NAIROBI EVANGELICAL GRADUATE SCHOOL OF THEOLOGY

FACTORS AFFECTING THE RESPONSE OF CHRISTIAN STUDENTS TOWARDS HIV/AIDS EPIDEMIC IN SELECTED KENYAN PUBLIC UNIVERSITIES

By
ROSELINE SHIMULI OLUMBE

A Thesis submitted to the Graduate School in partial fulfilment of the requirments for the degree of Master of Arts in Christian Education

JUNE, 2002

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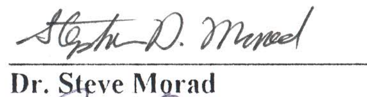
Second Reader: 
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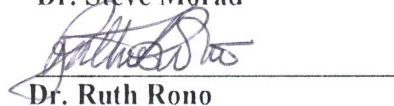
External Reader: 
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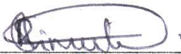
FACTORS AFFECTING THE RESPONSE OF CHRISTIAN STUDENTS TOWARDS HIV/AIDS EPIDEMIC IN SELECTED KENYAN PUBLIC UNIVERSITIES

I declare that this is my original work and has not been submitted to any other College or University for academic credit.

The views presented herein are not necessarily those of the Nairobi Evangelical Graduate School of Theology or the Examiners

(Signed)  ____________________

Roseline Shimuli Olumbe

June 24, 2002

ABSTRACT

This study involved an investigation of the factors affecting the response of Christian students towards HIV/AIDS in selected Kenyan public universities. HIV/AIDS is a national disaster in Kenya, with 240,000 Kenyans dying every year and over 2 million infected. This research was an attempt to find out whether the students' response was affected by gender, location of the Christian Union (CU), level of factual information, involvement in HIV/AIDS activities, and interaction with people living with HIV/AIDS (PLWHAs).

The researcher developed a written questionnaire to answer the research questions and null hypotheses which had been formulated. The research population was composed of Christian students who were Christian Union members from four selected university campuses. The questionnaires were administered directly to the sampled students and the resultant data analysed.

The study revealed that the students are generally positively inclined towards HIV/AIDS issues. They viewed HIV/AIDS as a critical issue in Kenya. It was observed that there was no significant difference between male and female students in their response towards HIV/AIDS. The research further showed that the locality of the CU affected the Christian students' response towards HIV/AIDS. That is, students from urban CUs exhibited a higher HIV/AIDS knowledge level compared to those from peri-urban CUs.

The research assumed that students with high level of factual knowledge about HIV/AIDS would be more involved in HIV/AIDS activities and would interact more with PLWHAs. However, the findings revealed that the level of factual information did not affect the students' involvement in HIV/AIDS activities and interaction with PLWHAs.

It was also established that Christian students who had been involved in AIDS awareness activities had a better response towards HIV/AIDS compared to those who had not. Lastly, the research did not show interaction with PLWHAs as a significant factor in the students' response towards HIV/AIDS. In other words, there was no significant difference between Christian students who had interacted with PLWHAs and those who had not, in their response towards HIV/AIDS.

The study also explored ways in which the response of Christian students towards HIV/AIDS could be improved. Some of the key suggestions were: public talks on HIV/AIDS, use of mass-media, incorporating HIV/AIDS into the education curriculum, HIV/AIDS seminars and workshops, video shows and films about AIDS, the need to love, encourage and give hope to PLWHAs, and avoiding stigmatising PLWHAs. The suggestions were very insightful and ought to form a basis for serious consideration by anyone wishing to be involved in HIV/AIDS education among the students.

