Seventh-day Adventist church to its young people, more of them still continue to be infected by the HIV virus.

Why infections after awareness	Responses	
	Frequency	Percent
Acting careless	59	58.4
May be raped	3	3.0
Due to peer pressure	26	25.7
Nil parental guidance	12	11.9
Still no awareness in church	1	1.0
Total	101	100.0

Table 4.10: Table showing why there is continued infection among young people in the Seventh-day Adventist church even in spite of awareness

The findings shows that 58.4% of the respondents indicated that the continued new infections are because of the carelessness of young people, while 25.7% indicated that they happen due to peer pressure influence, 11.9% indicated that there is completely no parental guidance to young people, 3% of respondents indicated that some youths may get the infections due to rape. 1% of the respondents said that there is no HIV/AIDS behavior change awareness in the SDA church. From the findings, young people seem to

agree that they are well equipped with relevant information on how the HIV virus is spread and what one can do to avoid infection yet infection rates remain high. A lot of the new infections are happening due to carelessness and peer pressure. This calls for a need to shift message to target training the youth on decision making skills and how they can stand their ground to do right even amidst pressure.

Young people in the SDA church in Homa Bay County have received a lot of information on HIV/AIDS. They are aware how the virus is spread, that HIV/AIDS has no cure but can be prevented. They are aware of the importance of behavior change in the prevention of HIV/AIDS. However, most of these young people have decided to ignore these facts and instead have developed an 'I don't care' attitude that has resulted in spread of the virus among young people. Often they want to experience sex, even worse with multiple sexual partners, without considering the risks involved. The famous say "*dhiani' tho gi lum e dhoge*" loosely translated as "a cow dies with the grass in its mouth", demonstrates the level of recklessness and shows the extent and impact on negative attitude among young people.

The situation has been compounded by the law that allows young girls to use family planning contraceptives. Earlier on, many young girls feared dropping out of school due to pregnancy and also ridicule by their friends and villagers, but with the new development that takes care of this fear, they feel no reservation to engage in risky sexual behaviors. To them HIV/AIDS is not as real a threat as pregnancy or rather most of these young people are ignorant about its seriousness. Parents have also not taken seriously their role to instill discipline and moral values in their children and this permissiveness

has led to many young people engaging in risky sexual behavior without considering the consequences. Worse still, some mothers take their young girls for family planning in a bid to keep them from getting pregnant, but without knowing that it puts the young girls at more risk of HIV infection as this encourages them have unprotected sex because the unwanted pregnancy has been taken care of.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0. Introduction

This chapter summarizes the findings of this investigation, which responds to the four research questions identified in chapter one. What are the HIV/AIDS behavior change messages used by the Seventh-day Adventist church among its young people in Homa Bay County? What are the communication tools used by the Seventh-day Adventist church to pass HIV/AIDS behavior change messages to its young people in Homa Bay County? What is the reception of HIV/AIDS behavior change messages by the young people in the Seventh-day Adventist church in Homa Bay County? Why, in spite of the HIV/AIDS behavior change messages given by the Seventh-day Adventist church to its young people, more of them still continue to be infected by the HIV virus. The summary of the findings are derived from analyzing the data gathered both qualitatively and quantitatively and discussed in chapter four. The findings form basis for the recommendations made thereafter.

5.1. Summary of Findings

The messages given by the SDA church regarding HIV/AIDS behavior change to its young people are that young people should take caution to and avoid behaviors that may predispose them to HIV/AIDS infection, HIV/AIDS has no cure but is preventable through adopting positive behavior change and to avoid stigmatizing to those living with HIV/AIDS. Even though the messages mainly emphasize abstinence as the best way to avoid infection, in the recent past the church has been more pragmatic by incorporating other means of protection like correct and consistent use of condoms as well as being faithful to one sexual partner. These messages have been widely received by most young

people in the SDA church. Young people in the SDA church are not any different from their peers outside and therefore HIV/AIDS behavior change messages targeted at them ought to address challenges faced in the secular world.

