FACTORS INFLUENCING HEALTH CHOICES IN VIEW OF EMERGING LIFESTYLE DISEASES AMONG THE SEVENTH-DAY ADVENTIST CHURCH MEMBERS IN ELDORET WEST STATION, KENYA

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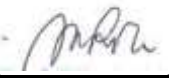
APPROVAL SHEET

This thesis entitled ***Factors influencing health choices in view of emerging lifestyle diseases among the Seventh-day Adventist Church members in Eldoret West Station, Kenya,*** written and submitted by **Limo Edward Kipng'eno** in partial fulfillment of the requirements for the degree of **Master of Science in Nursing (Community Health),** is hereby accepted and approved.



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ABSTRACT

This study identified the factors influencing health choices in view of emerging lifestyle diseases among Seventh-day Adventist (SDA) Church members in the Eldoret West station of Greater Rift Valley Conference of the SDA Church, Kenya. The objectives of the study were to determine the health choices among the SDA Church members, to evaluate their knowledge of lifestyle diseases, cultural beliefs on health, and attitudes towards the Adventist health message, and to find the correlations among these variables. Milio's framework for prevention-changing health-damaging to health-generating life patterns was adopted for the study. It employed descriptive, correlational and comparative research designs. The data from 237 randomly sampled church members was analyzed using descriptive statistics, Pearson product-moment correlation coefficient, t-test for independent samples, and one-way analysis of variance. The study findings showed that SDA church members have good health choices (mean of 3.30) and moderately positive attitude towards the Adventist health message (mean of 2.85). Seventy percent (70%) of the research participants have knowledge of the risk factors and 81% are knowledgeable of the preventive measures of lifestyle diseases. Church members who have positive attitude towards the Adventist health message tend to have positive health choices. Moreover, church members with lower level of education, with higher income, and are members of the church for at least 20 years have more positive health choices. In comparisons, there were no significant differences in health choices of respondents grouped according to age and location of residence. It is recommended that the church continues its health education to church members with emphasis on risk factors and preventive measures of lifestyle diseases and promotion of Adventist health message for the purpose of encouraging them to adopt positive health choices.

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DEDICATION

This thesis is dedicated to my beloved wife Juliet Jeptoo Limo, Son Victor Kibet, Daughter Patience Jelagat and my church members all over GRVC. I also dedicate this to everyone who came in to stand with me when I needed support in the study for their understanding, support and encouragement during this period of great sacrifice for studies

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I would like to sincerely thank the Almighty God for life, good health and sufficient grace throughout my studies

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I also want to appreciate all lecturers and fellow students whose input led to my completion of the course. May the almighty God richly bless all of you. I cannot mention all but a few of you. Thank you

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LIST OF ABBREVIATED ENTRIES

COVID 19: Corona Virus Disease 2019

SDA: Seventh-day Adventist Church

SES: Socioeconomic status

NCD: Non-communicable diseases

GRVC: Greater Rift Valley Conference

HIV: Human immunodeficiency virus

AIDS: Acquired immunodeficiency syndrome

KDHS: Kenya Demographic and Health Survey

ESV: English Standard Version

CHAPTER ONE

INTRODUCTION

This chapter presents the background of the problem, the statement of the problem, the purpose of the study, the objectives of the study, justification of the study, the theoretical framework, the conceptual framework, the rationale or significance of the study, the limitations, assumptions and definition of terms.

Background of the Study

Communicable diseases like malaria, cholera and polio have become manageable due to recent advancements in medicines. However, a new breed of diseases has developed, called 'Lifestyle diseases' also referred to as Non-Communicable Diseases (NCDs) such as heart disease, some cancers and diabetes, which were previously known as problems in wealthy nations. They may be a result of a combination of genetic, physiological, environmental and behavioral. Lifestyle diseases characterize those diseases whose occurrence is primarily based on the daily habits of people and are a result of an inappropriate relationship of people with their environment. The main factors contributing to lifestyle diseases include bad food habits, physical inactivity, wrong body posture, and disturbed biological clock (Sharma, 2009). According to the Global Status Report 2011on non-communicable diseases killed 36 million people in 2008. More than 16 million of the 36 million deaths attributed to NCDs each year occur before the age of 70, the most economic productive age; the loss of these lives is endangering industry competitiveness with a dramatic impact on productivity and quality of life and ultimately reducing the strengths of development of a country. Contrary to popular opinion, available data demonstrate that nearly 80% of NCD deaths occur in low- and middle-income

countries (WHO 2011). The magnitude of these diseases continues to rise, especially in low- and middle-income countries. Nearly 80% of these deaths occurred in low- and middle-income countries, where we have the highest proportion of deaths under the age of 70 from NCDs occurring (WHO2011). NCDs are the leading cause of disability and death in Europe: cardiovascular disease, diabetes, cancer and respiratory disease account for 77% of the burden of disease and 86% of premature mortality. NCDs are the leading causes of death (accounting for 63%) in all regions of the world except Africa. (WHO, 2013) World Health Organization's projections indicate that by 2020 the largest increases in NCD deaths will probably occur in Africa due to the rise of the middle class. Current hospital statistics seems to be confirming that this trend is a possibility. Over the next 20 years, NCDs are projected to cumulatively cost more than US$30 trillion 48% of global GDP in 2010, and push millions of people below the poverty line. The lifestyle diseases also known as non-communicable disease epidemic is increasingly recognized as a critical component of general public health. All public health strategies employed by governments are to attempt to reverse the trends. The prevalence of NCDs, and the resulting number of related deaths, is expected to increase substantially in the future, particularly in low- and middle-income countries, due to population growth and ageing, in conjunction with economic transition and resulting changes in behavioral, occupational and environmental risk factors (WHO 2011).

In Kenya, NCDs contribute to 33% of the total mortality, with prevalence of diabetes being reported at 4.2% and hypertension at 12.7% nationally. A total of 18% of preschool children are overweight and 4% are obese. The proportion of women aged 15-49 that are overweight and obese according to the KDHS report of 2008/09 is 25%, with the highest proportion being reported in Nairobi at 41%. Limited physical

activity, increased stress and poor diets has increased the incidences of NCDs. NCDs are the victims of increasing family economic strains and mortality data (Otieno, 2016). This is supported by Smyth 2014, who also said non-communicable diseases were a major cause of poverty and were undermining development worldwide. Several countries continued to face high numbers of undernourished children while affluent settings are responding to obesity, which results from poor nutrition too. "Every Kenyan has lost a family member or close friend to lifestyle diseases, this according to a recent survey by Broadway Bakery Limited, (Otieno 2016). Kenya is also tackling infectious diseases like HIV/AIDS, tuberculosis and malaria and the emergence of non-communication disease here complicates the health care strategies and projected national success estimations.

There is one health strategy that has been constant however; man has had the responsibility to work towards a healthy lifestyle. This has been evidenced by active participation in a healthy lifestyle, with its behavioral emphasis, which typically involves decisions about diet, exercise, smoking, alcohol, drug use, risk of infection and accidents. There is a lot about individual participation and cannot be downplayed. The nature of man as stated by the Adventist belief is that man and woman is created in the image of God with individuality, the power and freedom to think and to do (Ministerial Association 2015). The power of human choice is bestowed on individual and the church respects this. The Adventist stand on Christian behavior according the principles also states that man is called to be godly people who think feel and act in harmony with the principles of heaven. It further indicates that Christian character is recreated if we persist with those things that will produce Christ like purity, health and joy in our lives (Ministerial Association, 2015). This is also sported by bible statement 1 Timothy 4:8 ESV **"**For while bodily training is of some

value, godliness is of value in every way, as it holds promise for the present life and also for the life to come". In attempts to meet the Christ like character Adventist must adopt to the packages of health that are prescribed by the health principles summarized in lifestyle adaptations which include exercise, rest, abstaining from unclean food identified in scripture, proper cooking of foods and use of healthful diets. This attempts have been influenced to a larger extend by factors that will be important for the study including individual health choices, the knowledge levels of members on lifestyle diseases, the detrimental cultural health beliefs affecting lifestyle choices and the negative attitudes of members towards the Adventist health messages.

This has implications for the aggregate community practitioners working in the field of health promotion, in particular to promote healthy lifestyle. Indeed, the need for health promotion, prevention and treatment programs for NDCs is arguably the primary health challenge of the 21st century in Europe (Wittchen, 2011). All churches are community organs. Anything affecting the community touches on the very nerve of the church. Healthy behavior promoted by the SDA church -a plant-based diet, need for sunshine, no smoking, nuts, fibers, exercise and reduction of sugar -translate into a longer life, American studies find, with Adventists recorded to live up to 10 years longer than other subgroups (Thandiwe, 2011). SDA churches all over the world, including those in GRVC, have designated health ministries, which reinforce the church's commitment to the close relationship between bodily health and spiritual wholeness.

The church in totality believes that risk perception motivates attendance to healthcare providers, promotes behavioral and lifestyle changes and influences decisions regarding treatments. An understanding of risk perception as it relates to

prevention of chronic disease management is important (Webster 2010). This strategy of information dissemination is a culture of the Adventist Church through the department of health ministry. It is a ministry priority and assumption that the Adventist population is more educated than the general public on issues of health. Could this assumption also be taken as true for members of Greater Rift valley conferences of the seventh day Adventist church? This study put this question into right perspective by providing answers and suggesting strategies to improve the member commitments to the strategies on tackling NDCs.

Statement of the Problem

The Head of the Division of NCDs at the Ministry of Health, Dr. Kibachio, Joseph, states thus, "It is quite perturbing, considering that lifestyle changes are the cornerstone of prevention and treatment of lifestyle diseases. He further added that a primary focus on only medication without a corresponding adoption of a healthy diet, physical activity and cessation of alcohol and tobacco produces sub-optimal treatment outcomes for patients" as quoted by Mugo 2017. NCDs already disproportionately affect low- and middle-income countries. Current projections indicate that by 2020 the largest increases in NCD mortality will occur in Africa and other low- and middle-income countries (WHO 2011). The prevalence of NCDs is rising rapidly and is projected to cause almost three-quarters as many deaths as communicable, maternal, perinatal, and nutritional diseases by 2020, and to exceed them as the most common causes of death by 2030. The leading causes of NCD deaths in 2008 were as reported in the global reports indicated cardiovascular diseases (17 million deaths, or 48% of NCD deaths); cancers (7.6 million, or 21% of NCD deaths); and respiratory diseases, including asthma and chronic obstructive pulmonary disease (COPD), (4.2 million). Diabetes caused an additional 1.3 million deaths (WHO, 2011).

The Seventh-day Adventist church recognizes that God created man a free moral agent, endowed with power to understand the will of his Creator, to think for himself, and to act according to his enlightened conscience. This is also extended to the authority of SDA members to the lifestyle choices. The SDA church manual indicates that "health reforms and the teaching of health and temperance are inseparable parts of the church's message. The church teaches and instructs health choice on authority through clear instructions and teaching of healthy lifestyle choices as an offering acceptable to God's services (The Secretariat, General conference, 2016). The church has taken a variety of actions to promote healthy decisions and behaviors, enacting church policies, lifestyle laws, and regulations to help mitigate "unhealthy" choices and encourage "healthy" choices act as guardrails and signposts for health decisions. The church agrees with this fact that a wider recommendation that modifiable behaviors, such as tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol, all increase the risk of NCDs.

Every SDA member and the church are well aware of the health message that is endowed with the church and confirmed by all members any time before baptism. The Adventist must pursue a distinct way of daily living. She/he must change his/her eating habits, go on a diet, create a healthy lifestyle and keep to it. This is such that it is taken as part of the belief vows number 10 taken before baptism and also stated by the handbook, church manual (The secretariat General conference of the Seventh-day Adventist church, 2015). There is a promise for God's people in Exodus 15:26 ESV Says, "If you will diligently listen to the voice of the Lord your God, and do that which is right in his eyes, and give ear to his commandments and keep all his statutes, I will put none of the diseases on you that I put on the Egyptians, for I am the Lord, your healer." Faithfull belief and claim this promise. With this knowledge, the

research study here attempts to determine the factors that influence church members' health choices. While the magnitude of these health challenges has been progressively rising across the globe during the last three decades, so have substantial improvements in knowledge and understanding about their prevention and control (WHO 2011). It is real issue to have this information and knowledge in the church and on the other hand to experience the effects of inappropriate care of self as demonstrated by the existence of the NCDs within our membership. The study here established whether the memberships of the SDA church at the greater rift valley conference are aware of the consequences of health choices. After all according to Neal Boortz "The key to accepting responsibility for one's life is to accept the fact that your choices, every one of them, are leading you inexorably to either success or failure however you define those terms". Could there be a need for reawakening of members on the sole responsibility towards health choices?

Research Objectives

1. To determine the health choices among the Seventh-day Adventist Church members
2. To evaluate the church members'
    a. Knowledge on lifestyle diseases (lifestyle risks and lifestyle preventive measures)
    b. Cultural beliefs on health, and
    c. Attitudes towards the Adventist health message
3. To establish if there is a significant relationship between health choices and knowledge, cultural beliefs, and attitudes.
4. To ascertain if there is a significant difference in the health choices of church members classified according to a) gender, b) age group, c) level of education,

d) socio-economic status (income level per month), e) years as SDA church member, and f) location of residence.

Significance of the Study

The purpose of this research was to identifying factors influencing lifestyle choices of with intentions to promote physical well-being and to learn how the knowledge can be applied to better everyday life.

This research shall be used in the department of Health and the Seventh-day Adventist church. The church needs to understand where failure is despite the solid information base, an organized method of dissemination in the church, support structures for the messages and an evaluation subsystem for the church program. The recommendations shall benefit programs of the church and particularly GRVC from the initiatives of the health program, identification of the institutional development successes, GRVC church members and the world church development strategy being impacted by the health practice.

This research study is an integral part of problem solving. It is an independent academic research that contribute greatly to major stakeholder in the health sector, governments' departments of public health, hospital nutrition and dietetics departments and especially the Kenya ministry of health. The findings of this research may provide a significant basis for further academic research on the topic of health choices in regards to lifestyle diseases.

Justification of the Study

Non-communicable diseases (NCDs) have been on the rise in Kenya over the past decade. However, their potential effects on household welfare are unavailable despite strong evidence of economic and social consequences from developed countries (Ngugi, 2014). The Philippines, as many developing countries also, reflects

the global trend of rising deaths from NCDs (Department of Health, Republic of the Philippines, 2009). Many studies recommend that the health care system needs to develop mechanisms to promote preventive care for NCDs through control of NCDs risk factors, since preventive health is cost effective than curative health. Effective public policies such as community-based routine screening and health education/information dissemination for NCDs are required to address the raising prevalence of NCDs beside individual and household policies.

Churches have a lot of influence on membership, as such there needs to be a strategy to utilize this to reach out to people (Modise, 2015). The SDA church specifically is known in the fight against non-communicable diseases by use of this knowledge. The church seeks to encourage members and the wider society to adopt healthy lifestyles in part or full, including a plant-based diet including fruits, vegetables, grains, legumes and nuts; regular exercise, sufficient intake of water, fresh air and sunshine, rest and a connection with God through prayer (Hosen, 2018). Their strategy is however different because they want to disseminate the information about health issues during church services majorly to its members and congregations. This strategy is assumed to be working well in our church. However, the memberships are still victims of NCDs. Everyone in the church has been taught to adopt a change of behavior framework following the teachings of health and their recommendations for an improved life and a prevention of the NCDs. This is ensured and confirmed at baptism all the time by having members authenticate their knowledge to the church teachings and practice after teachings. This from time of message inception has had its own challenges and White (1923) commented thus, the gospel of health has able advocates, but their work has been made very hard because so many ministers, and others in positions of influence, have failed to give the

question of health reform its proper attention. They have not recognized it in its relation to the work of the message as the right arm of the body. Experience empowers health promoters with rational and emotional resources to testify of the advantages and benefits of living the lifestyle proposed by heaven. It gives moral authority, conviction, and emotion to the communication of the message. “We cannot stop telling about everything we have seen and heard” (Acts 4:20). Or “we proclaim to you what we ourselves have actually seen and heard” (1 John 1:3). (Cesar Augusto Galvez 2016). The statement here is a serious bridge of the supposed protocol which cannot be ignored in our church today. It is known that ministers teach and putting into practice what they teach is very important. The study has intentions to highlight the areas of weakness in the health ministry channel in the church. Understanding the various factors that influence the health choices of health is in order to suggest caution to gospel workers, family and individuals as it is indicated “to be forewarned is to be forearmed”. We therefore belief that the Adventist message has it all in telling the times when there shall be rise of diseases in the future that man has to take active role in prevention and control. As a Church we view the holistic nature of mankind through his health and wellbeing which is to say the physical, mental, social and spiritual, which are all impacted by the health habits of each individual. "We believe that with the impact that NCDs have on the society where the deaths far exceed that of our worrisome crime rate, it is time for each individual to adopt and maintain a healthy lifestyle," said Hosin (2018) (Health Ministries Director of the Jamaica Union Conference of Seventh-day Adventists). The SDA church should be in the above regards in the forefront in all aspects of approaches in combating NCDs. The study needed to establish the weak areas in the church strategies. There is also a need to

understand reasons for low uptake of the health message advises despite the importance attached to the program by the church.

Theoretical Framework/Conceptual Framework

In attempting to explain the logical framework of the study the Milio's (1976) framework of health was used. The framework of prevention emphasizes health change at the community level. She developed a framework for prevention that includes concepts of community-oriented and population-oriented framework. The framework identifies relationship between health deficits and availability of health-promoting resources. She also theorizes that behavior changes within a large number of people can ultimately lead to social change. She further states that behavioral patterns of the population and individuals that make up a population are a result of habitual selections from limited resources. A variety of indicators favors the development of self-care systems for a society. To be effective, self-care must be a community concept the framework indicates. This type of system requires an information base, an organized method of dissemination in a community, support structures and an evaluation subsystem. A community- oriented system would be an alternative and a complement to formal health services; individuals and families would manage common health problems, but would have ready access to formal services through community organizations. In this study apart from testing the knowledge of members, explored other parameters that are determinant of lifestyle choices. Health is also influenced by organizational behavior which includes policy makers since they provide options available to thus influencing selections made by individuals.

This framework provides that an individual's health selections are influenced by the objective to maximize valued resources therefore selection is based to personal

resources and societal resources. Change in choice making among a large number of people in the population leads to social change and that teaching and learning may be insignificant in affecting behavior patterns if new health. Governmental and institutional policies, she said set the range of options for personal choice making.

The SDA church has had motivational strategies that guide the membership on lifestyle choices and the resulting responsibility to choices. For the SDA members many of these are also linked to spiritual outcomes and biases and therefore very much self-reflective. Outcomes in this theory are both proximal and distal. The proximal outcome is actual engagement in self-management behaviors specific to a condition or health behavior. Distal outcomes refer to the long-term impact of personal behavior on health status. Failure to engage in healthy behaviors may result in premature onset of disease conditions. Distal outcomes are related, in part, to successful achievement of proximal outcomes. Although achievement of distal outcomes provides data about the effectiveness of the intervention, these outcomes are generally slow to be realized. Measurement of proximal outcomes is critical to evaluate whether people have made and are maintaining change in their health as shown in the framework below.