TO

My beloved husband Duncan

whose support and encouragement was without measure

and FOCUS

for dedicated work among Kenyan university students and financially supporting my studies at NEGST.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CU	Christian Union
CUs	Christian Unions
FOCUS	Fellowship of Christian Unions
HIV	Human Immunodeficiency Virus
PLWHAs	People/Person Living With HIV/AIDS

CHAPTER ONE

INTRODUCTION

HIV/AIDS is a global epidemic. "...AIDS has become the most devastating disease humankind has ever faced.... At the end of 2001, an estimated 40 million people globally were living with HIV.... About one-third of those currently living with HIV/AIDS are aged 15-24" (UNAIDS and WHO 2001, 2). According to a UNAIDS report,

> Sub-Saharan Africa remains the region most severely affected by HIV/AIDS. Approximately 3.4 million new infections occurred in 2001, bringing to 28.1 million the total number of people living with HIV/AIDS in this region....
>
> At least 10% of those aged 15-49 are infected in 16 African countries, including several in southern Africa, where at least 20% are infected (ibid., 16).

Kenya is reeling from the effects of HIV/AIDS. As such, the President Daniel Arap Moi, in a parliamentary address, declared HIV/AIDS a national disaster on 25 November 1999. He said:

> *AIDS is not just a serious threat to our social and economic development, it is a real threat to our very existence.... AIDS has reduced many families to the status of beggars...no family in Kenya remains untouched by the suffering and death caused by AIDS...the real solution of the spread of AIDS lies with each and everyone of us* (AIDS Control Unit, 2001, vi).

The people of Kenya have been called upon to take necessary precautions to prevent the further spread of the epidemic. This study seeks, therefore, to establish how Christian students in selected public universities have responded to the epidemic. Their response will be measured in terms of their attitudes towards the HIV/AIDS epidemic. The research will seek to measure their knowledge of HIV/AIDS facts, the source of such knowledge and how involved they have been in the fight against AIDS.

Statement of the Problem

This research is an inquiry into the factors affecting the response of Christian students towards HIV/AIDS epidemic in Kenyan public universities. The underlying problem is that despite HIV/AIDS being a national disaster in Kenya, the response of churches in general and Christian students in particular has been wanting. Christian university students have been chosen in this study because

majority of them, who fall in the age bracket 18 - 26 years, are those most affected by HIV/AIDS. Furthermore, Christian students who form a sizeable population in the Kenyan universities have the potential to play a significant role in the fight against HIV/AIDS if they improve their response.

Significance of the Study

The findings and recommendations of the study will serve as resource materials for all those who want to address the HIV/AIDS epidemic among university students. These findings will also enlighten all those concerned with the response of university students towards HIV/AIDS. In addition, though several studies have been carried out on HIV/AIDS in different contexts, no research has been done among Christian students in Kenyan public universities. Therefore, this study will enable curriculum planners to develop a training manual for those working among Christians in Kenyan public and private universities. It also will provide useful resource material for those working among Christians in Kenyan (public) universities.

Research Questions

This study will be guided by the following questions:

1. What is the response of Christian students towards HIV/AIDS epidemic?
2. What are some of the factors that affect the response of Christian students towards HIV/AIDS epidemic?
3. In what ways do Christian students think their response towards HIV/AIDS epidemic could be improved?

Research Hypotheses

From the research questions and literature review, the following research hypotheses were generated. The hypotheses are stated in the null form.

Research Question 1: What is the response of Christian students towards the HIV/AIDS epidemic?

Hypothesis 1: Generally, the response of Christian students towards the HIV/AIDS epidemic is negative.

Research Question 2: What are some of the factors that affect the response of Christian students towards the HIV/AIDS epidemic?

Hypothesis 2: There is no significant difference between male and female Christian students in their response towards the HIV/AIDS epidemic.

Hypothesis 3: There is no significant difference between Christian students from urban Christian Unions and those from peri-urban Christian Unions in their response towards the HIV/AIDS epidemic.

Hypothesis 4: There is no significant difference between Christian students with different levels of HIV/AIDS factual knowledge in their response towards the HIV/AIDS epidemic.

Hypothesis 5: There is no significant difference between Christian students who are personally involved and those who are not personally involved in HIV/AIDS awareness in their response towards the HIV/AIDS epidemic.

Hypothesis 6: There is no significant difference between Christian students who interact and those who do not interact with people living with HIV/AIDS (PLWHAs) in their response towards the HIV/AIDS epidemic.