HIV/AIDS behavior change messages are passed to young people through group discussions, books and magazines, lectures from experts/teachers and by peer educators. Technological development and the use of internet exposes young people to a lot of information regarding sex and sexuality. In order to counter this and make HIV/AIDS behavior change messages exciting for young people, the SDA church must use exciting modes of transmission that appeals to young people and involve their active participation. Teachers and leaders have to keep up with current communication trends and the TOT programs helps to equip teachers towards this goal.

The reception of the HIV/AIDS behavior change message by young people in the SDA church is moderate. There are several factors that hinder adoption of positive HIV/AIDS behavior change as taught by the church among young people. These include use of internet to access information that contradicts the HIV/AIDS behavior change as taught by the church, almost nil parental guidance from lower ages, very little contact time for parents and church to instill discipline in the young people due to school schedules, peer pressure and the effects of poverty and unemployment. The SDA church has produced an activity packed programs for young people during the holidays in order to give them maximum training effectively.

In spite of this level of awareness, young people in the SDA church still continue to be infected because of acting carelessly. They have the information on how to avoid infection but ignore it and bow to peer pressure and other factors that contribute to their vulnerability and engage in risky sexual behaviors. Laws and regulations that allow the use of family planning contraceptives by young people also contribute to loose sexual behavior among them as the 'feared' issue of early or unwanted pregnancy is taken care of. Young people continue to be infected because of negative attitude and lack of decision making skills to make right decisions to keep themselves from being infected.

5.2. Recommendations

Young people in the SDA church and elsewhere in the region are faced with a lot of pressures of life which make them loose their focus in life and ignorantly engage in risky sexual behavior. Therefore the SDA church should include in its HIV/AIDS behavior change message, messages that train the young people to develop such skills as negotiation, decision-making, critical and creative thinking as well as coping with stress and emotions. The message must be designed to foster individual attitudinal and behavior change as well as social norm change. In this way, the strong will not to engage in risky sexual behavior will come from within the individual.

The packaging and dissemination of HIV/AIDS behavior change message should be attractive to young people and fully involve their active participation so that they own it and feel part and parcel of it. Such modes of transmission should include some level of entertainment and incorporate current modes of communication that young people use. Young people should be actively involved in the process of designing and

dissemination of such communication. Teachers and leaders should be well aware of current social trends among young people to be able to reach them effectively.

Parents and the church must use the little time they have with the young people outside school effectively and give maximum and adequate HIV/AIDS behavior change message. In this way, young people are well equipped to be able to resist peer pressure in school and colleges and make healthy choices to avoid infection. Training of children from early ages on positive life values give them a strong moral foundation that help them to form and live by personal principles even later in life.

The government ought to re-evaluate the laws and regulations that allow young people to access and use family planning contraceptives. The regulations that allow NGOs to support 'safe' abortions should also be looked into. These regulations though meant to have positive impact in the society have led to loose behavior among young people exposing them to HIV/AIDS infection

This research limited itself to SDA church going young people in Homa Bay County. There are young people in the other forty six counties in Kenya and to develop a clear understanding of the HIV/AIDS behavior change messages to reach young people effectively, and to document more lessons learnt, there is need to undertake a comparative study that involves the whole country.

5.3. Conclusion

There is ongoing awareness HIV/AIDS behavior change in the SDA church, and the message of transmission of HIV/AIDS and preventive measures has been widely received by the young people. Yet they continue to be infected because they lack negotiation skills for safe sex, decision-making skills to choose on the right thing even under peer pressure and the right attitude to avoid infection. The message should therefore shift to include such skills so that young people are well equipped to say no to risky sexual behaviors. These young people need the ability to act and learn from skills such as coping with stress and emotions. Issues should shift from persuasion and the transmission of information from outside technical experts to dialogue, debate and negotiation on issues that resonate with these young people. For them, information alone is not enough and they require motivation through strategic communication such as effective counseling coupled with some level of entertainment to foster individual attitudinal and behavior change.