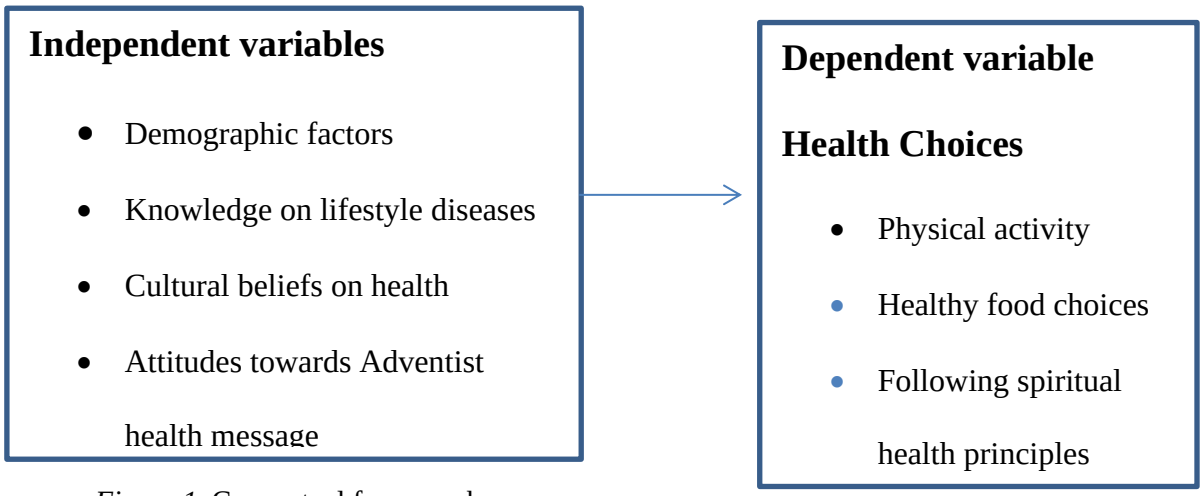

Figure 1. Conceptual framework.

According to WHO, 60% of related factors to individual health and quality of life are correlated to lifestyle or health choices (Ziglio, 2004). In the above illustration of the conceptual framework, Education is critical in improving the knowledge levels in general including that of lifestyle diseases. Education is critical to social and economic development and has a profound impact on population health. Zimmerman (2015**)**, in a study reviews evidence for the health benefits associated with education in the context of a socioecological model of health. The study concludes that the health benefits of education accrue at the individual level (e.g., skill development and access to resources); the community level (e.g., the health-related characteristics of the environments in which people live).

Cultural beliefs are also affecting lifestyle choices. Different cultures can produce people with varying health risks. Menus stressing lower-fat foods and lots of vegetables, such as those of many Asian cultures, can result in more healthful diets, even reducing the risks for diseases such as diabetes and cancer. On individual attitudes, unintentional physical activity may be influenced by non-conscious attitudes. The Adventist health lifestyle is learned and made to be a habit by making practice. A constant reminder of health principles and plans in churches to improve compliance is very evident in church programs.

Relationship between health choices and knowledge, cultural beliefs, and attitudes are seen as independent variables. An action one results to positive or negative impacts on health. Both population-wide primary prevention approaches and individual health-care strategies are needed to reduce NCDs and their impact. Decisions made outside the health sector, example in churches often have a major bearing on factors that influence NCD-related risk (WHO 2011). For example functional health education in health care management should enhance efforts to

improve peoples' knowledge of their potentials of disease and adherence to preventive strategies- right health choices. Knowledge whether academic or otherwise helps one to understand sciences of choices and at the end individual will understand the foods and their labels to either with consequences of use.

The demographic components also lead us to attempt to understand the challenges of various age sets also as social attributes to health choices in future studies. There are also social strategies to help lead people to the healthful choices of life.

Scope of the Study

The study was carried out in the Eldoret West station of Greater Rift valley Conference of the Seventh-day Adventist church, Rift valley. The participants of the study were baptized members of the SDA church.

Questionnaires were used to collect the data to respond to the study. The study was based on the factor influencing health choices amongst the SDA members given the rising trends of lifestyle diseases. The variables were both independent and dependent variables. The independent variables were health choices, knowledge on lifestyle diseases, cultural beliefs on health, attitudes towards Adventist health messages, and the demographic factors such as gender, level of education, and socio-economic status.

The study was carried out from January to July 2021, which was from the time of writing proposal, data collection and presenting the thesis paper.

Definition of Terms

Adventist: A member of any of various SDA churches in greater Rift Valley Conference.

Attitudes: A feeling or opinion about healthful living, or a way of behaving that is caused by these choices in healthful living.

Cultural beliefs: culture is a country or a place that has its own beliefs, a way of life.

District: It is used to convey a dual meaning. First it is an administrative section of a Pastor of the Seventh-day Adventist church- Could be one church to a group of them depending on area and population. Secondly it is the sub- County area of administration as demarcated by the government of Kenya.

Eldoret West: Also called Eldoret West Station a regional SDA church administration similar to the current Political Kapseret constituency

Gender: A set of characteristics and traits to males and females or traits that make up masculinity and femininity

Health Choices: Is the life effort to saturate life with balanced and healthy activities by body

Healthy Living: Is taking individual responsibility of/making smart health choices (strategies seen towards eating right, getting physically fit, emotional wellness, spiritual wellness and prevention)

Lifestyle diseases: Are diseases associated with the way a person or group of people lives. Lifestyle diseases include atherosclerosis, heart disease, and hypertension; obesity and diabetes; and diseases associated with smoking and alcohol and drug abuse.

Knowledge levels: That which represents a broad section of the education "ladder", that is, the progression from very elementary to more complicated learning experience.

Member: A person or group of persons that is/are part of Seventh –day Adventist body or community.

Urban churches: Churches located in the center of business district in Eldoret Town

Peri-urban churches: Churches located in the slum areas in Eldoret Station

Rural churches: Churches located at the regions of farming outside Eldoret town and slam areas

CHAPTER TWO

REVIEW OF RELATED LITERATURE AND STUDIES

The review of related literatures and studies was taken from books, journals, newspaper, theses both in print and online sources. The chapter discusses the health choices in general, Cultural beliefs affecting health choices, attitudes on health choices and the socio demographic factors affecting health choices including age and the levels of education. The literature here also attempts to discuss the relevance and of knowledge levels on lifestyle diseases.

Health Choices

Every day we make decisions about our health – some big and some small, some conscious and some subconscious. What we eat, how we live and even where we live can affect our health. Health choices may largely include the behavior and activities that make up individual daily life. This includes the work one does, leisure activities, the food eaten and as well as interaction with family, friends, neighbors, coworkers and strangers. We make decisions about where to source information about maintaining good health, as well as about whom to see for treatment when we are ill (Irwig 2008). Health choices are the life long effort to saturate life with balanced and healthy activities by everybody. Make healthy behaviors a habit while you're still young, and you're more likely to hold onto them throughout your life (Hilmantel, 2014). Choices often determine our destiny. To a large extent even our health can be determined by the choices we make on how we live, the risks we take, and the balance we seek in life. We each come into the world with an endowment for health that may vary from that of others, but how we care for the gift of our health influences the

expression of our genetic capacities (Handysides, 2012). This is a strategy adopted by the church in teaching of members as they grow in faith and all other measures.

In recent decades, life style factors of health attracted more interested by researchers. According to WHO, 60% of related factors to individual health and quality of life are correlated to lifestyle, (Ziglio, 2004). Millions of people have been following an unhealthy lifestyle. Hence, they encounter illness, disability and even death. Problems like metabolic diseases, joint and skeletal problems, cardio-vascular diseases, hypertension, overweight, violence and so on, can be caused by an unhealthy lifestyle. The relationship of lifestyle and health should be highly considered according to Farhud, 2015.

Food -related decisions made by individuals are influenced by a complex array of factors and processes. These include demographic factors, familial and household influences, habit and price, health considerations, ethical concerns and wider societal trends. As illustrated by the Food Choice Process Model, Sobal (2009) indicates that food choices are strongly influenced by events and experiences beginning early in life and continuing throughout the life course. The Adventist health programs starts as early for a member and even their children. According to research, food preferences are formed in early childhood and affect an individual's eating habits for life. Starting early is important to give our children the best chance to live healthy and successful lives and turn the tide on our obesity epidemic, (Gremont, 2015). This is in attempt to have the above principle affixed in early stages of life.

Despite the well-known benefits of maintaining healthy body weights and an active lifestyle, overweight/obesity is classified as the fifth leading cause of global mortality, and an important predictor of various non-communicable diseases (WHO 2009). This is also lifestyle malnutrition related problem of sedentary life.

NCDs such as hypertension and diabetes require patient education to achieve adequate control and prevent adverse health outcomes. Persons may need to understand how to properly take multiple medications and modify their lifestyle to achieve adequate lifestyle control. Healthcare is being revolutionized by a new movement called evidence-based medicine or evidence-based healthcare. Evidence based approach is encouraging the use of health practices that are based on sound evidence of their benefit exceeding their harm, rather than the opinions of experts or tradition, as has often been the case in the past and often to the detriment of our health. Every health decision you make, whether about a therapy, diagnostic or screening test, or change in lifestyle – will involve benefits and harms. However, their importance will be valued differently by different people depending on the knowledge given **(**Irwig 2008).

Finally, marital status has also been found to influence health and mortality. Married people have significantly better health and a lower mortality than their single counterparts (Smith, 1994). There are also family choices that are made together that may be affecting health. This study finds marital status an important variable for consideration while studying health choices.

Adventist Health Message

The Seventh-day Adventist Church recognizes the autonomy of each individual and his or her God-given power of choice. Rather than mandating standards of behavior, Adventists call upon one another to live as positive examples of God's love and care. Freedom of choice has been granted to every man.... This concept is a fundamental principle and a pillar of the Torah and its commandments. As it is written (Deuteronomy 30:15): "See, I have set before you life (good) and death (evil)"... Furthermore, the church beliefs according to 1 Corinthians 6: 19 (NIV)

“Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God? You are not your own”. For were God to decree that a person be righteous or wicked, or if there were to exist something in the very essence of a person's nature which would compel him toward a specific path, a specific conviction, a specific character trait or a specific deed. CELEBRATIONS® is an acronym for 12 healthful living principles: (1) choices, (2) exercise, (3) liquid, (4) environment, (5) belief, (6) rest, (7) air, (8) temperance, (9) integrity, (10) optimism, (11) nutrition, and (12) social support and services (Handysides, 2012). Adventists believe the key to wellness lies in a life of balance and temperance. Nature creates a wealth of good things that lead to vibrant health. Pure water, fresh air, sunlight and promote clean, healthy lives. Exercise and avoidance of harmful substances such as tobacco, alcohol and mind-altering substances lead to clear minds and wise choices. A well-balanced vegetarian diet that avoids the consumption of meat coupled with intake of legumes, whole grains, nuts, fruits and vegetables, along with a source of vitamin B12, will promote vigorous health. Such health is a gift from a loving God who wants us to live life in its abundance. When we benefit from such love, we feel a sense of gratitude and appreciation toward our creator.

Disease, whether it is cancer, heart disease or another of the big top disease killers in the world, is the leading cause of deaths all around the world. Because people choose to ignore the health message that God's people have been giving for hundreds of years. The health message is a pretty simple, clear message that we are giving to the world. It is a message of reformation in our health and habits; a message that if heeded, will bring both physical benefit and spiritual healing. We worship God and follow Jesus first and foremost in our minds. So everyone should know that if we are in poor health, then our minds are affected and we cannot give true devotion to

God. Not only that, God's Word also tells us that we are not to defile our bodies, because we are the 'temple of God.' 1 Corinthians 10:31 ...'Whether therefore ye eat, or drink, or whatsoever ye do, do all to the glory of God.' How can we 'give glory to God' in our bodies? The answer is simple and straight forward. Health and temperance!

The self-denial, humility, and temperance required of the righteous, whom God especially leads and blesses, is to be presented to the people in contrast to the extravagant, health-destroying habits of those who live in this degenerate age. God has shown that health reform is as closely connected with the third angel's message as the hand is with the body. There is nowhere to be found so great a cause of physical and moral degeneracy as a neglect of this important subject. Those who indulge appetite and passion, and close their eyes to the light for fear they will see sinful indulgences which they are unwilling to forsake, are guilty before God (CD 713).

Every SDA church as an institution has to adopt a change of behavior policy framework following the teachings of health and their recommendations for an improved life and a prevention of the NCDs. This is ensured and confirmed at baptism all the time by having members authenticate their knowledge of the church teachings and practice of these teachings. The SDA church has played a major role in identifying behaviors critical to health, assessing the needs of individuals and groups and recommending specific health behaviors, preparing and delivering interventions designed to enhance engagement in health behaviors and evaluating the effectiveness of interventions for individuals, groups, communities (Handysides. 2012). The church still simplifies the methods of internalization of the health concepts including putting in acronyms like “CELEBRATION” and “NEWSTART”. To fulfill these role responsibilities, the SDA church members benefit from understanding the theory and

science of health behavior change. Individual behavior also plays a role in health outcomes. For example, if an individual adopts recommended lifestyle advises, his or her risk of developing heart disease and other NDCs is greatly reduced. The public health and SDA church health care interventions focus on changing individual behaviors such as substance abuse, diet, and physical activity as recommended by the SDA church teachings. Positive changes in individual lifestyle behavior can reduce the rates of NCDs for individual and finally reduce the tally in the country.

Lifestyle Diseases

Globally, 14.2 million people between the ages of 30-69 years, die prematurely each year from diseases like heart attack, diabetes, and high blood pressure. Some of these diseases have emerged as more fatal than hereditary diseases or infectious ones (WHO 2013). Examples of lifestyle diseases are heart disease, stroke, diabetes, obesity, metabolic syndrome, chronic obstructive pulmonary disease, and some types of cancer. NCDs are of great risk, to the overall health and wellbeing of the nation. It creates utmost fear and insecurity in human life and living. The main NCDs are heart disease, stroke, cancer, chronic respiratory disease and diabetes. The risk factors associated with increase of NCDs include high blood pressure, high concentrations of cholesterol in the blood, inadequate intake of fruits and vegetables, overweight and obesity, physical inactivity, alcohol abuse and tobacco use (WHO, 2010).

Chronic conditions are frequently incorrectly considered to have limited impact on the burden of disease in Sub-Saharan Africa, because of the known high relevance of the infectious diseases. Nevertheless, these diseases occur in younger age groups more commonly in Sub-Saharan Africa than in the developed countries and are at least as common in the poor sector of society as in the more affluent.

NDCS management and control is to be implemented by a collaborative strategy as indicated by Dr Macharia the Cabinet secretary of health in Kenya on August 7th, 2015 thus "It is my belief that collectively we can make a difference: Let us all join hands in embracing healthy lifestyles towards achieving a NCD free society". The same was echoed by Dr Khadijah Kassachoon Principal Secretary Ministry of Health in Kenya, "The launch of this document is not an end in itself but the beginning of a rigorous process to prioritize NCD prevention and control to halt and reverse the burden of NCDs for the present generation and secure a healthier working and prosperous nation tomorrow. Risk factors can be encountered at all ages, and risk-associated behaviors may be adopted early in life. As a result, comprehensive, long-term strategies for control of NCDs must take a life-course approach to prevention of risk factor exposure, commencing in early life and continuing with interventions for adults and the elderly (WHO, 2011).

Socio-demographic Variables and Health Choices

Age and Health Choices

In Kenya, currently the proportion of the population aged over 50 is 17% and by 2050 the number of adults is expected to almost triple, from 21 million to about 60 million. A growing number of premature deaths are due to NCDs, with half of all hospital admissions and deaths being NCD related at present. Roughly a quarter of all deaths are caused by NCDs, with cancer and cardiovascular disease (including heart attacks and strokes) being the biggest killers, (Kenya post-2015 Development Agenda).

In tune with the thinking of Professor Martin Seligman, proper nutrition is essential to children's health, yet our society struggles with the paradox of children being overfed and undernourished. According to the Centers for Disease Control and

Prevention, in 2012 more than one-third of children and adolescents aged 6 to 19 were considered overweight or obese (Childhood obesity facts). Despite this, many children's diets lack nutritious food choices. More than 90% of children aged 4 to 18 don't meet recommendations for vegetable intake, and more than 75% don't meet guidelines for fruit intake. Moreover, more than 90% of children consume more than the recommended amounts of solid fats and added sugars (Muchiri, 2016). Dr Macharia Kiruhi, a surgeon and the Executive Director of Outspan Hospital in Kenya indicated that, "medics have raised the alarm over the increase of lifestyle diseases in Central Province and Nairobi. He said there was an increase in patients diagnosed with arthritis, high blood pressure, diabetes and heart conditions in the region (Otieno, 2016). Dr Kiruhi, who is also a surgeon, attributed the diseases to consumption of junk, processed and refined foods, lack of exercise and stress at home and in the work place, (Otieno, 2016).

Socioeconomic statuses (SES) are known to exert a profound influence on health. Data on household SES are often limited to self-reported parental education and income levels. Socioeconomic progress itself has created the conditions that favor the rise of non-communicable diseases, adding that the risk factors were part of the very fabric of modern society.

Coudouel 2002 argues that, provided the information on consumption obtained from a household survey is detailed enough to measure the socioeconomic power. Consumption will be a better indicator of poverty measurement than income for the following reasons: Consumption is a better outcome indicator than income. Actual consumption is more closely related to a person's well-being that is, of having enough to meet current basic needs. On the other hand, income is only one of the elements that will allow consumption of goods; others include questions of access and

availability. This disqualifies income as a measure of poverty levels. Coudouel (2002) further adds that consumption may be better measured than income because in poor agrarian economies, incomes for rural households may fluctuate during the year, according to the harvest cycle. In urban economies with large informal sectors, income flows also may be erratic. This implies a potential difficulty for households in correctly recalling their income. In estimating agrarian income, an additional difficulty in estimating income consists in excluding the inputs purchased for agricultural production from the farmer's revenues. Finally, large shares of income are not monetized if households consume their own production or exchange it for other goods, and it might be difficult to price these. This study therefore finds income levels as a very poor judge to help determine the socioeconomic status of a population. This is summary is being fairly considerate on both monetary and nonmonetary indicators of economic status.

Gender and Health Choices

Gender is a set of characteristics and traits socio-culturally considered appropriate to males and females or traits that make up masculinity and femininity. (Crawford 2006). Gender is an important influence on how one is viewed and evaluated by other people. An individual's gender also has an impact on how that person evaluates others. Research has shown that, on average, men and women make different dietary and lifestyle choices and that the health outcomes (including adiposity) differ. Nayga reported that males are less likely to perceive nutrition as important when food shopping than females. Further, males are less likely to use nutrition labels (Kuchler, 2002). Women were more likely than men to report avoiding high-fat foods, eating fruit and fiber, and limiting salt. They were also more

likely to be dieting and attached greater importance to healthy eating (Wardle 2004). This is a great link between health choices and gender that shall not be ignored easily.

In terms of male/female relations in health choices; males and females tend to have different perspectives on what constitutes healthy behavior. Men are less likely than women to perceive themselves as being at risk for illness, injury, and a variety of health problems Boehm, 1993 in published thesis (Budesa, 2008). Mahalik (2007) found that masculinity and the perceptions of other men's health predict participants' own health behaviors. As men adopt traditional masculine (risk taking) ideals they may be adopting health practices reflecting those ideals thus putting their health at risk. The study on the gaps in gender and the differences between men and women in risk-taking behavior and the uptake of preventive and curative health services, which in turn could be responsible for socioeconomic shifts must not be ignored as solutions are sought for the health choice studies (WHO, 2009). Non-communicable diseases (NCDs) have been on the rise in Kenya over the past decade. However, their potential effects on household welfare are unavailable despite strong evidence of economic and social consequences from developed countries (Ngugi, 2014).

Level of Education and Health Choices

This part of the literature attempts to discuss the relevance and application of knowledge and information towards health. According to Zimmerman (2016), a study that reviews the health benefits associated with education, focusing on the primary mechanisms by which education may be considered is a driving force in health outcomes. Besides obvious measures of the quality of education such as proficiency scores and understanding of mathematics, reading, science, and other core content, other dimensions of education are clearly important in the ecological context as well; cognitive development, character development, knowledge, critical thinking,

and problem solving are a few examples. In generalizing the context, it means that education should result in positive dimensions of life including character, knowledge and critical thinking. Health choices and the relationships to education are critical events for this study and the assumption is that they should relate directly.