Research Question 3: In what ways do Christian students think their response towards the HIV/AIDS epidemic could be improved?

There is no hypothesis for this research question since it is a survey of the opinions of Christian students in terms of what they think should be done to improve their response towards HIV/AIDS.

Limitations of the Study

First, a comprehensive study would need to examine Christian students from each of the several Christian groups in the Kenyan public universities. However, due to limited time and resources, this research focused on members of Christian Unions. This is because Christian Unions are the largest Christian group on campus, having at least 10% of the student population in all the universities.

A second limitation was that though there are 16 public university campuses in Kenya, the research was limited to four campuses which were purposely sampled. Therefore the results will not necessarily be applicable to all the public universities. However, the researcher hoped that limiting the study to a sample of students in the Christian Unions would not invalidate the study since the views and

experiences of students in any of the sampled universities were expected to be similar to those not sampled.

Third, the research was limited by the fact that on some campuses not all students are in session at any given time due to lack of accommodation and the staggered academic calendar. This means that not all Christian students were available to be sampled for the research.

A fourth limitation was that the self-administered questionnaire did not allow the researcher to ask deeper or follow-up questions. However, the researcher hoped to overcome this by using both closed-ended and open-ended questions so as to provide the respondents with an opportunity to give more in-depth answers.

The fifth limitation was Christian bias, where the students might tend to answer questions in terms of what they know is expected of a Christian instead of what they were actually doing. In other words, the students, knowing what a Christian response towards HIV/AIDS should be, might tend to answer the questionnaire in terms of what should be rather than what they actually do. However, the researcher made the questionnaire anonymous to help the students be honest, thus reducing the bias.

Definition of Concepts

Christian: This is a person who has experienced a conversion and believes in the Trinity. That is, God the Father and creator of the whole heaven and earth; Jesus the Son of God who died for our sins, rose from the dead and will come again; the Holy Spirit who was given by God as a comforter and guide; and the Holy Bible, the inspired Word of God (Lamport quoted in Nzigo 1997, 6).

Christian Union: This is a fellowship of Christian students in an educational institution who meet together to encourage one another in order to have impact for Christ where God has placed them. Christian Unions generally have the following objectives:

a) To strengthen the spiritual life of the members (Discipleship).

b) To witness to fellow students (Evangelism).

c) To equip the members for service in the church and society (Mission).

d) To develop Christian leadership.

Bible study group: This is a small group (6-10) of Christian Union members who meet regularly (weekly) to discuss the Bible, pray together and offer support to each other. Normally Bible study

groups comprise of randomly selected members of the Christian Union. The random selection is done by the Bible Study committee to ensure that each group has different members on the basis of year of study, gender, leadership roles and tribe. Each group has a leader who is responsible for the smooth running of the group.

AIDS awareness: This is an activity organised to help people know more about HIV/AIDS and how they can be involved. For example: a talk, seminar, posters, video show or play on AIDS, and visiting PLWHAs.

Response: This is used to refer to the actions of the students towards HIV/AIDS epidemic. In this research the actions included being involved in HIV/AIDS activities, interacting with PLWHAs, undertaking an AIDS test, etc.

CHAPTER TWO

LITERATURE REVIEW

The literature will be reviewed at two levels, substantive literature and methodological literature.

Substantive Literature Review

HIV/AIDS is an epidemic surrounded by many misconceptions. According to Sabatier, AIDS is a disease caused by a new and deadly virus called Human Immunodeficiency Virus (Sabatier 1989, 1). The virus weakens someone's immune system so that they are not able to fight against diseases. Therefore, it is important for people to understand clearly the facts surrounding AIDS.

Definitions

AIDS is an acronym that stands for Acquired Immunodeficiency Syndrome. Acquired means that AIDS is caught from someone else who already has the virus hence it is not genetically determined. Immuno relates to the body's immune system, that is, the body's defence against diseases. Deficiency refers to the weakening of the immune system, making it deficient in resisting diseases and making the body susceptible to diseases. The cells that defend the body from sicknesses and infections are depleted. Syndrome means a set of symptoms of illnesses, which present themselves in various forms.