REFERENCES

- Ajzen I. and Fishbein, T. (1984). *Belief, Attitude, Intention and Behavior: An Introduction to Theory and Research Reading*. Wesley: AM; Addison.
- All Africa Conference of Churches, Leaders' Consultation Conference, 15-17 January 2001, Mukono.
- Ann Pollock, Julia Coffman, M. Elena Lopez (2002): Using behavior Change Theory to Communicate Effectively. Harvard Family Research Project.
- AVERT' 2012, <http://www.avert.org/worldwide-hiv-aids-statistics.htm>
- Bandura, A. (1997), *Self-efficacy: The exercise of control*. New York: W. H. Freeman.
- Bandura, A. (1986), *Social foundations of thought and action: A social-cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Blue, C.L. (1995), *The predictive capacity of the theory of reasoned action and the theory of planned behavior in exercise behavior: An integrated literature review*. *Research in Nursing & Health*, 18,105 -121
- Collins O. Airhihenbuwa and Raphael Obregon (2000), *Critical assessment of theories/models used in health communication for HIV and AIDS*.
- Edward, C. Green, (2001). *AIDS, Behavior and Culture*
- Family Health International (FHI) (USAID) (2001). *HIV/AIDS Prevention and Care in Resource Constrained Settings. A Handbook for the Design and Management of Programs*. Arlington: USA
- Global HIV Prevention Working Group (2003). *Access to HIV Prevention: Closing the Gap*. Geneva.
- Global HIV Prevention Working Group (2008). *Bringing HIV Prevention to Scale: An Urgent Global Priority*. Geneva
- Global statistics, AIDS.gov <https://www.aids.gov/hiv-aids-basics/hiv-aids-101/global-statistics/>
- Heidi, Denler, Christopher Wolters, Maria Benzon, (2014) *Social cognitive theory*
- Henry J. Kaiser Family Foundation Policy Fact Sheet, 2014
- Justin, Du Toit (Consultancy Africa). *HIV, AIDS and Religion: An Ambiguous Relationship*
- Kaiser Health News (2009), Cultural Practices in Namibia Hinder Prevention Group

Kenya AIDS Response Progress Report 2014

Kenya Demographic and Health Survey (KDHS) (2009). Central Bureau of Statistics. Nairobi: Government Printing Press

Kenya HIV Estimates Technical Report 2013

Kenya Ministry of Health 2014 HIV Estimate Report

Makahamadze, T and Sibanda F. (2008) '*Battle for survival*': responses of the Seventh-day Adventist church to the HIV and AIDS pandemic in Zimbabwe.

Mugenda, O. and Mugenda, A. (1999). *Research Methods. Quantitative and Qualitative Approaches*. Nairobi: African Center for Technology Studies (ATCS).

NASCOP. (2008). Kenya AIDS Indicator Survey (KAIS). NASCOP: Nairobi.

Obiero, C., Nyagero, J., Mwikali, M., Tendo, W., and Omurwa, T. (2000). *Young People's Knowledge and Experience with STDS/HIV/AIDS in Nyamira District*, in East African Medical Journal Vol. 77 No. 6 pp s11-s14

Peter, Okaalet (2002), *Role of Faith-based Organizations in the fight against HIV/AIDS in Africa*

Peter, M. Bartos, P.D. Ghyns, DHL Hymann (2001) *Global Impact of HIV/AIDS*, Nature Publishing Group

Population Council Annual Report on HIV/AIDS (2013)

Rev. Francis Mkandawire, *Role of Churches in a World Living with HIV/AIDS*

Rhoun Ochako, Dunstone Ulwodi, Purity Njagi, Steven Kimetu and Aggrey Onyango, (2011) *Trends and determinants of Comprehensive HIV and AIDS knowledge among urban young women in Kenya*

Servaeas, J. (Ed) (2002). *Approaches to Development Communication*. Paris; UNESCO

Seventh-day Adventist church General Conference: www.adventist.org/.../general-conference/

Seventh-day Adventist church Health Ministries: www.AdventistAIDSInternationalMinistries.org

Uganda Ministry of Health, 2001, *HIV/AIDS Surveillance Report*: Kampala, Uganda

UNAIDS (2008). *Report on the Global AIDS Epidemic*. Geneva: Arlington

UNAIDS (2012) *Senegal: A Success Story of AIDS Investment and Impact*

WHO Global Statistics, AIDS.gov

World Council of Churches, (2005). *Church Statements on HIV/AIDS*

Appendices

Appendix A Letter to respondents

Millicent A. Odondi
University of Nairobi
P.O. Box 30197
Nairobi.
25th Sept, 2015.