In the field of education, one could use the level of literacy as the defining characteristic and some level judged to represent the threshold for illiteracy as the poverty line. In countries where literacy is nearly universal, one might opt for specific test scores in schools as the relevant outcome indicator to distinguish among different population groups. Another alternative would be to compare the number of years of education completed to the expected number of years that, in principle, should be completed (Coudouel, 2002). Richer, better-educated people live longer than poorer, less-educated people. Many economists have attributed these correlations to the effects of education, arguing that more educated people are better able to understand and use health information, and are better placed to benefit from the healthcare system (Whitehead, 2012).

A Nigerian survey indicated that good knowledge on ill-health of respondents in a research on participants with secondary education may not represent better action toward prevention of cardiovascular diseases (CVDs) and diabetes which is essence are examples of NCDs (Oguoma, 2014). In overall, we find considerable international evidence that education is strongly linked to health and to determinants of health such as health behaviors, risky contexts and preventative service use. Moreover, we find that a substantial element of this effect is causal. For women in the United States at the margin of college enrolment, being able to enroll in college and stay for a minimum of two years decreases the probability of smoking (a health choice) during pregnancy by 5.8 percentage points. This is a large effect given that on

average only 7.8% of the women in the sample smoked during pregnancy (Currie, 2002).

Despite the availability of extensive health education materials with relatively consistent message content, many may have been written at too high a level for low-literate patients to comprehend essential points. Thus, people with inadequate literacy may not benefit from such educational efforts. This indicates a direct correlation between knowledge, important lifestyle modifications and essential self-management skills. It may also be a general assumption that people with overall higher literacy levels are more adherent to health principles than the less literate. We should attempt to compare the adherences to the principles without assuming that higher functional literacy may be more knowledgeable or simply better at taking tests and answering questions than low-literate patients who may take the messages and practice. Illiteracy is an impediment to positive achievements. Just as with any other chronic disease, a good outcome can only be achieved through a strong commitment to serving the interest of the patient (Keszthelyi, 2003). From a medical perspective, patients who do not comply with the doctor's orders are usually seen as deviant, and deviance requires correction. In the Adventist setting we need to focus on the reasons for non-compliance in all to health prescriptions as reviewed by literature that it has several causes and implies also several remedial strategies.

Not all of the effects of education on health costs are positive. Education can increase uptake of preventative care which may lead to long-run savings but short-term increases in health care costs. Those with more education are also more likely to take advantage of health care provision. Moreover, the association of education and some forms of illicit drug use and sometimes alcohol use is found to be positive, i.e. education is associated with increased use. The health effects of education are much

broader in scope, reflecting a much wider set of outcomes with an equivalently wider set of mechanisms.

Understanding the role of functional health literacy in health care management and member education should enhance efforts to improve peoples' knowledge of their potentials of disease and adherence to preventive strategies.

Knowledge and Health Choices

Studies provide strong evidence that consumer knowledge is an important variable to consider in markets for differentiated products. Knowledge allows people to make greater use of objective label information when valuing wine in an experimental auction context, with high knowledge participants updating their bids more after participants received new information. In a field experiment, we find that high knowledge consumers derive greater value when selecting wines from a substantial inventory than do low knowledge consumers (Gustafson, 2015).

Information and education methods can help to empower people knowledge scales. True empowerment from health education places an emphasis on the different stages that an individual needs to go through. These include exploring the relevance of information for individual situation through personal questions (Ellins, 2009). In addition to being prepared for better jobs, people with more education are more likely to learn about healthy behaviors. In health educated patients may be more able to understand their health needs, follow instructions, advocate for themselves and their families, and communicate effectively with health providers (Cutler, 2014). The ability of patients to make informed decisions about their health and health care is critically dependent on information. Evidence about the relationship between information and behavior suggests that information alone rarely changes behavior once it has become a habit. Information is the first requisite for behavior change but

not necessarily sufficient in isolation. The second component, motivation, results from personal attitudes towards changing, perceived social support for the changed behavior and the person's perception of how other similar people might behave. This has been discussed in some detail in socio-demographic presentation in this study. The third component focuses on the skills required for the behavioral change and on generating a belief that the behavior can be achieved (Ellins, 2009). Most of the time researched results are very important to encourage that an adoption to a particular skill or behavior has health resulting tendencies.

Cultural Beliefs on Health

No matter what we do, culture is part of the society we live in; whether it is our culture by birth or the culture of the new country in which we reside. Today, where most of us live in a completely different society or environment from which we were born into, we sometimes do not even speak the language of our birth-culture. To truly understand culture's role in shaping us, we must understand that culture is not just the inert repository of ideas and customs we all live with, but that it too is shaped by various factors (Obama, 2006)

President Obama (2006) wrote in "The Audacity of Hope", fending off claims that black culture is to blame for African Americans' plight, "In other words, African Americans understand that culture matters but that culture is shaped by circumstance. We know that many in the inner city are trapped by their own self-destructive behavior but that those behaviors are not innate. Culture shapes us, but many events mold culture and we shape these just as much. This is because much of culture depends on our biological and evolutionary hardware. And our evolutionary heritage is largely one of aggression and violence, despite our pains to sublimate these influences through cultural activities like art and religion.

All cultures have systems of health beliefs to explain what causes illness, how it can be cured or treated, and who should be involved in the process. Cultural issues play a major role in individual needs compliance. As can be seen, each ethnic group brings its own perspectives and values to the health care system, and many health care beliefs and health practices differ from those of the traditional American health care culture. Unfortunately, the expectation of many health care professionals and the SDA church has been that people will conform to mainstream values; choosing health. Such expectations have frequently created barriers to care that have been compounded by differences in language and education between persons and care providers from different backgrounds. The cultural standard for example; the extended family has significant influence, and the oldest male in the family is often the decision maker and spokesperson. The interests and honor of the family are more important than those of individual family members. These may not be assumed not to impact individual on choices including health which is our concern.

Attitudes and Health Choices

For marketers the study of consumer attitudes is one of the most important means to understanding consumer behavior. Attitudes influences, guides, shapes and predict actual behavior. Strongly held attitudes are a good predictor of behavior. Healthy eating attitudes are significantly and positively associated with healthy eating behavior. Healthy eating attitudes and healthy living: An examination of the relationship between attitudes, food choices and lifestyle behaviors in a representative sample of Irish adults (Teagasc, 2007).

Individual behavior also plays a role in health outcomes. For example, if an individual quits smoking, his or her risk of developing heart disease is greatly reduced. Many public health and health care interventions focus on changing

individual behaviors such as substance abuse, diet, and physical activity. The more often you eat healthy, the easier it will be and the more you will start to enjoy healthy food over un-healthy food. It can be difficult sometimes to choose an apple over a candy bar and you don't always have to, but in the long run, your body will thank you for eating healthy (Whitehead, 2012).

Positive changes in individual behavior can reduce the rates of chronic disease in this country. Acknowledging that diet, physical activity and healthy behaviors involve complex personal choices and that healthy choices lessen the impact of non-communicable diseases; Noting that cost-effective interventions exist and need to be prioritized in countries; Affirming that the strengthening of health systems is fundamental to address non-communicable diseases in particular, through the integration of NCD prevention and control into primary health care and community-based interventions using the chronic care model. The diet or lifestyle of different populations might partly determine their rates of cancer, and the basis for this hypothesis was strengthened by results of studies showing that people who migrate from one country to another generally acquire the cancer rates of the new host country, suggesting that environmental or lifestyle factors rather than genetic factors are the key determinants of the international variation in cancer rates. Occupational lifestyle diseases include those caused by the factors present in the vicinity like heat, sound, dust, fumes, smoke, cold, and other pollutants. These factors are responsible for allergy, respiratory and hearing problems, and heat or cold shock. So, A healthy lifestyle must be adopted to combat these diseases with a proper balanced diet, physical activity and by giving due respect to biological clock. Kids spending too much time slouched in front of the Television or Personal Computers, should be encourage to find a physical sport or activity they enjoy. Fun exercises should be

encouraged into family outings. A pizza-and-video evening should be replaced for a hike and picnic. Kids who do participate in sport, especially at a high competitive level, can find the pressure to succeed very stressful. To decrease the ailments caused by occupational postures, one should avoid long sitting hours and should take frequent breaks for stretching or for other works involving physical movements.

Summary: Gaps in Literature

Not all of the effects of education on health costs are positive. Education can increase uptake of preventative care which may lead to long-run savings but short-term increases in health care costs. Those with more education are also more likely to take advantage of health care provision. Moreover, the association of education and some forms of illicit drug use and sometimes alcohol use is found to be positive, i.e. education is associated with increased use. The health effects of education are much broader in scope, reflecting a much wider set of outcomes with an equivalently wider set of mechanisms. Despite the availability of extensive health education materials with relatively consistent message content, many may have been written at too high a level for low-literate patients to comprehend essential points. Thus, people with inadequate literacy may not benefit from such educational efforts. This indicates a direct correlation between knowledge, important lifestyle modifications and essential self-management skills. It may also be a general assumption that people with overall higher literacy levels are more adherent to health principles. We should attempt to compare the adherences to the principles without assuming that higher functional literacy may be more knowledgeable or simply better at taking tests and answering questions than low-literate patients who may take the messages and practice. While it is obvious that scientific and technical terms should be translated into everyday language, and acknowledging that providing patients with information is an essential

part of care, it is not possible, and not even necessary to give every piece of information to every patient.

Understanding the role of functional health literacy in health care management and member education should enhance efforts to improve peoples' knowledge of their potentials of disease and adherence to preventive strategies.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter outlines the research design, location of study, the population, sample size and sampling techniques and research instruments, validity of instruments, reliability of instruments, data gathering procedures, statistical treatment of data, and ethical considerations for the study.

Research Design

This cross-sectional study employed descriptive, correlational and comparative research designs. Descriptive research can be explained as a statement of affairs as they are at present, with the researcher having no control over variable. Moreover, "descriptive studies may be characterized as simply the attempt to determine, describe or identify what is, while analytical research attempts to establish why it is that way or how it came to be" (Ethridge, 2004, p. 24). Descriptive research is "aimed at casting light on current issues or problems through a process of data collection that enables them to describe the situation more completely than was possible without employing this method" (Fox & Bayat, 2007, p. 45)

Descriptive research can be explained as a statement of affairs as they are at present with the researcher having no control over variable. Moreover, "descriptive research may be characterized as simply the attempt to determine, describe or identify what are the health practices of health in the Adventist churches and the effects on health choices for members. A correlational study determines whether or not two variables are correlated. This means to study whether an increase or decrease in one variable corresponds to an increase or decrease in the other variable. The results will either produce a positive correlation, occurs when an increase in one variable leads to

an increase in the other and a decrease in one leads to a decrease in the other, Negative correlation is when an increase in one variable leads to a decrease in another and vice versa and finally No correlation where two variables are uncorrelated when a change in one doesn't lead to a change in the other and vice versa **(**Waters, 2016**).** Comparative research essentially compares two groups in an attempt to draw a conclusion about them. Researchers attempt to identify and analyze similarities and differences between groups. Comparative studies can be used to increase understanding between cultures and societies and create a foundation for compromise and collaboration (Waters, 2016).

Population and Sampling Techniques

The current membership of the Seventh-day Adventist in GRVC is 56000 covering the whole region of Nandi, Uasin Gishu, Elgeiyo Marakwet and Baringo Counties. This study will use the Eldoret west station of Uasin Gishu County as presented with a population of 4952 in table below. However a sample of the churches selected had a total population of 1536. The sample of 237 was 15.4% as shown in table 1.

A sample is a smaller number or the population that is used to make conclusions regarding the whole population. According to Mugenda and Mugenda (2003), a sample size of 10% of the sample size is considered adequate for descriptive study. Its purpose is to estimate the unknown characteristics of the population. Sampling is a procedure, process or technique of choosing a sub-group from a population to participate in the study (Ogula 2005). It is the process of selecting a number of individuals for a study in such a way that the individuals selected represent the large group from which they were selected. The study applied random sampling procedures to obtain the respondents for questionnaires. The sample frame of the

study includes a representative sample of the individuals living in the informal settlement. Attached sheet in appendix V provided by the secretary of the conference shows 126 churches in the Eldoret west station. The regrouping is 1-7 urban churches, 1-8 Peri-urban churches and 1-111 rural churches as presented in appendix 5 attached. 13 churches shall be the 10% sample taken by randomly selecting number as follows:

Table 1

List of Selected Churches for Interview

Setting	**Church**	**Membership**	**Distributed**	**Actual interviewed**
Urban	ELDORET WEST	148	65	36
Peri urban	STAREHE	408	65	44
Rural	AIRPORT CENTRAL	65	25	12
	ARIZONA HURUMA	45	15	7
	CHEBARUS	42	20	11
	KOSACHEI	191	35	22
	TUMAINI KUU	27	10	5
	SIMAT	134	30	16
	TENDWET	60	25	16
	NDALAT TOWNSHIP	46	10	14
	KOLONGET	140	35	28
	KAMULAT	156	40	18
	KIPKARREN RIVER	74	25	8
	Total	1536	400	237

Exclusion Criteria

i) **Less than 18 years of age**: The study did not include baptized members under the age of 18 for reasons of need to seek permission from parents or guardians that will limit the study. At the same time, it is at this age that the minors are in custody of caregivers and may not have much to decide on what is served on the table.

ii) **School going age**: The routines of life are dictated to them by academic schedules and will limit the independence of the individual to make choice decisions.

Inclusion criteria

i) All baptized members over age 18 are to participate in the study if selected on the sample.

Research Instruments

The main data collection instrument that was used in this study was a structured questionnaire. The questions were structured that they can be answered in a Likert-type scale of 5 points and 4 points. This was used for the purpose of collecting primary quantitative data. The other reason for choice of the tool is that the researcher has potentials in reaching out to a large number of respondents within a short time, the questionnaire is able to give the respondents adequate time to respond to the items, the questionnaire offers a sense of security (confidentiality) to the respondent and it being an objective method since no bias resulting from the personal characteristics, (Owens, 2002). The questionnaire is divided into the main areas of investigation except the first part which captures the demographic characteristics of the respondents. Questionnaires were to be administered to 400 among a cross section of men, women and youth as they attended the church services.

Validity of the Questionnaire

Validity referred to the degree to which evidence and theory support the interpretation of test scores entailed. Validity is the measure to which an instrument measures what it is intended to measure, Creswell, 2008. The validity of instrument is the extent to which it does measure what it is supposed to measure. According to Mugenda, (1999), Validity is the accuracy and meaningfulness of inferences, which are based on the research results. It is the degree to which results obtained from the analysis of the data actually represent the variables of the study. Content validity assesses whether a test is representative of all aspects of the construct. Content was approved for use by the supervisors of the study. Face validity considers how suitable the content of a test seems to be on the surface. Review of wordings on the questionnaire was checked so that all vocabulary used needed no interpretations to the respondents. It is similar to content validity, but face validity is a more informal and subjective assessment. Construct validity evaluates whether a measurement tool really represents the thing we are interested in measuring. This is central to establishing the overall validity of a study method. Criterion validity evaluates how closely the results of your test correspond to the results of a different test. This was done by giving the questionnaires to qualified experts in research to study and validate the contents. The research supervisors of the University of Eastern Africa, Baraton, approved the instruments of study before proceeding to administer them. The supervisors' advice and corrections well considered and put on the tools of study before reliability testing is done.

Reliability of the Questionnaire

Reliability refers to the extent to which an item triggers the same response every time it is administered. Reliability means that the scores from an instrument are

stable and consistent (Cresswell, 2008). In order to establish the reliability of the instruments, a pilot study was conducted in three churches (Kamungei, Kapkenduiwa and Chepchuina) of the Seventh-day Adventist in Eldoret. The questionnaires were distributed to respondents for the study the 3 churches. Then the collected data was tabulated and analyzed to ascertain the reliability. Cronbach's alpha statistical method was used to test the reliability and analyzed using the Statistical Packages for social Sciences (SPSS). The result of the pilot study is presented below.

Table 2

Cronbach's Alpha Coefficients

Variable	**Cronbach's alpha**
Experience with non-communicable diseases	.731
Individual health choice	.708
Knowledge of lifestyle risks of heart diseases	.757
Lifestyle preventive measures of heart diseases	.637
Knowledge of lifestyle risks of obesity	.727
Lifestyle preventive measures of obesity	.651
Lifestyle preventive measures of diabetes disease	.836
Lifestyle preventive measures of cancer diseases	.738
Lifestyle risks of hypertensive diseases	.740
Lifestyle preventive measures of hypertensive disease	.791
Lifestyle preventive measures of arthritis disease	.790
Lifestyle risks of depression diseases	.723
Lifestyle preventive measures of depression diseases	.697
Cultural beliefs on health	.725
Attitudes towards Adventist health messages	.775

The results indicated all Cronbach's alpha coefficients as above 0.6, thus the instrument was approved for adoption as being reliable for the study. This was therefore used to judge as a reasonable measure of internal reliability of the questionnaire.

Data Gathering Procedures

Upon approval of the research proposal by the faculty of the School of Health Sciences, the researcher sought a letter of ethical clearance and a letter of authorization from the office of the Graduate Studies and Research of University of Eastern Africa, Baraton. Audience with the church administrative board in the region was requested to clarify the purpose of the study and seek authorization. Upon getting clearance, the researcher in person distributed the questionnaires to the sampled individuals who are members of the SDA church in churches on a selected Sabbath afternoon and time was given for them to answer the questionnaires. The questionnaires were collected for analysis. Assistance from the church pastors was sought.

Use of questionnaires is expected to ease the process of data collection as all the selected respondents were reached in time. During the distribution of the instruments, the purpose of the research was explained. Selected pastors had a session of interaction with the researcher on clarification and insights on the questionnaire requirements. Enough time was given to all respondents to complete the questionnaire.

Statistical Treatment of Data

Descriptive and inferential statistics were used to analyze the data. Data addressing research objectives one and two were analyzed using means and standard deviations. For objective three, Pearson's product-moment correlation coefficient was

used. For objective four, group means were compared using t-test for independent samples (for two groups) and one-way analysis of variance (ANOVA) (for more than two groups). The level of significance was set at .05.

Quantitative data from the questionnaire was coded and entered into the computer for computation. The Statistical Package for Social Sciences (SPSS) version 23 was used to analyze the data. The statistical results are presented in tables.

Ethical Considerations

The University of Eastern Africa, Baraton Director of Graduate Studies provided a consent letter from the university Research Ethics Committee (REC) on 15th May 2019. This letter was attached as application was done to National Commission for Science, Technology and Innovation (NACOSTI) whose approval permit was done on 23rd March 2020. Permission to collect data from churches was given by the Greater Rift valley conference on 13th August 2020 and this marked the commencement of data collection and analysis.

The researcher explained to the respondents about the research and that the study was for academic purposes only. It was made clear that the participation is voluntary and that the respondents will be free to decline or withdraw any time during the research period. Respondents were not coerced into participating in the study. The participants had been informed to make the choice to participate or not. They were guaranteed that their privacy was protected by strict standard of anonymity. No names or codes for respondents was used or mentioned in this study. The respondents were also told to expect no incentives of any kind for the participation on the study.

CHAPTER FOUR

PRESENTATION OF FINDINGS, ANALYSIS AND INTERPRETATION

Demographic Profile of the Participants

Table 3 shows the gender distribution of the Seventh Day Adventist church members who participated in the study on lifestyle choices in the view of the emerging diseases. The distribution shows that majority of the participants are male who make 59.9% of the participants. One participant did not want to reveals his/her gender. The conclusion is be made that the data collected is largely contributed by male participants.

Table 3

Participant's Gender

	Frequency	Percent
Male	142	59.9
Female	94	39.7
No response	1	.4
Total	237	100.0

Looking at table 4, it is evident that 24.5% of the participants fall between the age bracket of 50 years and above. This was followed closely by ages 43-49 at 21,5%. The smallest number of participants is between the age bracket of 37 and 42 making the overall percentage of 9.3%. Nonetheless, the age distribution of the participants is fair with all the age group at least represented during the study. This is very important in this study following the fact that the study is interested to know if age is a factor that may influence health choices in the view of the emerging diseases across the worked. The ages chosen are independent minds to make choices for their

lives. Adelaiden (2008) discusses that age-related changes require a greater understanding of associations among age, lifestyle factors, and body composition. This implies that age is a real factor in making lifestyle choices.

Table 4

Participant's Age Distribution

	Frequency	Percent
18-24 years	42	17.7
25-30 years	38	16.0
31-36 years	25	10.5
37-42 years	22	9.3
43-49 years	51	21.5
50 years and above	58	24.5
No response	1	.4
Total	237	100.0

In societies, interactions among members have wide influence on the way of life. In this study, health choices can also be influenced by marital status of the participants or individuals. Han, Kyu-Tae et al (2014) in his published research found that there was a significant relationship between marital status and Quality of Life. The results of this study would provide the reference information for developing the management policy for this study as well. Referring to table 6 indicates that during this study, majority of the participants are married representing 70.9% of the participants. This means that health choices data as presented in this study is contributed majorly by those who are married. A small number of 3.8% represent divorced people while singles are represented by 24.9%. Therefore, the distribution is good since in the societies the numbers of divorced members are actually minimal in number.

Table 5

Participant's Marital Status

	Frequency	Percent
Single	59	24.9
Married	168	70.9
Divorced	9	3.8
No response	1	.4
Total	237	100.0

Table 6 below shows that findings in terms of family sizes of the population of study. In this study, as far as family size is concern, it means that singles and divorced considered their families size as the number of children and other extended family members. High number of family may impede opportunities for economic development, increase health risks for women and children, and erode the quality of life by reducing access to education, nutrition, employment, and scarce resources such as potable water (Da Vanzo et.al. 2004). These dynamics may influence health choices among Seventh Day Adventist church members and also societies at large. Majority of the family member size in this study is between 4-6 members comprising of 54%. The possible conclusion on health choices during the study could be influence major by this group. Quite noted during the study is that 6.8% of the families comprises of members above 10 in number while below 3 members and between 7 -10 represent 19% of the total number of participants.

Table 6

Family Size

	Frequency	Percent
3 or below	47	19.8
4-6	128	54.0
7-10	45	19.0
above 10	16	6.8
No response	1	.4
Total	237	100.0

Informed health choices may also be influenced by participant's level of education. CDC (2010). In the report concludes that simply that more education means better health. People with fewer years of education have worse health than those with more education—even when they have the same access to health care. However, according to Booske (2010), health care is necessary but not sufficient for improved health; in fact, health care accounts for only about 10–20% of health outcomes and health care has a bigger impact for people with limited education than for those with more education, but access to health care by itself doesn't eliminate the relationship between education and health according to Zimmerman (2010).

In table 7, the distribution of participants level of education implies that over half of the participants have studied up to tertiary or college level, this does not mean college as university. It is followed by those who have their highest level of education as university and secondary school level in that order. Targeting the large group in health choices program requires heavy resources directed towards tertiary and college level participants.

Table 7

Participant's Education Level

	Frequency	Percent
None	11	4.6
Primary level	16	6.8
Secondary level	32	13.5
Tertiary/College	120	50.6
University	44	18.6
Post-graduate level	13	5.5
No response	1	.4
Total	237	100.0

Only 5.5 % of the participant has studies up to post graduate level. The study also revealed that 4.6% of the participants did not attend any formal education while

6.8% are primary school leavers. In view of the emerging diseases, the study understand that majority of the members are aware of new emerging health challenges since majority of them are tertiary or college level leavers in terms of their academics.

When asked to rate their current health status, majority rated their health status as good and 23.2% rated fair health status, as shown in table 8.

Table 8

Respondent's Current Health

	Frequency	Percent
Excellent	22	9.3
Good	154	65.0
Fair	55	23.2
Poor	5	2.1
No response	1	.4
Total	237	100.0

A small number of 9.3% rated their health status as excellent. In combination, 74.3% of the respondents rated their health as good and above. This implies that majority of the participants make good health choices in view of the emerging diseases. However, the study noted that 2.1% of the respondent's experienced poor health while one participant out of 237 did not respond to this item. The study was dealing majorly with healthy population on the health choices in order to prevent new and emerging diseases.

Income level is one of the critical factors that may influence people's health choices especially during the time of new emerging diseases. During this study, data was collected to ascertain the participant's level of income. The consequences of this factor on health choices can be bidirectional. With high income, the population can have enough finances to pay for heath choices. In reference to table 9, majority of the participants earn a monthly income of less than 5,000 shillings in a month. This could

be having negative consequences on the choices. While only 5.5% and the same percentage earn a monthly income of more than 26,000. At least 88.6 % of the participants earn a monthly income of less than 16,000 with a majority in families of between 4-6 members.

Table 9

Participant's Income Level per Month

	Frequency	Percent
less than 5,000	151	63.7
5,000-15,000	27	11.4
16,000-25,000	32	13.5
26,000-35,000	13	5.5
36,000-45,000	13	5.5
No response	1	.4
Total	237	100.0

Religion is additionally of essential interest to health professionals. Faith has a good thing about empowering the individual through connecting them to a community in belief and to a superior force, which may successfully offer influence on their health choices. This has ability to empower those who struggle with a lifestyle disease to healthier mode.

Table 10

Participant's Years in SDA Church

	Frequency	Percent
less than 5 years	17	7.2
6-10 years	19	8.0
11-20 years	69	29.1
over 20 years	131	55.3
No response	1	.4
Total	237	100.0

In reference to table 10, most participants are over 20years as a member of the SDA church which give them a better understanding on the health choices of the

church. Another group of 11-20 years in the church make up 29.1% of the study population, Therefore, 80% of the study population is conversant with SDA church health choices and make informed decisions as far as health choices are concerned

In reference to table 11, majority of the participants reside in rural areas making an overall percentage of 80.6 and 10.5% live in semi-urban areas. Semi urban areas are those places like townships and small shopping centers. While those living in urban centers are the one who reside in place assumed by the government of Kenya as towns or cities. The residence could also affect lifestyle choices in some way. Cole BL (2007), says the economic, social, urban or rural, transportation, and other policies that affect the environment were not traditionally thought of as relevant to health policy but are now attracting greater attention because decision makers are beginning to recognize their health implications

Table 11

Family Residence

	Frequency	Percent
Rural area	191	80.6
Semi-urban	25	10.5
Urban	20	8.4
No response	1	.4
Total	237	100.0

When asked whether they have close experience (table 12a) with non-communicable diseases, participants rated this experience as affected, immediate family member, distant family member, friend or neighbor affected, non-affected and no respond. According to the Institute of Medicine (2002) Social determinants of health reflect social factors and the physical conditions in the environment in which people are born, live, learn, play, work and age. Also known as social and physical

determinants of health, they impact a wide range of health, functioning and quality of life outcomes.

Table 12a

Close Experience with Non-communicable Diseases (Diabetes)

Diabetes

	Frequency	Percent
Affected	31	13.1
Immediate family	24	10.1
Distant family	46	19.4
Friend/neighbor	50	21.1
Non-affected	85	35.9
No response	1	.4
Total	237	100.0

Starting with diabetes, participants reported that 13.1% are affected with diabetes. The same study revealed that 10.1% of the participants have immediate family member affected with diabetes while 19.4% of the participants mentioned that distant family member is affected with diabetes and 21.1% revealed that a friend or a neighbor is affected with diabetes. According to this study majority who make up 35.9% indicated that they don't know anyone who is affected with diabetes.

In addition to diabetes, the study also wanted to know which percentages of the members are affected with arthritis.

Table 12b

Close Experience with Non-communicable Diseases (Arthritis)

Arthritis

	Frequency	Percent
Affected	44	18.6
Immediate family	30	12.7
Distant family	10	4.2
Friend/neighbor	45	19.0
Non-affected	108	45.6
Total	237	100.0

The data collected revealed that 18.6% of the participants were affected with arthritis. The study also noted that 12.7% of the participants have had immediate family member affected with arthritis. Moreover, the study also revealed that participants in that 19% of the participants showed that a friend or a neighbor is affected with arthritis. Furthermore, the same temple shows at 45.6 per se indicated that they don't know of anyone who is affected with arthritis.

Table 12c

Close Experience with Non-communicable Diseases (Cardiovascular Diseases/Hypertension)

Cardiovascular diseases/Hypertension

	Frequency	Percent
Affected	35	14.8
Immediate family	49	20.7
Distant family	24	10.1
Friend/neighbor	48	20.3
Non-affected	80	33.8
No response	1	.4
Total	237	100.0

Cardiovascular diseases for hypertension were also one of the non-communicable disease considered for a study in this research. In regard to this disease 14.8% participants revealed that they were affected with arthritis well 20.7% apparently indicated that their immediate family member is affected with cardiovascular disease. To add on this, 10.1% of notified that a distant family member was affected and 20.3 % friend of a neighbor is affected with cardiovascular disease. Also, the study found out that 33.8% the participants close to them who is affected with cardiovascular disease or hypertension and 0.4% did not give the response during the study. Therefore, this study is revealing a very important data that participants are actually affected with cardiovascular disease and family members are

also affected including distant family members. This is a lifestyle disease which requires lifestyle modification and lifestyle choices informed by good health choices. Despite the fact that their Seventh-day Adventist members they are not immune or making good health choices that can help them prevent new diseases.

Table 12d

Close Experience with Non-communicable Diseases (Cancer)

Cancer

	Frequency	Percent
Affected	48	20.3
Immediate family	28	11.8
Distant family	16	6.8
Friend/neighbor	47	19.8
Non-affected	97	40.9
No response	1	.4
Total	237	100.0

Between the three listed non-communicable diseases, cancer remains the most prevalent non-communicable disease Seventh-day Adventist Church members' greater Rift Valley conference. The data collected in this study showed that 20.3% affected directly with cancer though the study did not classify cancer as breast cancer, Colón cancer etc. During the study it is also clear from the study that 11.8% of the immediate family member is affected with cancer while 6.8% of the participants mentioned that distant family member is affected and 19.8% revealed that a friend or neighbor they know is affected with cancer. Finally, 40.9% of the members revealed that they are not affected with cancer and one respondent did not indicate weather affected or not.

Table 12e

Close Experience with Non-communicable Diseases (Chronic Respiratory Diseases)

Chronic respiratory diseases (Asthma and Chronic obstructive respiratory disease)

	Frequency	Percent
Affected	43	18.1
Immediate family	8	3.4
Distant family	32	13.5
Friend/neighbor	36	15.2
Non-affected	117	49.4
No response	1	.4
Total	237	100.0

Chronic respiratory diseases such as asthma, chronic obstructive respiratory disease is one of the lifestyle diseases that can be successfully managed through good health choices and lifestyle modifications. When participants were asked to rate the prevalence of this disease, 18.1% of the respondents mentioned that they are affected with chronic respiratory diseases, 3.4% respondents indicated that their immediate family member is affected with chronic respiratory disease, and 13.5% rated that distant family member is affected with chronic respiratory disease. On a positive note, 49.4% of the participants revealed that they are not affected with any chronic respiratory disease and one responded did not mention whether affected or not.

Chronic respiratory disease is inherited or developed due to unhealthy choices that population makes in life. The presence of affected peoples is a revelation that some percentage of the Seventh-day Adventist church did not make well informed health choices resulting into development of non-communicable such as cancer chronic respiratory disease diabetes etc. It is very important to understand factors that may influence their choices of good health choices so as to prevent and as well manage these non-communicable diseases. The use of this Health study to review

needed, proposed, and existing social policies of the church as well as governments to establish strategies to teach and may result in likely impact on health

Individual Health Choices

Research objective 1. To determine the health choices among the church members

Health ministries are an integral part of the mission of the Adventist Church. "Whether therefore ye eat, or drink, or whatsoever ye do, do all to the glory of God" (I Cor. 10:31). Health ministry is the gospel of Christ illustrated, the message of God practiced. Without it, the gospel witness is muted; it is merely a theory, an idea. In this matter there are potential, health principles that are recommended for practiced. According to Fraser (2003) since its organization as a denomination in the mid nineteenth century, the Seventh-day Adventist Church has been advocating the counsel of the church's primary health reformer, Ellen G. White, which emphasizes the role of lifestyle in promoting health, happiness, and enhanced spirituality

One of the research objectives of the study specific principles formed a question to be used to determine the healthy choices among the church members of the Seventh-day Adventist Church. Respondents were asked a number of questions to respond and the mean rating of the responses was computed using statistical package for social sciences. The objective was also interpreted using the table of scale of interpretation. The presentation of the findings is shown in table 13.

The overall rating shows that respondents do intentional exercises routinely with intention to improve personal health for more than 20 minutes per day; this is a good healthy choice. Rehearsal exercise is a very good health choice often by sleeping a maximum of 8 hours a day. Similarly, respondents rated very good that they drink at least eight glasses of water per day, this is a good health choice. In addition to these,

members of the Seventh-day church in Greater Rift Valley conference and said that they have sunlight in the morning for some hours.

Table 13

Health Choices among the SDA Church Members

	Mean	Std. Deviation
I do intentional exercise routinely with intentions to improve personal health for more than 20 minute per day	2.76	1.102
I sleep to a maximum of 7-8 hours a day	3.77	.982
I drink at least 8 glasses of water per day	3.08	1.222
I ensure that I have sunlight in the morning for some hours	3.23	1.207
I avoid taking tea leaves and coffee beverages that I know are harmful to health	3.00	1.514
I do things in my life in moderation (avoid what is harmful and use judiciously that which is healthful)	3.78	1.093
I ensure that my house and rooms I occupy are well ventilated, with open windows during the day	4.41	.831
I make recognitions of balanced diet in my meals	3.58	.965
I avoid eating between meals	3.14	1.273
I do personal assessment and consult a doctor when I have deviations from normal	2.84	1.337
I go for medical checks at least by end of two years in health facility regardless of body wellness	2.03	1.164
I take control on dietary intakes of sugar, salt and fats for personal good and not necessarily for test (choice)	3.30	1.225
I choose the liquid oils for cooking for my foods	3.98	1.299
Individual health choices	**3.30**	**.629**
N = 237		

Scale of interpretation of the mean of each item

4.50 – 5.00	All the time/Excellent health choice
3.50 – 4.49	Usually/Very good health choice
2.50 – 3.49	Sometimes/Good health choice
1.50 – 2.49	Rarely/Fair health choice
1.00 – 1.49	Never/Poor health choice

As a good healthy choice, they also avoid taking tea leaves and coffee beverages that are harmful to health. Interestingly the study found out that members of the church do things in moderation in order to avoid those excesses which are

harmful, they also rated strongly excellent that the rooms they occupy are ventilated with open windows during the day. Another good practice worth noting is that church members take balanced diet in every meal that they take and also avoid eating between meals. On routine medical checks however, they sometimes do personal assessment and only attend to a doctor when there is a deviation from their normal physiology. This means that the visit to their doctors is not routine. Though it is a generally rated as fair healthy choice but it is not sufficiently good, the church members also need to know that it is a good health practice to go for medical check-ups once every year regardless of body wellness. This is an area which requires improvement among the church members because some diseases may not the known and a sound may be asymptomatic until medical checkups are done. With a good health choice rating, members of the church also revealed that they take control of dietary intake of sugar salt and fats for their personal good and not necessarily for test preference.

With a rating of 3.98, members of the church excellently choose liquid oils for cooking and avoid solid cooking oils. The overall rating of 3.30, in reference to the table of interpretation, indicates that the church members have good health choices. The individual members according to the data provided suggest that they sometimes take control of their individual health choices.

Evaluation of Knowledge, Cultural Beliefs, and Attitudes

Research Objective 2. To evaluate the church members knowledge on lifestyle diseases, cultural beliefs and attitude towards Adventist health message

Knowledge of Risks of Lifestyle Diseases

There were 237 church members who participated in the study. Of these, an average of 70% are knowledgeable of the risks of lifestyle diseases. The knowledge

of the lifestyle risks of different types of diseases are discussed in this section. For the Adventist church attention is focused on providing health messages to empower members. The main reason is that people who are not knowledgeable are vulnerable to hazards that could be detrimental to their health and well-being.

Heart diseases. In reference to table 14 which shows analysis of data on the knowledge of risk of heart diseases, respondents were asked to indicate whether they know that each item is related to lifestyle risk of heart diseases. The table presents the data analysis in terms of percentages. In this study the interpretation of the findings is that in general, an average of 70% of church members know the lifestyle risks of heart diseases. This is a suggestion that respondents know the specific items responsible for development of heart diseases or it is a risk factor for development of heart diseases.

Table 14

Lifestyle Risks of Heart Diseases

	% of Respondents*
People are born with heart defects	45
High blood pressure causes heart disease	81
Diabetes causes heart disease	39
Smoking causes heart disease	78
Excessive use of alcohol or caffeine causes heart disease	74
Drug abuse causes heart disease	78
Stress causes heart disease	82
Knowledge of Lifestyle Risks of Heart Diseases	**70**

N = 237

*Those who identified the item as risk

Participants were asked whether people are born with heart defects, and the mean percentage rating shows that it is 45%. This means that respondents did not know that people are born with heart defects. This is a lack of knowledge on this

particular item. Moreover, they were asked whether they know high blood pressure causes heart disease, and the mean percentage rating was at 81% meaning that they are aware that blood pressure then results to heart disease. The possible reason is that during the rating of the diseases which have affected church members hypertension was one of them diseases which is prevalent among the SDA church members from this basis is that they may be knowing that blood pressure causes heart disease. Additionally, majority of the members do not know that diabetes causes heart disease because the rating was 39%. Nonetheless, it was evident that members know that smoking, excessive alcohol or caffeine, drug abuse and stress can cause heart disease.

Obesity. The knowledge of lifestyle risk of obesity is very important in controlling and prevention of the disease. Table 15 shows that 40% of the respondents know that obesity is transmitted or inherited from parents to children.

Table 15

Participants' Knowledge of Lifestyle Risks of Obesity

	% of Respondents*
Transmitted from parents to children	40
Family lifestyle causes obesity	84
Inactivity causes obesity	90
Unhealthy diet causes obesity	69
Social and economic issues-you're more likely to become obese if you have obese friends or relatives.	24
Obesity is Age related.	19
Pregnancy causes obesity.	13
Quitting smoking can lead to obesity.	20
Knowledge of Lifestyle Risks of Obesity	**62**

N = 237

*Those who identified the item as risk

Also, despite the well-known benefits of maintaining healthy body weights and an active lifestyle, overweight/obesity is classified as the fifth leading cause of

global mortality, and an important predictor of various non-communicable diseases, (WHO 2009). This is also lifestyle malnutrition related problem of sedentary life

The study also revealed that 84% of the respondents know that family lifestyle causes obesity while 90% associates in activity with obesity. 69% of the members of the Seventh-day Adventist Church greater Rift Valley conference unhealthy diet causes obesity that 24% knows that social and economic issues when exposed are likely to become obese if you have a best friends or relatives. Similarly, in the study, participants, 19% agreed that obesity is age-related wild 13% of the same respondent's associate pregnancy with obesity. The study also revealed that 20% of the members does that quitting smoking can lead to obesity. Overall, 62% of the church members know the lifestyle risks of obesity.

According to Bush, Lovejoy, Deprey, and Carpenter (2017), tobacco remains one of the major public health challenges as it leads death. The biggest problem is that those who quit smoking end up gaining weight predisposing them to other lifestyle diseases such as diabetes. It is noted that minority of smokers will gain an excess amount which may increase their risk for diabetes onset.