Dear Respondent,

REF: REQUEST FOR DATA

I am a final year student at the University of Nairobi, School of Journalism, pursuing a masters of arts in communication studies degree. As part of my course requirement, I am undertaking a research titled “ASSESSMENT OF HIV/AIDS BEHAVIOR CHANGE COMMUNICATION USED BY THE SEVENTH-DAY ADVENTIST (SDA) CHURCH AMONG ITS YOUNG PEOPLE IN HOMA BAY COUNTY”. In this regard, you are kindly requested to support this research by responding to the questions below. Please note that your response will be treated with the highest level of confidentiality and will be used purely for academic purposes.

Your cooperation will be highly appreciated.

Yours sincerely

Millicent A. Odondi

Appendix B: Questionnaire

Section A: Personal Information

Name (optional)

Gender.....

Age bracket (tick as appropriate)

Age category	Tick
15-18	
19-24	

Education (tick as appropriate)

Highest level of education	Tick
Primary education	
Secondary education	
College education	
University education	

Section B: information on HIV/AIDS behavior change communication

How frequently do you attend youth programs in church? (tick as appropriate)

Frequently Less frequently Never

Have you ever received information about HIV/AIDS from church? If yes, briefly describe the information you received and what you learned from it.

Yes No

.....

.....

.....

.....

Kindly, briefly describe what you know about HIV/AIDS.

.....

.....

How do you usually get information about HIV/AIDS and behavior change from church? (tick as appropriate)

Books and magazines	
Youth group discussions	
Teaching by peer leaders	
Lectures and teachings from youth teachers	
Others	

How different do you think the youth in the church are from those youths who do not go to church? Briefly describe.

.....

In your opinion, why are young people more vulnerable to HIV/AIDS than mature adults?

.....

How do you make sure you are not infected with HIV/AIDS?

.....

How can you describe the kind of information you would wish to seek for on HIV/AIDS? (tick as appropriate)

Urgent Vital Personal

What kind of information concerning HIV/AIDS would you like to receive from church?

.....

How would you like to be taught issues concerning HIV/AIDS?

.....

Are you satisfied with how awareness is being carried out on HIV/AIDS and behavior change among the youth in the SDA church? (tick as appropriate)

Very high(5)	High (4)	Moderate(3)	Low(2)	Very low(1)	I don't know

If NO, what do you propose should be done to make the information useful based on your experience? Briefly describe.

.....

In your opinion, why do more youths within the SDA church still continue to be infected with HIV even after receiving awareness on HIV/AIDS? Briefly describe.

.....

Section C: General Recommendations on HIV/AIDS behavior change communication

In your opinion, what messages concerning HIV/AIDS and behavior change should the SDA church communicate to the youth?

.....
.....

What methods of communication should the SDA church use to build awareness on HIV/AIDS and behavior change among the youth?

.....
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Appendix C: Interview Guide

1. Do you have any formal training pertaining to HIV/AIDS teacher education or any other training related to HIV/AIDS?
2. Are you aware youths are engaged in risky sexual behaviors that would predispose them to HIV/AIDS infections?
3. In your opinion, what factors increase the vulnerability of the youth to HIV/AIDS?
4. What changes are there in the society today that influence HIV/AIDS trends among the youth?
5. How are you as a teacher/leader of the youth and the SDA church prepared to address these challenges?
6. How different do you think the youth in the church are from those outside the church?
7. What information do the youth need to have concerning HIV/AIDS?
8. How do you package HIV/AIDS information that you teach to the youths?
9. How has the SDA church tailored its programs and communication on HIV/AIDS and behavior change that can result in significant changes in knowledge and attitudes that affect sexual behavior of young people?
10. Why, in your opinion, do the youth continue to be infected despite receiving information about how to keep themselves from getting infected?