Diabetes diseases. The researcher also wanted to understand during the study whether participants have knowledge of the risk factors of diabetes. Table 16 shows the findings in percentage of the respondents who have knowledge of the risk factors.

The study revealed that 82% of the respondents know that increased body weight is associated with diabetes development. On the other hand, at 82% also revealed that inactivity is one of the factors that leads to development of diabetes. Close to half of the respondents that are 63% relate development of diabetes with family history. On average, 61% of the respondents know that as one grows older the

risk of diabetes increases. While for the 43% understand that pregnancy-related diabetes and also that high blood pressure or hypertension, 78% of the participants associate this condition with development diabetes. This study of pregnancy and diabetes is good because the finding can be used to support ante natal care. On average, 68% of the church members know the lifestyle risks of diabetes diseases.

Table 16

Participants' Knowledge on Lifestyle Risks of Diabetes

	% of Respondents*
Increased body weight.	82
Inactivity.	82
Family history. .	63
Age. Your risk increases as you get older.	61
Pregnancy related diabetes.	43
High blood pressure	78
Knowledge of Lifestyle Risks of Diabetes Diseases	**68**
N = 237	

*Those who identified the item as risk

Pregnancy related diabetes also known as Gestational diabetes mellitus (GDM) is an increasing problem among pregnant women globally and is associated with short- and long-term consequences for both mother and newborn. The lack of knowledge on this condition could be due to background of our respondents. Health professionals and health promotors in the churches should be aware of the various knowledge levels concerning GDM and tailor their information towards women's knowledge.

Cancer diseases. The referenced table 17, representation of the lifestyle risk of cancer, the study revealed that 95% of the participants does that tobacco is a risk factor of cancer. On the other hand, 46% of the respondents know that overweight

is a risk factor for cancer. Furthermore, 18% of the respondents mentioned that fruits and vegetables are associated with risk of cancer development. To add on, 90% of the respondents indicated that alcohol is a risk factor for cancer development while 41% revealed that occupation or the one that one does is a risk factor for development of cancer.

Table 17

Lifestyle Risks of Cancer

	% of Respondents*
Tobacco	95
Overweight	46
Fruit and vegetables	18
Alcohol.	90
Occupation.	41
Is related to viral infections	43
Red and processed meat	87
Eating highly processed foods	81
Physical activity	30
Salt – high-salt diets.	58
Knowledge of Lifestyle Risks of Cancer Diseases	**71**
N = 237	

*Those who identified the item as risk

Occupational exposure to chemicals, dusts, radiation, and certain industrial processes have been tied to occupational cancer. Exposure to cancer-causing chemicals (carcinogens) may cause mutations that allow cells to grow out of control, causing cancer. In addition, 43% of the respondents understand that cancer can be caused by viral infections. It is common health knowledge that there are several viruses that can lead to cancer. For example, the human papillomavirus (HPV) can cause cervical and several other cancers. And hepatitis C can lead to liver cancer and non-Hodgkin's lymphoma. 87% know that red and processed meat is a risk factor for cancer. Finally, 30% of the respondents know that physical activity is a risk factor in

development of cancer while 58% revealed that high salt intake in the diet contributes to risk of developing cancer. On average, 71% of the church members know the lifestyle risks of cancer diseases. It is common knowledge that staying active can help you lower your risk of many types of cancer including breast and uterine cancers. Exercises helps burn excess fatty tissues and helps the body with the elimination of body toxic products.

Hypertensive diseases. The present study looked into the lifestyle risks of hypertensive diseases. It aims to understand whether the church members know the lifestyle risk factors of hypertension.

Table 18

Lifestyle Risks of Hypertensive Diseases

	% of Respondents*
Smoking	73
Being overweight or obese	91
Lack of physical activity	92
Too much salt in the diet	84
Too much alcohol consumption (more than 1 to 2 drinks per day)	64
Stress	86
Older age	59
Genetics	65
Family history of high blood pressure	65
Knowledge of Lifestyle Risks of Hypertensive Diseases	**76**

N = 237

*Those who identified the item as risk

From the findings, 73% of the participants know that smoking is a risk factor of hypertension, 91% understand that overweight or obese he is a risk factor, 92% understand that lack of physical activity is a risk factor for hypertension, while 41% associate high salt the diet as one of the risk factors that can contribute to the development of hypertension. In addition, 64% of the participants mentioned that too

much alcohol consumption contributes to hypertension, and at 6% know that stress is a factor that can lead to hypertension diseases. Furthermore, church members associated stress, old age, genetics, and family history of high blood pressure with development of hypertensive diseases with the percentage of responses as 86%, 59%, 65% and 65%, respectively. On average, 76% of the church members know the lifestyle risks of hypertensive diseases.

Depression. Members of the church were asked in the questionnaire to find out whether they understand lifestyle risk factors of depression. The presentation of the findings is shown in table 19.

Table 19

Lifestyle Risks of Depression

	% of Respondents*
Abusing drugs and alcohol	87
Overwork	83
Poor diet, including excess caffeine or sugar	68
Lack of exercise	71
Poor sleep	82
Lack of leisure time as well as fun and recreational activities	78
Environmental causes such as air pollutions, noises	65
Knowledge of Lifestyle Risks of Depression Diseases	**76**

N = 237

*Those who identified the item as risk

In reference to table 19, 87% of the participants agreed that abusing drugs and alcohol is a risk factor of depression, 83% agreed that of our is a factor that can contribute to the risk of depression, while 71% agreed that lack of exercise can be a risk of developing depression. In addition, 82% attributed that poor sleep can result to depression and lack of leisure time as well as fun and recreational activities according to the participants is that 78% agreed that this can risk one to develop depression. Finally, 65% of the respondents agreed that environmental causes such as air

pollution, noises can cause depression. On average, 76% of the church members know the lifestyle risks of depression disease.

Knowledge of Preventive Measures of Lifestyle Diseases

Of the two hundred thirty-seven research participants, an average of 81% have knowledge preventive measures of lifestyle diseases. This section presents the knowledge of lifestyle preventive measures of different types of diseases. Jimson, D T, (2006) provides a comprehensive Convincing and Probable Relationships between Dietary and Lifestyle Factors and Chronic Diseases. A lot of what is discussed in the book are Specific interventions that will depend on local physical and cultural conditions and should be based on careful analysis of existing dietary and activity patterns and their determinants.

Heart diseases. The present study also wanted to find out the knowledge of preventive measures of lifestyle diseases among respondents who are the members of the Seventh-day Adventist Church. Table 20 presents the findings of the percentage of the members who understand the lifestyle preventive measures of heart diseases.

It is revealed that 92% of the respondents agree that quitting smoking is one of the preventive measures of heart diseases, 98% agreed that control other health conditions for example high blood pressure high cholesterol and diabetes is one way of preventing heart diseases, while 93% agreed that exercise at least 30 minutes a day on most days of the week is a way of preventing heart diseases. The study also found out that 97% of the agreed that eating a diet that is low in salt and saturated fat prevent the development of lifestyle diseases. The study further revealed that 93% of the participants agreed that maintaining healthy weight is a way that can prevent lifestyle diseases, and 90% have read that reduced weight and management is a lifestyle preventive measure of heart diseases. Furthermore during the study 70% of

the respondents agreed that practicing good hygiene is also another way of preventing diseases and 43% agreed that excessive use of alcohol or caffeine is also another way of preventing have diseases. Finally, 41% agreed that controlling drug abuse is a factor that is considered during prevention of heart diseases in overall rating is the 83% of the respondents have knowledge of lifestyle preventive measures of heart diseases. The study concluded that this is a good percentage.

Table 20

Lifestyle Preventive Measures of Heart Diseases

	% of Respondents*
Quit smoking	92
Control other health conditions, such as high blood pressure, high cholesterol and diabetes	98
Exercise at least 30 minutes a day on most days of the week	93
Eat a diet that's low in salt and saturated fat	97
Maintain a healthy weight	93
Reduce and manage stress	90
Practice good hygiene	70
Excessive use of alcohol or caffeine	43
Drug abuse	41
Knowledge of Lifestyle Preventive Measures of Heart Diseases	**83**

N = 237

*Those who identified the item as preventive measure

Obesity. The current study also wanted to find out whether members understand the lifestyle preventive measures of obesity. In table 21 respondents (97%) agreed that the regular exercise is a lifestyle measure that prevent obesity, 94% agreed that following healthy eating plan is a lifestyle preventive measure of obesity, and 88% I tried that knowing and avoiding the food traps that cause you to eat is one of the ways of preventing obesity. The data also revealed that 96% of the respondents agreed that monitoring weight regularly is the best way of preventing obesity and 48% agreed that one can depend on God only in order to prevent obesity. In an overall

rating 85% of the respondents have understanding of lifestyle preventive measures of obesity.

Table 21

Lifestyle Preventive Measures of Obesity

	% of Respondents*
Exercise regularly.	97
Follow a healthy eating plan.	94
Know and avoid the food traps that cause you to eat.	88
Monitor your weight regularly.	96
Depend on God only	48
Knowledge of Lifestyle Preventive Measures of Obesity	**85**
N = 237	

*Those who identified the item as preventive measure

Diabetes. Table 22 presents the percentage of respondents who identified the preventive measures of diabetes.

Table 22

Lifestyle Preventive Measures of Diabetes

	% of Respondents*
Eat healthy foods	95
Get more physical activity.	90
Lose excess pounds.	64
Knowledge of Lifestyle Preventive Measures of Diabetes Diseases	**83**
N = 237	

*Those who identified the item as preventive measure

In reference to table 22, ninety-five percent of the respondents agreed that eating and food prevent the development of diabetes, 90% agreed that getting more physical activity is a way of preventing the development of diabetes while 64% agreed that producing excess pounds is a preventive measure of diabetes. On average,

83% of the church members know the lifestyle preventive measures of diabetes diseases.

Cancer. In reference to table 23, on the knowledge of lifestyle preventive measures of cancer, 95% of the respondents know that avoiding the use of tobacco is a lifestyle preventive measure of cancer, 93% know that eating plenty of fruits and vegetables prevent cancer, 81% agree that maintaining healthy weight and be physically active prevent cancer development, 68% now that protecting yourself from the sun by avoiding midday Sun or staying in the shade and covering exposed area is a lifestyle mention of preventing cancer.

Table 23

Lifestyle Preventive Measures of Cancer

	% of Respondents*
Don't use tobacco	95
Eat a healthy diet (Eat plenty of fruits and vegetables)	93
Maintain a healthy weight and be physically active	81
Protect yourself from the sun (Avoid midday sun, Stay in the shade, Cover exposed area)	68
Get vaccinated (Hepatitis B, Human papillomavirus (HPV))	45
Avoid risky behaviors (Practice safe sex, don't share needles.)	50
Get regular medical care: Regular self-exams and screenings	91
Avoid obesity, If you choose to drink alcohol, do so only in moderation, Limit meats)	44
Knowledge of Lifestyle Preventive Measures of Cancer Diseases	**71**

N = 237

*Those who identified the item as preventive measure

The study further noted from the data that 45% of the participants agreed that getting vaccinated such as hepatitis B or even human papillomavirus vaccine prevent cancer. On the other hand, 91% of the participants know that getting regular medical care and regular cell exam and screening prevent cancer and 50% know that avoiding

risk behavior such as practicing safe sex and not sharing needles is a preventive measure of cancer. The study further found out from the data that 44% of respondents know that avoiding drinking or drinking in moderation and limiting meat intake is a preventive measure of cancer. On average, 71% of the church members know the lifestyle preventive measures of cancer diseases.

Hypertensive diseases. Table 24 shows the data analysis of lifestyle preventive measures of hypertensive diseases. The findings revealed that 97% of the response didn't help prevent hypertension, 90% agree that eating a balanced diet can prevent hypertension and 84% agree in time prevent hypertension. The study further revealed that 93% of the respondents no the exercising regularly prevent hypertension and also 77% know that limiting the alcohol in time prevent hypertension while 94% no that monitoring one's blood pressure is a lifestyle preventive measure of hypertensive diseases. On average 89% of the respondents know the lifestyle preventive measures of hypertensive diseases.

Table 24

Lifestyle Preventive Measures of Hypertensive Diseases

	% of Respondents*
Maintain a healthy weight.	97
Eat a balanced diet.	90
Cut back on salt.	84
Exercise regularly.	93
Limit the alcohol.	77
Monitor your blood pressure	94
Knowledge of Lifestyle Preventive Measures of Hypertensive Diseases	**89**

N = 237

*Those who identified the item as preventive measure

Arthritis. During the study, the researchers also wanted to find out the knowledge of respondents and lifestyle preventive measures of arthritis diseases.

Table 25

Lifestyle Preventive Measures of Arthritis Diseases

	% of Respondents*
Osteoarthritis – Maintain a healthy weight	80
Rheumatoid arthritis – Do not smoke	73
Gout – Eat a healthful diet, low in sugar, alcohol and purines	82
Limited amounts of processed food	79
Avoid animal-based products and foods that contain high amounts of salt and oil, including many processed products	84
Knowledge of Lifestyle Preventive Measures of Arthritis Diseases N = 237	**79**

*Those who identified the item as preventive measure

In table 25, 80% of the respondents know that Osteoarthritis can be prevented by maintaining a healthy weight, 73% of the respondents know that rheumatoid arthritis can be prevented by avoiding smoking, and 82% know that gout can be prevented by eating healthful diet which is low in sugar and alcohol as well as purines. The study also found out that 84% the respondents understand that avoiding animal-based products that contain high amount of salt and oil including many processed products is a lifestyle preventive measure of arthritis diseases and also 79% of the respondents realizes that limiting the amount of processed food is a lifestyle preventive measure that can be used to prevent development of arthritis diseases. On average, 79% of the church members know the lifestyle preventive measures of arthritis diseases.

Depression. Table 26 presents the lifestyle preventive measures of depression. In reference to this table, the findings show that 94% of the respondents

believe that getting enough sleep prevent depression, 94% again understand that exercise can prevent depression, 77% not regulating blood sugar level is a way of preventive measures of depression, 65% agreed that eating healthy fats prevent the development of depression and 91% accurate and finding a passion or having a sense of purpose in life is a lifestyle preventive measure of depression. On average, 78% of the church members know the lifestyle preventive measures of depression diseases.

Table 26

Lifestyle Preventive Measures of Depression

	% of Respondents*
Get enough sleep.	94
Exercise.	94
Regulate your blood sugar.	77
Eat healthy fats.	65
Find passion/have sense of purpose in life.	91
Knowledge of Lifestyle Preventive Measures of Depression Diseases	**78**

N = 237

*Those who identified the item as preventive measure

Cultural Beliefs on Health

Cultural beliefs, defined as a set of behavioral patterns related to thoughts, manners and actions, which members of society have shared and passed on to succeeding generations. The present study wanted to find the cultural beliefs on health which relate to lifestyle diseases among Seventh-day Adventist members of the Greater Rift Valley conference in the Republic of Kenya. The data was analyzed and used means to interpret the findings of the study as presented in table 27.

Table 27

Cultural Beliefs on Health

	Mean	Std. Deviation
I would go for exercise in the morning or evening but it may look unique among my neighbors	2.82	1.005
Lifestyle illnesses are associated with the way we treated our elders	1.65	.901
Lifestyle illnesses are inherited and it is a waste of time and money treating or preventing them	1.57	.991
When I visit a friend or in a party, its right to eat any meal that is provided without any objection	1.62	.939
I prefer prayer only as a way through which I can be healed; visiting a medical doctor is an option.	1.94	.930
Traditional herbs I inherited from my parents are the best over hospital medication	1.92	.801
Lifestyle diseases are due to failure to pray	1.64	.846
Only a doctor should know my lifestyle illness	1.90	.958
It is shame to suffer from lifestyle diseases and I do not tell anyone	1.82	.984
A belly is a sign of wealth I admire it	1.49	.928
When one asks for water, its better I give milk instead	1.70	.974
Sugarless drinks at home is a sign of lack of money, I buy sugar in my house to avoid that	1.63	.955
I do accept services from any healthcare provider, no matter the age or gender	2.58	1.104
Cultural beliefs on health	**1.87**	**.501**
N = 237		

Scale of Interpretation of the Mean of Each Item

3.50 – 4.00 Strongly agree
2.50 – 3.49 Agree
1.50 – 2.49 Disagree
1.00 – 1.49 Strongly disagree

Respondents agree (M = 2.82) that they would go for exercise in the morning but this may look unique among their neighbors. This belief is the influence of culture on adoption of lifestyle measures to prevent lifestyle diseases. Respondents disagreed

that lifestyle illnesses are associated with the way they treat their elders, with mean rating of 1.65, therefore they do not believe that this particular kind of cultural belief influences the development of lifestyle diseases. Participants also disagreed that lifestyle disease is inherited and it is just a waste of time and money preventing with a mean rating of 1.57, hence they believe that it is possible to treat and prevent lifestyle diseases.

In addition, respondents also disagreed that when they visit their friends or when they are in party, it is good to eat any meal that is provided without objecting it. They also disagreed that they prefer prayer through which they can be healed and therefore visiting a medical doctor is an option with a mean rating of 1.94. With a mean rating of 1.92, church members did not agree that traditional herbs they inherited from their parents are better than hospital medication and also disagreed with a mean rating of 1.64 that diseases are due to failure to pray, disagreed that only the doctors should know about their lifestyle illnesses with a mean rating of 1.90. Furthermore, respondents disagreed with a main rating of 1.82 that it is shameful to suffer lifestyle diseases and they should not tell anyone. With a mean rating of 1.49, respondents disagreed that the belly is a sign of wealth that should be admired.

When asked if one ask for water it is better that they give milk instead, respondents disagreed on this item with a mean rating of 1.70 and also disagreed that sugarless drinks at home is a sign of lack of money and they buy sugar in their houses to avoid that with a mean rating of 1.63. Finally, respondents agreed at they accept services from any Healthcare provider no matter the age or gender, with mean rating of 2.58. With an overall rating of 1.87, respondents disagreed to the cultural beliefs that influence the adoption of preventive measures of lifestyle diseases.

President Obama (2006) wrote in “The Audacity of Hope”, fending off claims that black culture is to blame for African Americans’ plight, “In other words, African Americans understand that culture matters but that culture is shaped by circumstance. We know that many in the inner city are trapped by their own self-destructive behavior but that those behaviors are not innate. Culture shapes us, but many events mold culture and we shape these just as much. This is because much of culture depends on our biological and evolutionary hardware. And our evolutionary heritage is largely one of aggression and violence, despite our pains to sublimate these influences through cultural activities like art and religion.

Attitudes towards the Adventist Health Message

The present study determined the attitude of the of the Seventh-day Adventist church members towards the Adventist health message. Referring to table 26, respondents agreed that they choose their residence in strict consideration of the Adventist health message that is ventilation, space with a mean rating of 3.0. With a mean rating of 2.92, Seventh-day Adventist church members agreed that they intentionally follow the guidelines of the Adventist health message of breathing in and out exercise every morning as a way to maintain good health. They also agreed with a mean rating of 2.60 that they deliberately bask in the early morning healthy sunshine because it is an Adventist health message. Respondents also agreed that because of the view of the Adventist health message they balance all their activities and behaviors that they do, with a mean rating of 3.07.

Respondents also agreed that they sleep for at least 7 hours every day with a mean rating of 3.08. Moreover, with a mean rating of 2.84, members of the Seventh-day Adventist church agreed that they take annual break out of their work. Members also agreed that they do overnight physical exercise frequently with a mean rating of

2.88. In addition to these, members of the Seventh-day Adventist church of Greater Rift Valley conference, agreed that they do physical exercises least 2 hours per week.

Table 28

Attitudes towards the Adventist Health Message

	Mean	Std. Deviation
I chose my residence in strict consideration of the Adventist health message in pure air (ventilation, space and lighting)	3.00	1.039
I intentionally follow the guidelines of the Adventist health message of breathing in and out exercise every morning as a way of maintaining my good health	2.92	1.014
I deliberately bask in the early morning healthy sunshine; this is an Adventist health message	2.60	1.051
In view of the Adventist health message, I find balance in all my activities and behaviors that I do.	3.07	.911
I sleep for at least 7 hours everyday	3.08	.982
I take annual break out of my work	2.84	1.015
I do organize physical exercise frequently	2.88	.891
I do physical exercises that totals to at least two hours a week	2.68	.905
I do not take processed food	2.43	.930
All my meals are balanced (composed of vitamins, protein, carbohydrate)	2.81	.956
I do not eat meat (including fish and chicken)	2.40	.997
I take heavy meals in the morning, average at lunch time and very little before going to bed	2.69	.972
I drink at least 8 glasses of water per day	2.74	1.060
*Drinks such as tea, coffee, energy drinks, and sugar-sweetened drinks form part of the liquids consumed in a day	1.89	1.021
Trusting in God's power boosts emotions and helps neutralize negative emotions, serving both to enhance life and increase coping skills as negative life events	3.44	1.009
Attitude towards the Adventist health message	**2.85**	**.646**
N = 237		

*Contrary to the SDA health message – recoded

Scale of Interpretation of the Mean of Each Item

3.50 – 4.00 Strongly agree
2.50 – 3.49 Agree
1.50 – 2.49 Disagree
1.00 – 1.49 Strongly disagree

The mean on aggregate became 2.85 which implies the respondents' attitude towards Adventist health message was moderate. Where the respondents rated highest is on balancing health with activity 3.7 and Choosing of place of residence with consideration of Adventist health message (3.0) However, they rated lowest on Taking beverages like Tea and coffee at 1.89 and meat eating at 2.40, a mean rating of 2.43 that they do not take processed food.

When it comes to meal balancing, the respondents agreed that they take heavy meals in the morning, average meals at lunch time and very little meals before going to bed with a mean rating of 2.69. Members also agreed that they drink at least eight glasses of water per day with a mean rating of 2.74. Finally, they agreed that trusting in God's power boosts emotions and helps neutralize negative emotions, serving both to enhance life and increase coping skills as negative life events with a mean rating of 3.44

The average presentation could be due to postulation that knowledge may be attributed to inadequate teaching and learning about the Adventist Health Messages or to a teaching plan of the church which may be just focused on diet, without a balance of teaching on other physical dimensions (Galvez, Calbayan, Pondi, & Vallejos, 2020). The other postulation may be according to Skrzypaszek (2014, p. 147) "Not all who profess to believe in dietetic reform are really reformers. The final postulation is that people may not understand clearly the principles of health, and their tables, still loaded with harmful dainties, are far from being an example of Christian temperance and moderation."

Relationship between Health Choices and Knowledge, Cultural Beliefs, and Attitudes

Research objective 3. To establish if there is a significant relationship between health choices and knowledge, cultural beliefs, and attitudes

Table 29 shows correlation analysis between individual health choices and knowledge, cultural beliefs, and attitudes.

Table 29

Correlation Coefficients

		Individual health choices
Knowledge of Risks of Lifestyle Diseases	Pearson Correlation	-.029
	Sig. (2-tailed)	.660
	N	237
Knowledge of Preventive Measures of Lifestyle Diseases	Pearson Correlation	.028
	Sig. (2-tailed)	.665
	N	237
Cultural beliefs on health	Pearson Correlation	.029
	Sig. (2-tailed)	.653
	N	237
Attitude towards the Adventist health message	Pearson Correlation	.179**
	Sig. (2-tailed)	.006
	N	237

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

The analysis output indicates that there is no significant relationship between individual health choices and knowledge of risks of lifestyle disease, knowledge of preventive measures of lifestyle diseases, and cultural beliefs on health. There is a significant relationship between individual health choices and attitude towards the Adventist health message. This implies that church members who have positive attitude towards the Adventist health message tend to have positive health choices.

The individual health choices are not influenced by knowledge of risk factors of life style diseases. Having knowledge of the factors that are associated with certain lifestyle diseases does not make SDA church member in GRVC to make good health choices. In this context, the absence of the relationship either positive or negative relationship means knowledge of risk factors is not a factor that influence members on health choices. There could be other factors but not this particular variable. If one knows that these are the preventive measures to prevent the occurrence of lifestyle diseases, they are not going to use the measure on their health choices. This is because there was no any significant relationship between the two.

Likewise, to the knowledge of factors, this variable did not influence SDA members of GRVC on their health choices. Nonetheless, it is the attitude created by the SDA health message in terms of spiritual influence that can change SDA members of the GRVC to make informed health choices. This is evidenced by the fact that there was positive significant relationship between the two variables. The more enhanced SDA health message, the better the health choices.

According to WHO, 60% of related factors to individual health and quality of life are correlated to lifestyle (Ziglio, 2004). Millions of people follow an unhealthy lifestyle. Hence, they encounter illness, disability and even death. Problems like metabolic diseases, joint and skeletal problems, cardio-vascular diseases, hypertension, overweight, violence and so on, can be caused by an unhealthy lifestyle. The relationship of lifestyle and health should be highly considered (Farhud, 2015).

A study conducted by Latchman (2018) revealed that generally, 43% of the African-American ladies stated utilizing religion for wellbeing reasons in the previous year. Factors altogether connected with the utilization of religion for wellbeing reasons included having a pay of dollar 40,000-dollar 60,000, an instruction level of

college alumni or more, or being 37-56 years old; more regrettable wellbeing status moved toward importance. African-American ladies used religion and otherworldliness frequently for genuine conditions, for example, malignancy, coronary illness, and wretchedness. African-American ladies who had utilized religion in the previous year for wellbeing reasons were more than twice as liable to have utilized clinical specialist during the year before compared with their partners.

Also, a regression analysis tested the associations between relative deprivation and four obesity risk factors (skipping breakfasts, physical activity, and healthful and unhealthful food choices) plus dietary restraint. Relative deprivation uniquely related to skipping breakfasts, less physical activity, fewer healthful food choices (e.g., fruits, vegetables, whole grain breads), and a lower likelihood of dieting to lose weight. Consistent with Runciman's theory of relative deprivation and with psychosocial interpretations of the health consequences of income inequality, the results indicate that having mostly better off schoolmates can contribute to poorer health behaviors independently of school-level affluence and subjective social status (Elgar et al., 2016).

Comparison of Health Choices

Research objective 4. To ascertain if there is a significant difference in the health choices of church members classified according to a) gender, b) age group, c) level of education, d) socio-economic status (income level per month), e) years as SDA church member, and f) location of residence.

Comparison by Gender

According to the findings presented in table 28, there is no significant different between the individual health choices of male and female church members. This finding contradicts the finding of Li (2010) that gender differences have been

reported for dietary intakes and eating behaviors. He further says that dietary habits and physical activity are strongly influenced by gender attitudes and behaviors that promote different patterns of healthy or unhealthy lifestyles among women and men. However as per this study the Adventist lifestyle is not necessarily affected by the gender biases.

Table 30

Comparison of Health Choices by Gender

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Individual health choices	Male	142	3.3234	.59771	.05016
	Female	94	3.2660	.67915	.07005

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Individual health choices	Equal variances assumed	1.153	.284	.684	234	.494	.05744	.08395

Comparison by Age Group

Table 31 indicates that there is no significant difference in the individual health choices of church members classified according to age group. However, Liu (2012) says that maintaining a healthy lifestyle from young adulthood into your 40s is strongly associated with low cardiovascular disease, which is a lifestyle condition risk in middle age. Age-related lifestyle modification is a fact in controlling lifestyle conditions.

Table 31

Comparison of Health Choices by Age Group

Descriptives

Individual health choices

	N	Mean	Std. Deviation	Std. Error
18-30 years	80	3.1971	.68298	.07636
31-49 years	98	3.3312	.66900	.06758
50 years and above	58	3.3912	.45435	.05966
Total	236	3.3005	.63062	.04105

ANOVA

Individual health choices

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1.425	2	.713	1.804	.167
Within Groups	92.030	233	.395		
Total	93.455	235			

Comparison by Level of Education

In table 32, the findings indicate that there is a significant different in the individual health choices of church members classified according to level of education. Church members whose education is secondary level and lower have better health choices than their counterparts with higher level of education. In this incidence we consider choices to be influenced by education of the person. Education therefore acts as a modifying factor to choices made.

According to Feinstein (2006), we find considerable international evidence that education is strongly linked to health and to determinants of health such as health behaviors, risky contexts and preventative service use. Moreover, we find that a substantial element of this effect is causal. Education does not act on health in isolation from other factors.

Table 32

Comparison of Health Choices by Level of Education

Descriptives

Individual health choices

	N	Mean	Std. Deviation	Std. Error
Secondary level and lower	59	3.6454	.58129	.07568
Tertiary/College	120	3.1583	.63786	.05823
University/Post-graduate	57	3.2429	.53131	.07037
Total	236	3.3005	.63062	.04105

ANOVA

Individual health choices

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	9.632	2	4.816	13.386	.000
Within Groups	83.824	233	.360		
Total	93.455	235			

Post Hoc Tests

Multiple Comparisons

Dependent Variable: Individual health choices

LSD

(I) Educational level	(J) Educational level	Mean Difference (I-J)	Std. Error	Sig.
Secondary level and lower	Tertiary/College	.48704*	.09537	.000
	University/Post-graduate	.40246*	.11140	.000
Tertiary/College	Secondary level & lower	-.48704*	.09537	.000
	University/Post-graduate	-.08458	.09649	.382
University/Post-graduate	Secondary level & lower	-.40246*	.11140	.000
	Tertiary/College	.08458	.09649	.382

*. The mean difference is significant at the 0.05 level.

As far as this study is concerned, health choices considered are sleep, water and exercise, avoidance of eating between meals and drinking beverages, and temperance, among others. These healthy habits may be difficult to practice by individuals whose jobs are sedentary, which are more common for those with higher education.

Moreover, time constraints prevent individuals from adopting healthy choices. Although it is expected that people who are educated and knowledgeable about

healthy practices are more likely to opt for healthy choices, it still depends on whether the individual is able to apply their knowledge (Pheasant, 2008).

Comparison by Socio-economic Status (Income Level per Month)

In Table 33, the study found that there is a significant different in the individual health choices of church members classified according to socio-economic status.

Table 33

Comparison of Health Choices by Socio-economic Status

Descriptives

Individual health choices

	N	Mean	Std. Deviation	Std. Error
less than 5,000	151	3.1997	.64421	.05242
5,000-25,000	59	3.4811	.53725	.06994
26,000-45,000	26	3.4763	.63879	.12528
Total	236	3.3005	.63062	.04105

ANOVA

Individual health choices

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	4.263	2	2.131	5.568	.004
Within Groups	89.193	233	.383		
Total	93.455	235			

Post Hoc Tests

Multiple Comparisons

Dependent Variable: Individual health choices

LSD

(I) Income level	(J) Income level	Mean Difference (I-J)	Std. Error	Sig.
less than 5,000	5,000-25,000	-.28140*	.09499	.003
	26,000-45,000	-.27664*	.13137	.036
5,000-25,000	less than 5,000	.28140*	.09499	.003
	26,000-45,000	.00476	.14564	.974
26,000-45,000	less than 5,000	.27664*	.13137	.036
	5,000-25,000	-.00476	.14564	.974

*. The mean difference is significant at the 0.05 level.

Church members' income level per month of 5,000 and higher have better health choices than those with income level of less than 5,000. According to Mukong (2017), he argues that it is common relate account of income levels, employment status, occupations, and differences in educational levels, as determinants as socioeconomic factors that are determinants of both mental and physical health.

Gustafson (2013) argues that it will never be easy for poor families to make healthier diet and lifestyle choices. It is a reality that food prices keep rising and supermarkets and grocery stores are not easily accessible in many low-income neighborhoods. Moreover, they lack basic information about their health needs.

Comparison by Years of Membership in the SDA Church

Table 34 presents the results of comparing the health choices of church members by years of membership in the church. Statistical results reveal that there is a significant different in the individual health choices of church members classified according to years as SDA church member. Respondents who are church members for over 20 years have better health choices than those who are church members between 11-20 years. However, those whose years of membership is 10 years or less have comparable health choices with their counterparts whose years of membership is above 20 years. This implies that those who are newly converted and those who have been members of the church for a longer time tend to have healthy choices. Pappas (2012) observed that regular and active participation in faith-based activities has an impact on peoples' health decisions, which include resisting junk foods (temperance), regular doctor visits to get preventative care, stress management, among others.

Table 34

Comparison of Health Choices by Years of Membership in SDA Church

Descriptives

Individual health choices

	N	Mean	Std. Deviation	Std. Error
10 years or less	36	3.2885	.65540	.10923
11-20 years	69	3.1037	.63622	.07659
over 20 years	131	3.4075	.59948	.05238
Total	236	3.3005	.63062	.04105

ANOVA

Individual health choices

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	4.178	2	2.089	5.453	.005
Within Groups	89.277	233	.383		
Total	93.455	235			

Multiple Comparisons

Dependent Variable: Individual health choices

LSD

(I) Years as SDA church member	(J) Years as SDA church member	Mean Difference (I-J)	Std. Error	Sig.
10 years or less	11-20 years	.18478	.12727	.148
	over 20 years	-.11905	.11648	.308
11-20 years	10 years or less	-.18478	.12727	.148
	over 20 years	-.30384*	.09208	.001
over 20 years	10 years or less	.11905	.11648	.308
	11-20 years	.30384*	.09208	.001

*. The mean difference is significant at the 0.05 level.

Comparison by Location of Residence

Table 35 presents the statistical analysis comparing the health choices of church members by location of residence. The results show that there is no significant different between the individual health choices of church members whose location of residence is rural area and semi-urban/urban area. There remains a

question about what model is suitable for the analysis of the effect of area over the lifestyle course, particularly in examining the relationship between the place of residence and health and the reasons why such a relationship may exist. Environmental influences on health extend beyond the obvious physical factors such as a lack of clean water or exposure to pollutants to socio-economic factors (Marmot, 2005).

Table 35

Comparison of Health Choices by Location of Residence

Group Statistics

	Location of Residence	N	Mean	Std. Deviation	Std. Error Mean
Individual health choices	Rural area	191	3.2980	.62560	.04527
	Semi-urban/ Urban area	45	3.3111	.65865	.09819

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means				
		F	Sig.	T	df	Sig. (2-tailed)	Mean Difference	Std. Error Diffe-rence
Individual health choices	Equal variances assumed	.460	.498	-.125	234	.901	-.01308	.10472

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary of the Study

The study aimed to identify factors influencing health choices among the SDA church members given the rising trends of lifestyle diseases. The independent variables were knowledge on lifestyle diseases, cultural beliefs on health, attitudes towards Adventist health message, and the demographic factors such as gender, age, level of education, socio-economic status, years of membership in the SDA church, and location of residence. The theoretical basis of the study was Milio's framework for prevention -- changing health-damaging to health-generating life patterns. The study was carried out in the Eldoret West station of Greater Rift valley Conference of the Seventh-day Adventist church, Rift valley. The study used a combination of descriptive, correlational and comparative research designs. The participants of the study were 237 baptized members of the SDA church. Questionnaires were used to collect the data, which were analyzed using descriptive statistics, Pearson product-moment correlation coefficient, t-test for independent samples, and one-way analysis of variance.

Summary of Findings

1. The mean rating of the individual health choices of SDA church members in Eldoret West is 3.30 (on a scale of 1 to 5), which is considered to be good.
2. Results of the evaluation of church members in the indicated areas are as follows:
    a. In regard to the knowledge of lifestyle diseases, 70% of the respondents know the lifestyle risk factors of heart diseases, 62% knows the lifestyle risk factors

of obesity, and 68% knows the lifestyle risk factors of diabetes diseases, while 71% understand the risk factors of cancer diseases. In addition, 76% of the respondents know the risk factors of hypertensive diseases, while 76% know the risk factors of depression diseases. Overall, 70% of the church members have knowledge of the risks of lifestyle diseases.

On the knowledge of preventive measures, 83% understand the preventive measures for heart diseases, 85% for obesity, 83% of the respondents know the preventive measures for diabetes, 71% understand how to prevent cancer, 89% understand the preventive measure for hypertensive diseases, while 79% know the lifestyle preventive measures for arthritis and 78% knows measure to be taken to prevent depression diseases. Overall, 81% of the church have knowledge of preventive measures of lifestyle diseases.

b. When it comes to cultural beliefs, the overall mean of 1.87 shows that church members disagree with cultural beliefs on health.

c. The mean attitude of the respondents towards the Adventist health message is 2.85 (on a scale of 1 to 4), which is interpreted as moderate.

3. There is no significant relationship between individual health choices and knowledge of risks and preventive measures of lifestyle disease and cultural beliefs on health. However, there is a significant direct relationship between individual health choices and attitude towards the Adventist health message.

4. There is no significant difference in the individual health choices of church members classified according to gender, age group, and location of residence, but significant differences exist in the individual health choices of church members classified according to level of education, socio-economic status, and years of membership in the SDA church.

Conclusions

On the basis of the findings, the following conclusions were drawn:

1. The Seventh-day Adventist Church members in Eldoret West have good individual health choices.
2. Majority of the SDA church members are knowledgeable of the risks (70%) and preventive measures (81%) of lifestyle diseases and do not accept the cultural beliefs on health. Moreover, they have moderately positive attitude towards the Adventist health message.
3. Church members who have positive attitude towards the Adventist health message tend to have positive health choices. However, knowledge of risks and preventive measures of lifestyle diseases and acceptance of cultural beliefs have no significant influence on individual health choices.
4. Church members with lower educational level, with higher income, and who have been members of the church for a long period of time have better individual health choices. Nevertheless, gender, age, and location of residence do not account for differences in individual health choices.
5. The church needs to need for reawakening of members on their responsibility towards health choices and to emphasize the linkage of spiritual commitment with the lifestyle choices

Recommendations

On the basis of the findings, it is recommended that:

1. The health ministry department of the church continues its education and promotion of Adventist health message for the purpose of encouraging them to adopt positive health choices.

2. Risk factors on obesity should be emphasized during SDA church health ministry's seminars.
3. Lifestyle preventive measure for arthritis should be emphasized during SDA church ministries seminar.

Recommendations for Further Studies

1. Study the factors that influence the attitude towards the Adventist health message as this has influence on individual health choices.
2. Explore lifestyle factors and elucidate facilitators and barriers to the adoption of a healthy lifestyle in the church population.
3. Identify the knowledge gaps and behavioral patterns that may hamper lifestyle diseases prevention and control among Seventh-day Adventist population.

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APPENDICES

Appendix I: Questionnaire

Demographic factors

1. Gender: [a] male [b] female
2. Age: [a]18-24 years [b] 25-30 years [c] 31-36 years [d] 37-42 years [e] 43-49 years [f] above 50
3. Marital status: [a] single [b] married [c] separated [d] divorced
4. Average size of a family: [a] 3 or below [b] 4-6[c] 7-10 [d] above 10
5. Education level: [a] non [b] primary level [d] secondary level [d] tertiary college [e] university [f] post graduate level
6. How do you rate your current health? [a] Excellent [b] Good [c] Fair [d] Poor
7. Income level per month: [a] Less than 5000 [b] 5,000-15,000 [b] 16,000-25,000 [c]26,000-35,000 [d] 36,000-45,000 [e] above 45,000
8. Years in SDA church [a] Less than 5 years[b] 6-10 years [c] 11-20 years[d] over 20 years
9. Family Residence: [a] rural area [b] semi urban [c] urban
10. **Close experience with non-communicable diseases (Tick one per column)**

Experience with non-communicable diseases	Affected	Immediate family	Distant family	Friend/ Neighbor	Non affected
Diabetes					
Arthritis					
Cardiovascular diseases/Hypertension					
Cancer					
Chronic respiratory diseases (Asthma and Chronic obstructive respiratory disease)					

11. To determine individual health choice

Never =*N*
Rarely =*R*
Sometimes =*S*
Usually =*U*
All the time =*A*

1	I do intentional exercise routinely with intentions to improve personal health for more than 20 minute per day	N	R	S	U	A
2.	I Sleep to a maximum of 7-8 hours a day	N	R	S	U	A
2	I drink at least 8 glasses of water per day	N	R	S	U	A
3	I ensure that I have sunlight in the morning for some hours	N	R	S	U	A
4	I avoid taking tea leaves and coffee beverages that I know are harmful to health	N	R	S	U	A
5	I do things in my life in moderation (avoid what is harmful and use judiciously that which is healthful)	N	R	S	U	A
6	I ensure that my house and rooms I occupy are well ventilated, with open windows during the day	N	R	S	U	A
7	I make recognitions of balanced diet in my meals	N	R	S	U	A
8	I avoid eating between meals	N	R	S	U	A
9	I do personal assessment and consult a Doctor when I have deviations from normal	N	R	S	U	A
10	I go for medical checks at least by end of two years in health facility regardless of body wellness	N	R	S	U	A
11	I take control on dietary intakes of sugar, salt and fats for personal good and not necessarily for test (choice)	N	R	S	U	A
12	I choose the liquid oils for cooking for my foods	N	R	S	U	A

12. Knowledge on heart diseases: Tick the one you agree with MOST

Heart Diseases	1	2	3
	Yes	No	Don't know
People are born with heart defects			
High blood pressure causes heart disease			
Diabetes causes heart disease			
Smoking causes heart disease			
Excessive use of alcohol or caffeine causes heart disease			
Drug abuse causes heart disease			
Stress causes heart disease			

13. Tick the one you agree with MOST on lifestyle Preventive measures of heart Diseases

	Yes	No	Don't know
Quit smoking			
Control other health conditions, such as high blood pressure, high cholesterol and diabetes			
Exercise at least 30 minutes a day on most days of the week			
Eat a diet that's low in salt and saturated fat			
Maintain a healthy weight			
Reduce and manage stress			
Practice good hygiene			
Excessive use of alcohol or caffeine			
Drug abuse			

14. Tick as many as possible the lifestyle risks of Obesity

	Yes	No	Don't know
Transmitted from parents to children			
Family lifestyle causes obesity			
Inactivity causes obesity			
Unhealthy diet causes obesity			
Social and economic issues-you're more likely to become obese if you have obese friends or relatives.			
Obesity is Age related.			
Pregnancy causes obesity.			
Quitting smoking can lead to obesity.			

15. Tick as many as possible the lifestyle Preventive measures of Obesity

	Yes	No	Don't know
Exercise regularly.			
Follow a healthy eating plan.			
Know and avoid the food traps that cause you to eat.			
Monitor your weight regularly.			
Depend on God only			

16. Tick as many as possible the lifestyle risks of Diabetes Disease

	Yes	No	Don't know
Increased body weight.			
Inactivity.			
Family history. .			
Age. Your risk increases as you get older.			
Pregnancy related diabetes.			

High blood pressure			

17. Tick as many as possible the lifestyle Preventive measures of Diabetes Disease

	Yes	No	Don't know
Eat healthy foods			
Get more physical activity.			
Lose excess pounds**.**			

18. Tick as many as possible the lifestyle risks of Cancer Diseases

	Yes	No	Don't know
Tobacco.			
Overweight			
Fruit and vegetables			
Alcohol.			
Occupation.			
Is related to viral Infections			
Red and processed meat			
Eating highly processed foods			
Physical activity			
Salt – high-salt diets.			

19. Tick as many as possible the lifestyle Preventive measures of Cancer Diseases

	Yes	No	Don't know
Don't use tobacco			
Eat a healthy diet (Eat plenty of fruits and vegetables)			
Maintain a healthy weight and be physically active			
Protect yourself from the sun (Avoid midday sun, Stay in the shade, Cover exposed area)			
Get vaccinated (Hepatitis B, Human papillomavirus (HPV))			
Avoid risky behaviors (Practice safe sex, don't share needles.)			
Get regular medical care: Regular self-exams and screenings			
Avoid obesity, If you choose to drink alcohol, do so only in moderation, Limit meats)			

20. Tick appropriately possible the lifestyle risks of hypertensive Diseases

	Yes	No	Don't know
Smoking			
Being overweight or obese			
Lack of physical activity			
Too much salt in the diet			

Too much alcohol consumption (more than 1 to 2 drinks per day)			
Stress			
Older age			
Genetics			
Family history of high blood pressure			

21. Possible lifestyle Preventive measures of hypertensive disease

	Yes	No	Don't know
Maintain a healthy weight.			
Eat a balanced diet.			
Cut back on salt.			
Exercise regularly.			
Limit the alcohol.			
Monitor your blood pressure			

22. Tick as many as possible the lifestyle Preventive measures of Arthritis Disease

	Yes	No	Don't know
Osteoarthritis – Maintain a healthy weight			
Rheumatoid arthritis – Do not smoke			
Gout – Eat a healthful diet, low in sugar, alcohol and purines			
Limited amounts of processed food			
Avoid animal-based products and foods that contain high amounts of salt and oil, including many processed products			

23. Tick as many as possible the lifestyle risks of depression Diseases

	Yes	No	Don't know
Abusing drugs and alcohol			
Overwork			
Poor diet, including excess caffeine or sugar			
Lack of exercise			
Poor sleep			
Lack of leisure time as well as fun and recreational activities			
Environmental causes such as air pollutions, noises			

24. Tick as many as possible the lifestyle Preventive measures of depression Diseases

	Yes	No	Don't know
Get enough sleep.			
2. Exercise.			
3. Regulate your blood sugar.			

4. Eat healthy fats.			
5. Find passion/have sense of purpose in life.			

25. Cultural beliefs on health

1. ***Strongly disagree 2. Disagree. 3. Agree. 4. Strongly agree***

No.	Item	Rating			
1	I would go for exercise in the morning or evening but it may look unique among my neighbors	1	2	3	4
2	Lifestyle illnesses are associated with the way we treated our elders	1	2	3	4
3	Lifestyle illnesses are inherited and it is a waste of time and money treating or preventing them	1	2	3	4
4	When I visit a friend or in a party, its right to eat any meal that is provided without any objection	1	2	3	4
5	I prefer prayer only as a way through which I can be healed; visiting a medical doctor is an option.	1	2	3	4
6	Traditional herbs I inherited from my parents are the best over hospital medication	1	2	3	4
7	Lifestyle diseases are due to failure to pray	1	2	3	4
8	Only a doctor should know my lifestyle illness	1	2	3	4
9	It is shame to suffer from lifestyle diseases and I do not tell anyone	1	2	3	4
10	A belly is a sign of wealth I admire it	1	2	3	4
11	When one asks for water, its better I give milk instead	1	2	3	4
12	Sugarless drinks at home is a sign of lack of money, I buy sugar in my house to avoid that	1	2	3	4
13	I do accept services from any healthcare provider, no matter the age or gender	1	2	3	4

26. Attitudes towards Adventist health messages

No.	Item	Rating			
1	I chose my residence in strict consideration of the Adventist health message in pure air (ventilation, space and lighting)	1	2	3	4
2	I intentionally follow the guidelines of the Adventist health message of breathing in and out exercise every morning as a way of maintaining my good health	1	2	3	4
3	I deliberately bask in the early morning healthy sunshine; this is an Adventist health message	1	2	3	4

4	In view of the Adventist health message, I find balance in all my activities and behaviors that I do.	1	2	3	4
5	I sleep for at least 7 hours everyday	1	2	3	4
6	I take annual break out of my work	1	2	3	4
7	I do organize physical exercise frequently	1	2	3	4
8	I do physical exercises that totals to at least two hours a week	1	2	3	4
9	I do not take processed food	1	2	3	4
10	All my meals are balanced (compost of vitamins, protein, carbohydrate)	1	2	3	4
11	I do not eat meat (including fish and chicken)	1	2	3	4
12	I take heavy meals in the morning, average at lunch time and very little before going to bed	1	2	3	4
13	I drink at least 8 glasses of water per day	1	2	3	4
14	Drinks such as tea, coffee, energy drinks, and sugar-sweetened drinks form part of the liquids consumed in a day	1	2	3	4
15	Trusting in God’s power boosts emotions and helps neutralize negative emotions, serving both to enhance life and increase coping skills as negative life events	1	2	3	4

Thanks for your Cooperation.

Appendix II. CONSENT FORM

Dear Respondents,

I am a Master of Nursing student at The University of Eastern Africa Baraton Department of Nursing and conducting study on Factors Influencing Health Choices in view of Emerging Lifestyle Diseases among the Seventh-day Adventist church Members in Eldoret, Kenya. You have been identified as one of the respondents to in the study. Your sincere contribution to this study is highly valued. Your participation is voluntary and you are free to withdraw from the study and any stage. This research may not benefit you directly but it will provide essential information to the church health sector and help them in policy development as well as strategy layouts. This research is only meant for academic purposes and your responses will be treated confidentially.

By signing this consent this form you agree to fully take part in the study

_____	_____
Signature of respondent	Date:
_____	_____
Signature of Investigator	Date

I certify that I have explained to the above individual the nature and purpose of this study. I have also provided answers to questions raised concerning the study on the date stated on this consent.

For further information or questions about this study please contact the investigator:

Edward Kipngeno Limo
P. O. Box 3059 Eldoret
0722614903/073431068

Thanks for your Cooperation.

Appendix III. Reliability Analysis

Experience with non-communicable diseases

Reliability Statistics

Cronbach's Alpha	N of Items
.731	8

Item Statistics

	Mean	Std. Deviation	N
Experience with non-communicable diseases	2.5000	1.60591	35
Diabetes	3.1500	1.49649	35
Arthritis	3.6000	1.42902	35
Cardiovascular diseases/Hypertension	3.6500	1.13671	35
Cancer	3.9000	1.29371	35
Chronic respiratory diseases (Asthma and Chronic obstructive respiratory disease)	3.3000	1.45458	35
Ulcers	3.7000	1.52523	35
Heart Diseases	1.7000	.80131	35

Individual Health Choices

Reliability Statistics

Cronbach's Alpha	N of Items
.789	13

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
I do intentional exercise routinely with intentions to improve personal health for more than 20 minute per day	40.15	60.660	.294	.786
I Sleep to a maximum of 7-8 hours a day	39.14	62.476	.225	.790
I drink at least 8 glasses of water per day	39.83	55.940	.520	.765
I ensure that I have sunlight in the morning for some hours	39.68	62.522	.155	.799
I avoid taking tea leaves and coffee beverages that I know are harmful to health	39.91	56.415	.361	.784
I do things in my life in moderation (avoid what is harmful and use judiciously that which is healthful)	39.13	57.916	.470	.771
I ensure that my house and rooms I occupy are well ventilated, with open windows during the day	38.51	61.022	.402	.778
I make recognitions of balanced diet in my meals	39.33	57.825	.557	.765
I avoid eating between meals	39.77	58.211	.365	.780
I do personal assessment and consult a Doctor when I have deviations from normal	40.07	54.728	.526	.764
I go for medical checks at least by end of two years in health facility regardless of body wellness	40.89	56.483	.520	.766
I take control on dietary intakes of sugar, salt and fats for personal good and not necessarily for test (choice)	39.61	54.426	.609	.756
I choose the liquid oils for cooking for my foods	38.93	55.779	.488	.768

Knowledge on Heart diseases

Reliability Statistics

Cronbach's Alpha	N of Items
.757	7

Item Statistics

	Mean	Std. Deviation	N
People are born with heart defects	1.5000	.60698	35
High blood pressure causes heart disease	1.9500	.88704	35
Diabetes causes heart disease	1.1500	.48936	35
Smoking causes heart disease	1.2500	.63867	35
Excessive use of alcohol or caffeine causes heart disease	1.2000	.52315	35
Drug abuse causes heart disease	1.4500	.75915	35
Stress causes heart disease	1.2500	.55012	35

Preventive measures of heart Diseases

Reliability Statistics

Cronbach's Alpha	N of Items
.637	8

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Quit smoking	8.3000	2.747	-.185	.451
Control other health conditions, such as high blood pressure, high cholesterol and diabetes	8.3000	2.116	.275	.238
Exercise at least 30 minutes a day on most days of the week	8.1500	1.608	.406	.950
Eat a diet that's low in salt and saturated fat	8.3500	2.450	.248	.793
Maintain a healthy weight	8.3500	2.345	.407	.954
Reduce and manage stress	8.3000	2.537	.043	.544
Practice good hygiene	8.1500	2.450	-.092	.764
Avoid use of alcohol or caffeine	7.9000	1.674	.296	.683

Lifestyle risks to Obesity

Reliability Statistics

Cronbach's Alpha	N of Items
.727	8

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Transmitted from parents to children	10.8000	3.432	.152	.615
Family lifestyle causes obesity	10.5500	3.524	-.078	.591
Inactivity causes obesity	10.6000	2.989	.166	.403
Unhealthy diet causes obesity	10.2000	2.800	.159	.812
Social and economic issues-you're more likely to become obese if you have obese friends or relatives.	10.0000	2.421	.461	.543
Obesity is Age related.	10.0500	2.050	.669	.906
Pregnancy causes obesity	10.0500	2.997	.109	.834
Quitting smoking can lead to obesity	10.7000	3.695	-.157	.495

Lifestyle Preventive measures of Obesity

Reliability Statistics

Cronbach's Alpha	N of Items
.651	5

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Exercise regularly.	4.7000	1.168	-.152	.950
Follow a healthy eating plan	4.6500	.976	.121	.838
Know and avoid the food traps that cause you to eat	4.6500	.976	.121	.638
Monitor your weight regularly	4.4000	.463	.421	.745
Depend on God only	4.6000	.674	.288	.677

Lifestyle risks of Diabetes Disease

Reliability Statistics

Cronbach's Alpha	N of Items
.680	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Increased body weight	7.7500	5.987	.216	.689
Inactivity	7.2000	3.958	.631	.547
Family history	7.2500	3.776	.693	.517
Age. Your risk increases as you get older	6.9000	4.411	.393	.655
Pregnancy related diabetes	7.4000	4.674	.511	.604
High blood pressure	7.7500	6.724	-.099	.731

Lifestyle Preventive measures of Diabetes Disease

Reliability Statistics

Cronbach's Alpha	N of Items
.836	3

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Eat healthy foods	2.4000	.463	.850	.773
Get more physical activity	2.3000	.642	.780	.525
Lose excess pounds	2.5000	.684	.207	.669

Lifestyle risks of Cancer Diseases

Reliability Statistics

Cronbach's Alpha	N of Items
.809	10

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Tobacco	13.4500	3.103	.367	.934
Overweight	13.3500	3.292	.514	.954
Fruit and vegetables	13.6500	4.029	.044	.209
Alcohol	13.3500	4.661	.144	.292
Occupation. And practice	13.6000	3.726	.107	.167
Is related to viral or other Infections	13.8500	4.871	.228	.328
Eating meat	13.9000	4.937	.266	.308
Eating highly processed foods	13.3000	4.011	.094	.179
Physical activity	13.4000	3.305	.231	.066
Salt – high-salt diets	14.0500	4.787	.221	.255

Lifestyle Preventive measures of Cancer Diseases

Reliability Statistics

Cronbach's Alpha	N of Items
.738	8

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Don't use tobacco	8.7500	1.987	.142	.173
Eat a healthy diet (Eat plenty of fruits and vegetables)	8.9500	2.366	.233	.166
Maintain a healthy weight and be physically active	8.6000	2.147	.031	.269
Protect yourself from the sun (Avoid midday sun, Stay in the shade, Cover exposed area)	8.9000	1.989	.540	7.869
Get vaccinated (Hepatitis B, Human papillomavirus (HPV))	8.6000	2.463	.078	.934
Avoid risky behaviors (Practice safe sex, don't share needles.)	9.0000	2.316	.464	.822
Get regular medical care: Regular self-exams and screenings	8.5000	2.263	.069	.969
Avoid obesity, If you choose to drink alcohol, do so only in moderation, Limit meats)	9.0500	2.682	.000	.243

Lifestyle risks of hypertensive Diseases

Reliability Statistics

Cronbach's Alpha	N of Items
.740	9

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Smoking	9.8500	7.818	.181	.749
Being overweight or obese	9.8500	8.450	-.069	.778
Lack of physical activity	9.8000	6.800	.561	.696
Too much salt in the diet	9.7000	6.958	.417	.717
Alcohol consumption	9.7500	7.355	.426	.719
Stress	9.5500	6.682	.463	.708
Old age	9.7000	6.011	.655	.670
Genetics	9.6500	5.397	.653	.665
Family history of high blood pressure	9.7500	6.724	.429	.715

Lifestyle Preventive measures of hypertensive disease

Reliability Statistics

Cronbach's Alpha	N of Items
.791	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Maintain a healthy weight	6.1000	6.621	.137	.848
Eat a balanced diet	6.1500	5.082	.704	.720
Cut back on salt	6.2500	4.618	.849	.678
Exercise regularly	6.1000	6.200	.270	.820
Limit the alcohol	6.3000	5.484	.874	.711
Monitor your blood pressure	6.1000	4.621	.654	.730

Lifestyle Preventive measures of Arthritis Disease

Reliability Statistics

Cronbach's Alpha	N of Items
.790	5

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Osteoarthritis – Maintain a healthy weight	4.9500	4.155	.699	.733
Rheumatoid arthritis – Do not smoke	4.9500	4.366	.908	.730
Gout – Eat a healthful diet, low in sugar, alcohol and purines	4.6500	2.134	.785	.723
Limited amounts of processed food	4.8000	4.695	.190	.861
Avoid animal-based products and foods that contain high amounts of salt and oil, including many processed products	4.8500	3.608	.879	.669

Lifestyle risks of depression Diseases

Reliability Statistics

Cronbach's Alpha	N of Items
.723	7

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Abusing drugs and alcohol	7.3500	3.397	.610	.489
Overwork	7.4000	4.147	.181	.643
Poor diet, including excess caffeine or sugar	7.6000	4.358	.475	.577
Lack of exercise	7.5500	3.524	.433	.550
Poor sleep	7.4500	3.945	.280	.607
Lack of leisure time as well as fun and recreational activities	7.2000	3.221	.462	.537
Environmental causes such as air pollutions, noises	7.6500	5.082	-.068	.655

Lifestyle Preventive measures of depression Diseases

Reliability Statistics

Cronbach's Alpha[a]	N of Items
.697	5

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Get enough sleep	5.9500	2.261	.011	.727
Exercise	5.8000	2.379	.238	.486
Regulate your blood sugar	5.7500	1.671	.155	.508
Eat healthy fats	5.8000	1.853	.141	.920
Find passion/have sense of purpose in life	4.9000	1.674	.231	.564

Cultural beliefs on health

Reliability Statistics

Cronbach's Alpha	N of Items
.725	13

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
I would go for exercise in the morning or evening but it may look unique among my neighbors	19.7500	26.934	.272	.717
Lifestyle illnesses are associated with the way we treated our elders	19.4500	25.208	.337	.710
Lifestyle illnesses are inherited and it is a waste of time and money treating or preventing them	19.6000	25.516	.370	.707
When I visit a friend or in a party, its right to eat any meal that is provided without any objection	19.7000	26.642	.314	.714
I prefer prayer only as a way through which I can be healed; visiting a medical doctor is an option	19.6500	25.503	.373	.706
Traditional herbs I inherited from my parents are the best over hospital medication	19.8000	27.011	.269	.718
Lifestyle diseases are due to failure to pray	19.4500	24.366	.440	.697
Only a doctor should know my lifestyle illness	19.4000	24.358	.409	.701
It is shame to suffer from lifestyle diseases and I do not tell anyone	19.8500	26.766	.429	.709
A belly is a sign of wealth I admire it	19.4500	24.261	.414	.700
When one asks for water, its better I give milk instead	19.3500	21.713	.610	.668
Sugarless drinks at home is a sign of lack of money, I buy sugar in my house to avoid that	18.9000	25.253	.134	.758
I do accept services from any healthcare provider, no matter the age or gender	18.8500	24.345	.384	.704

Attitudes towards Adventist health message

Reliability Statistics

Cronbach's Alpha	N of Items
.775	9

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
I chose my residence in strict consideration of the Adventist health message in pure air (ventilation, space and lighting)	28.9000	21.358	.182	.686
I intentionally follow the guidelines of the Adventist health message of breathing in and out exercise every morning as a way of maintaining my good health	28.5000	21.211	.253	.668
I deliberately bask in the early morning healthy sunshine, this is an Adventist health message	28.4000	20.884	.317	.655
In view of the Adventist health message, I find balance in all my activities and behaviors that I do	28.4000	20.674	.286	.662
I sleep for at least 7 hours everyday	28.5000	17.737	.645	.582
I take annual break out of my work	28.3500	19.397	.468	.624
I do organize physical exercise frequently	28.7000	23.379	.039	.703
I do physical exercises that totals to at least two hours a week	27.9000	19.358	.324	.657
I restrict use of plastic materials on hot drinks	27.5500	17.418	.693	.570

APPENDIX IV: Map of Eldoret West District

Eldoret west Station is almost similar and covered by the Kapseret constituency in the political map of the Uasin Gishu County

Appendix V: Comprehensive Sampling Frame

PASTOR		CHURCHES	MEM/SHIP AT THE END OF THE 4TH QUARTER
N. CHUMO	1	**ELDORET CENTRAL***	425
	2	ALPHA	56
	3	ALFAJIRI	164
	4	KURASINI	187
	5	ELDORET WEST	148
T. NGOKO	6	**SUNSHINE***	405
	7	ELDOVILLE	239
P. NYALILEI	1	**LANGAS***	357
	2	NAZARETH ELDORET	74
	3	ELDO BIRMING'HAM	265
	4	PHILADELPHIA	126
	5	TELEVIEW	53
	6	STAREHE	408
	7	CHARITY	136
J. KEMBOI	8	**KAPSERET CENTRAL***	106
	1	KAMUNG'EI	183
	2	KAPKENDUIYWO	124
	3	JASHO CENTRAL	77
	4	UMOJA	56
	5	AIRPORT CENTRAL	65
	6	KAPTELDET	68
	7	LAMAYWET	58
J. KISORIO	8	**KAPKOROS/ TUMAINI***	352
	9	SOSIOT	101
	10	BARCHOK	52
	11	KAPSAOS	140
	12	HURUMA	160
	13	MILIMANI ELDORET	86
	14	TUMAINI	245
	15	ARIZONA HURUMA	45
	16	BONDENI	65
	17	SIGOWET	74
Z. BWAMBURA	18	**SUGOI***	92
	19	CHERAMEI	225
	20	LESERU	158
	21	KAPTICH	181
	22	CHEPTABACH	109
	23	MARINYIN	79
	24	CHEPKOIYO CENTRAL	184
	25	CHEBARUS	42
	26	MIMOSA	71

	27	TAUNET	128
	28	TUIGOIN CENTRAL	83
	29	SUGOI CENTRAL	38
	30	LAMAYWET	39
J. MAKERE	31	**TURBO***	70
	32	MURGUSI	197
	33	SOKYOT	110
	34	TEBESONIK	114
	35	KOSACHEI	191
	36	KOIBARAK	82
	37	CHEBAIYWA	60
	38	SINENDET	62
O. KIBOIT	39	**SERGOIT***	106
	40	SOY	86
	41	CHEMOSET	47
	42	SOY BARAK	92
	43	LIKUYANI	70
	44	NASIANDA MAWE TATU	80
	45	TUMAINI KUU	27
I. INYANGALA	46	**CHEPKOILEL***	227
	47	KAMAGUT	114
	48	MOI BARACKS	46
	49	SAMBUT	131
	50	KAPKWENIO	50
	51	KAPLELACH	101
	52	KAPNG'ETUNY	103
	53	KAPKAWA	61
	54	KISOR	42
J.KIRWA SANG	55	**SIMAT***	134
	56	ATUREI	185
	57	TAMURYAKIAT	81
	58	LAMAIYWET	86
	59	LEMOOK	95
	60	MOGOIYWET	64
	61	MUTWOT	113
	62	SAMBUL-KIPKENYO	55
	63	CHEPCHUINA	69
	64	TARTAR	129
	65	TENDWET	60
	66	TUIYO	117
	67	KAPSERTON	50
	68	MUMETET	73
	69	KAPTINGA	44
C. CHUMO	70	**KAIGAT***	182
	71	CHEPTIL	139
	72	KAIGAT TOWNSHIP	87

	73	KAPKATET	123
	74	KAPTIGILIS	58
	75	NDALAT TOWNSHIP	46
	76	NGARIET TUIYOBEI	45
	77	KORMAET	58
	78	KAPMOKOIWO	64
	79	KAPKORIO	57
	80	CHEPCHERGEI	52
	81	MARURIAT	45
	82	CHEBARUS KAIGAT	50
	83	DARAJA TATU	41
S.K. YATOR	84	**KABIEMIT***	229
	85	KOLONGET	140
	86	KAPLEMUR	142
	87	TUKTUK	162
	88	SALIENT CENTRAL	161
	89	LABORET	78
	90	KAKIPTUI	200
	91	KAPTENDON	85
G. MAKOKHA	92	**TAPSAGOI TOWNSHIP***	203
	93	ELGON ESTATE	133
	94	LABUIYWET	86
	95	KAMULAT	156
	96	TIRET	118
	97	KAMAGUT – TURBO	55
J. NDIWA	98	**KAPKOIMUR***	117
	99	CHEPTILILSUSWO	103
	100	CHEPTERWAI	100
	101	CHEPTONON	130
	102	KAPKENYELOI	79
	103	OSORONGAI	82
	104	NGOROIN	84
	105	KIPKARREN RIVER	74
	106	NG'ENYILEL	84
	107	KAPKURES	86
	108	KAPKOI	65
	109	CHEPKEMEL MAIN	41
	110	KAMOGOIYWA	46
	111	KOIBAN	37
		TOTAL	**14276**

Table IV: Comprehensive list of churches in GRVC

Sample frame showing the churches classifications

URBAN CHURCHES			
N. CHUMO	1	**ELDORET CENTRAL***	425
T. NGOKO	2	**SUNSHINE***	405
	3	ELDOVILLE	239
	4	**TURBO***	70
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	69	KAPMOKOIWO	64
	70	KAPKORIO	57
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	72	MARURIAT	45
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	97	NG'ENYILEL	84
	98	KAPKURES	86
	99	KAPKOI	65
	100	CHEPKEMEL MAIN	41
	101	KAMOGOIYWA	46
	102	KOIBAN	37

Table V: Comprehensive list of churches in GRVC in groups

Appendix VI: NACOSTI Research Permit

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **749324**

Date of Issue: **23/March/2020**

RESEARCH LICENSE

This is to Certify that Mr.. EDWARD KIPNGENO LIMO of "University of Eastern Africa, has been licensed to conduct research in Uasin-Gishu on the topic: FACTORS INFLUENCING HEALTH CHOICES IN VIEW OF EMERGING LIFESTYLE DISEASES AMONG THE SEVENTH-DAY ADVENTIST CHURCH MEMBERS IN ELDORET WEST, KENYA for the period ending : 23/March/2021.

License No: **NACOSTI/P/20/4349**

749324

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

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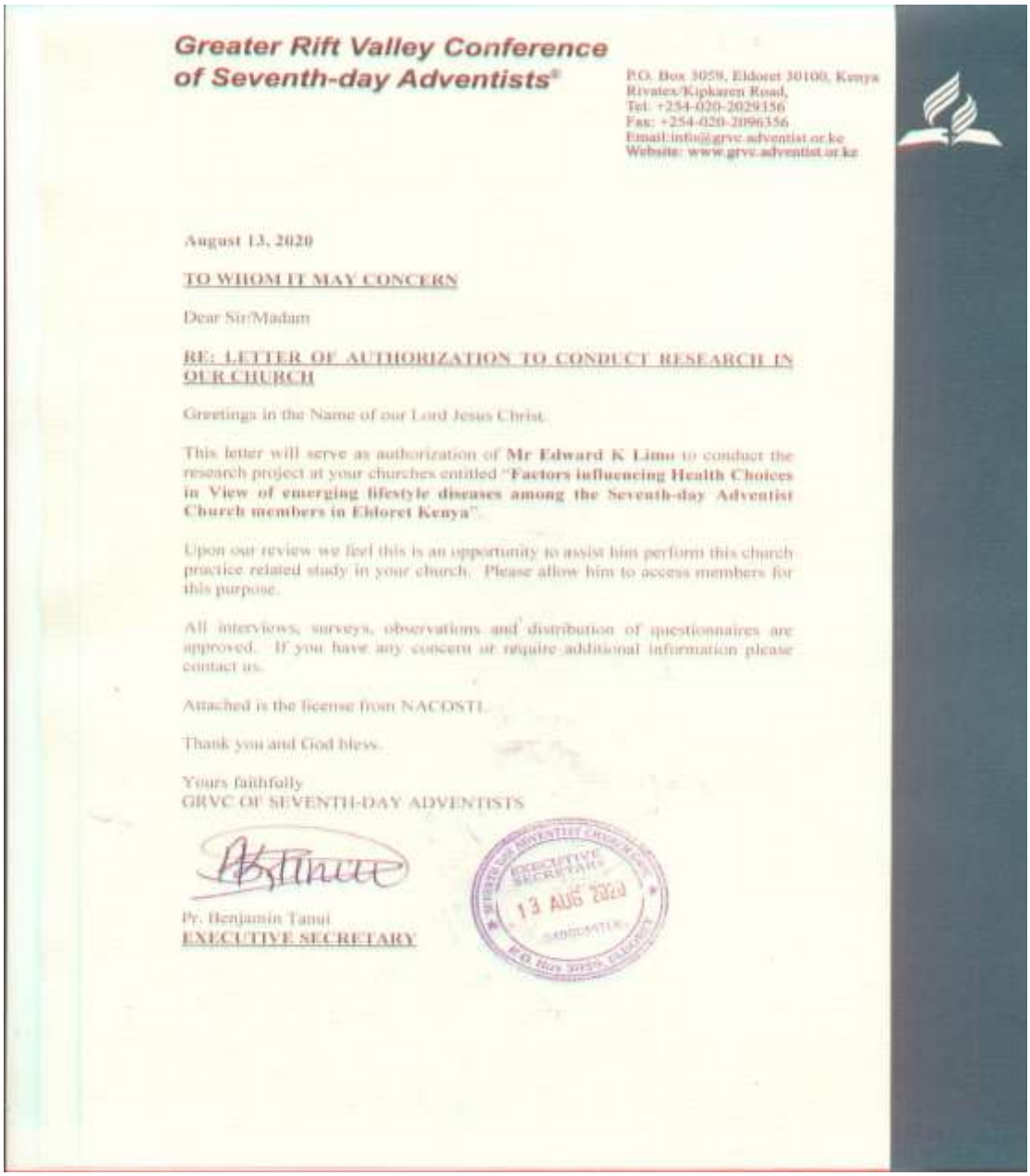
Appendix VII: GRVC Letter of Authorization



Greater Rift Valley Conference of Seventh-day Adventists®

P.O. Box 3059, Eldoret 30100, Kenya
Rivatex/Kipkaren Road,
Tel: +254-020-2029356
Fax: +254-020-2096356
Email:info@grvc.adventist.or.ke
Website: www.grvc.adventist.or.ke

August 13, 2020

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE: LETTER OF AUTHORIZATION TO CONDUCT RESEARCH IN OUR CHURCH

Greetings in the Name of our Lord Jesus Christ.

This letter will serve as authorization of **Mr Edward K Limo** to conduct the research project at your churches entitled "**Factors influencing Health Choices in View of emerging lifestyle diseases among the Seventh-day Adventist Church members in Eldoret Kenya**".

Upon our review we feel this is an opportunity to assist him perform this church practice related study in your church. Please allow him to access members for this purpose.

All interviews, surveys, observations and distribution of questionnaires are approved. If you have any concern or require additional information please contact us.

Attached is the license from NACOSTI.

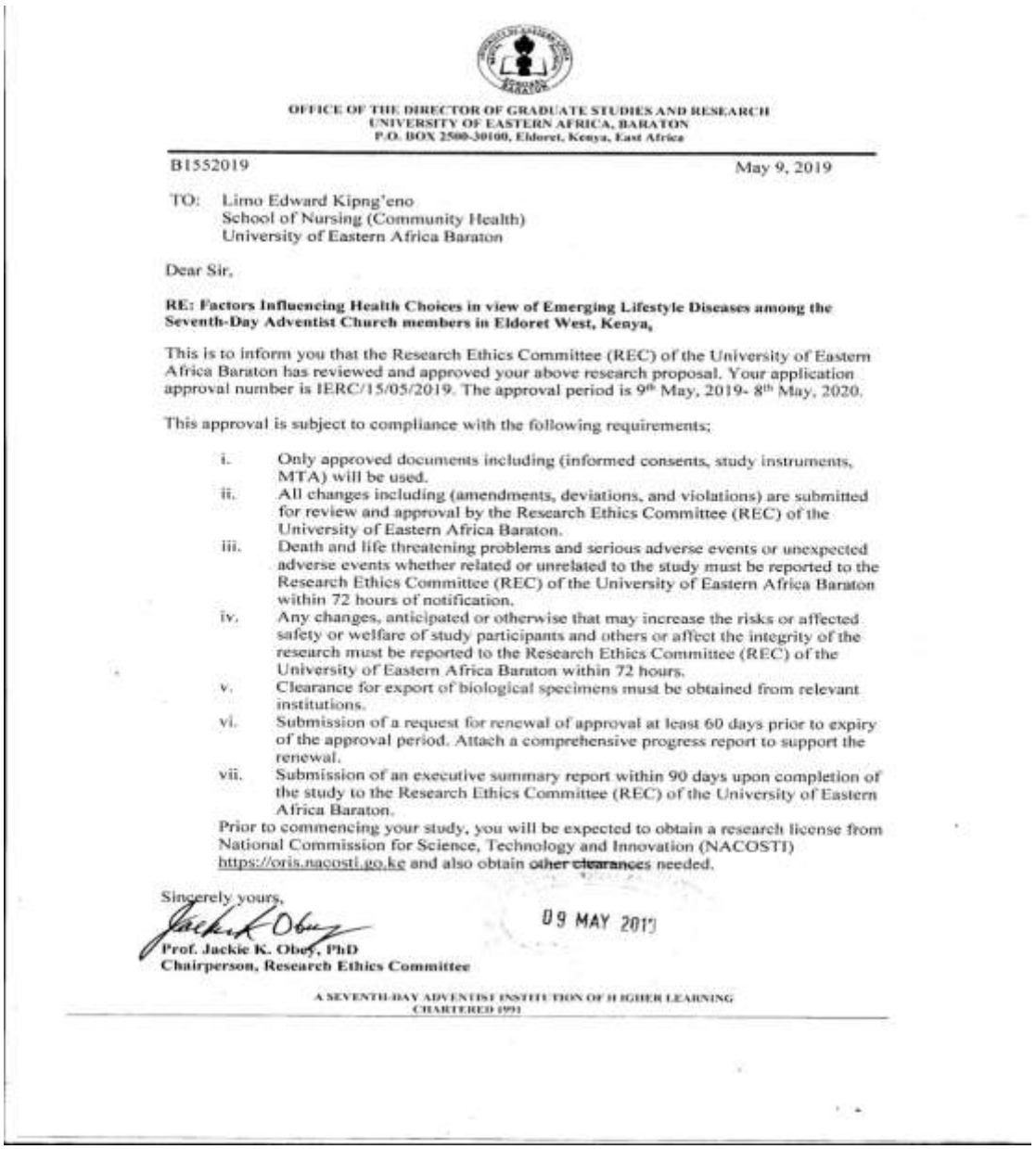
Thank you and God bless.

Yours faithfully
GRVC OF SEVENTH-DAY ADVENTISTS

Pr. Benjamin Tanui
EXECUTIVE SECRETARY

EXECUTIVE SECRETARY
13 AUG 2020

Appendix VIII: Institutional Ethical Review Letter



OFFICE OF THE DIRECTOR OF GRADUATE STUDIES AND RESEARCH
UNIVERSITY OF EASTERN AFRICA, BARATON
P.O. BOX 2500-30100, Eldoret, Kenya, East Africa

B1552019 May 9, 2019

TO: Limo Edward Kipng'eno
School of Nursing (Community Health)
University of Eastern Africa Baraton

Dear Sir,

RE: Factors Influencing Health Choices in view of Emerging Lifestyle Diseases among the Seventh-Day Adventist Church members in Eldoret West, Kenya,

This is to inform you that the Research Ethics Committee (REC) of the University of Eastern Africa Baraton has reviewed and approved your above research proposal. Your application approval number is IERC/15/05/2019. The approval period is 9th May, 2019- 8th May, 2020.

This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consents, study instruments, MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by the Research Ethics Committee (REC) of the University of Eastern Africa Baraton.
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to the Research Ethics Committee (REC) of the University of Eastern Africa Baraton within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to the Research Ethics Committee (REC) of the University of Eastern Africa Baraton within 72 hours.
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to the Research Ethics Committee (REC) of the University of Eastern Africa Baraton.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

Sincerely yours,

09 MAY 2019

Prof. Jackie K. Obey, PhD
Chairperson, Research Ethics Committee

A SEVENTH-DAY ADVENTIST INSTITUTION OF HIGHER LEARNING
CHARTERED 1991

Appendix IX: Curriculum Vitae

Education

Schools attended	
1978-1981:	Kaptebeng'wet Primary school P. O. Box 943, Kericho
1982-1986:	Kericho Boys Boarding Primary P. O. Box 305, Kericho
1987-1990:	Kericho High School P. O. Box 205, Kericho
1990- 1991:	Kaptebeng'wet secondary school P.O. Box 776, Kericho
1992-1996:	University of Eastern Africa, Baraton. P. O. Box 2500, Eldoret, Kenya
Major:	Bachelor of science-Nursing, Kenya Registered community Health Nurse (KRCHN)
Sept 2007 to date:	Bugema University P. O. Box 6529, Kampala, Uganda East Africa
Major:	Master of Arts in Development studies
Jan 2017 to date:	University of Eastern Africa, Baraton P. O. Box 2500, Eldoret, Kenya
Major:	Master of Science (Nursing) - Community health

Nursing Professional Career Duties

September 2015 to Date: **Department Director**: **Health, Communication and Special needs Ministries, Seventh-day Adventist church central office: Greater Rift Valley conference (GRVC)**

March 2011 to May 2015: Clinical instructor (University of Eastern Africa, Baraton Main Campus and The Eldoret Extension Centre)

Sept 1998 to September 2009: Project Coordinator and program implementation OFDA/USAID- with ADRA South Sudan on Primary health Care program, Guinea worm Eradication program in Upper Nile, Barr el Gazzal, Eastern Equatorial States of South Sudan,

Sept-1997- January 1999: Primary Health Care Centre in charge of ADRA.

Oct 1996- Sept 1997: Social Service League- M. P. Shah Hospital Intensive Care Unit Nurse (ICU)