HIV stands for Human Immunodeficiency Virus, which is the virus that causes AIDS. Human means that the virus can only be found in humans and not in animals or insects. Immunodeficiency means it weakens the body's immune system, making it unable to fight infections; leading to AIDS (a manifestation of various illnesses). A virus is a microscopic germ. The virus causing AIDS is contained in sexual fluids and blood. When the sexual fluids or fresh blood of an infected person come into contact with an uninfected person's sexual fluids and fresh blood then transmission of the virus occurs.

Mode of Transmission of the Virus

There are three ways in which the virus is transmitted from an infected person to an uninfected person. The first and most common way is through sexual intercourse. "More than 75% of all HIV infections in Kenya are spread in this way" (MAP International 1996a, 4). The virus is more easily acquired when other sexually transmitted diseases are present.

The second way is from an HIV positive mother to her child. An HIV positive mother is likely to spread the virus to the child during pregnancy, at birth or during breast-feeding. However, not all babies born to infected mothers are infected. In Kenya, "About 30 to 40% babies born to infected mothers will themselves be infected.... About 100,000 children under the age of 5 are infected today" (AIDS Control Unit 2001, 7). Sometimes infants may test HIV positive up to 12 or 18 months but they are not positive. This is due to the presence of the mother's antibodies in the child. The test measures the antibodies and not the actual virus. If the child is infected, the child will still test HIV positive even after 18 months. If the baby's immune system is depleted then the child will fall sick in the first year and may die in the second year. However, some children live longer, especially when good care is given to them.

The third mode is through direct blood contact. When fresh blood from an infected person comes into contact with fresh blood in an uninfected person then transmission may occur. If this happens during blood transfusion, the recipient of the blood has a 100% chance of getting the virus. Other ways of coming into contact with fresh blood are through sharing a needle, syringe, or circumcision knife that is not sterilised. Toothbrushes and razor blades carry very little risk.

It is important to note that AIDS cannot be spread through the following modes: body fluids, except blood and sexual fluids, mosquitoes, bedbugs, animals, air, coughing or sneezing, hugging, touching or usual (not deep) kissing, sharing a toilet, kitchen utensils, food, clothing and drink.

Preventing the Spread of HIV/AIDS

The truth is that "AIDS IS ALWAYS FATAL ... anyone can get it" but another truth is that "AIDS IS PREVENTABLE ... everyone can avoid it" (Africa Ministry Resources 1995, 1). The following are some recommended ways of prevention:

First, people should be encouraged to practise sexual abstinence before marriage and total faithfulness within marriage.

Secondly, thorough blood screening before transfusions and ensuring that blood transfusion is carried out only when necessary.

Thirdly, people with risky sexual behaviour (for example prostitution, having many sexual partners, etc) should use condoms. In a marriage setting, an infected spouse also should use condoms.

The fourth measure is the need to use sterile needles and syringes while dealing with patients or casualties. In addition, thorough care must be taken while handling blood, for example using gloves or clean plastic bags.

Fifth, there is need to treat other sexually transmitted diseases promptly since these diseases make it easier for the transmission of AIDS (Dixon 1994, 352).

Finally, pre-marital testing for AIDS is necessary for all couples planning to get married (ibid., 351). This helps the couple to be aware of their HIV status and decide what steps to take. In addition, preventive counselling should be provided to the young people (Clarke 1994, 125). Furthermore, sex education in schools, churches and homes should be encouraged (Christie 1997, 24).

HIV Testing

The presence of the virus in one's system will be evidenced by the results of the test indicating HIV positive status. When people are aware of their status, it is hoped that they will not go around infecting others out of ignorance. In this regard, it is important for all people to take this test. It is essential especially if one suspects that he or she has the virus. People planning to wed are strongly advised to take the test.

Symptoms of AIDS

There are three stages that someone suffering from AIDS undergoes. At the first stage, the person is a carrier and has no symptoms. At this stage, the person has the virus but looks healthy and shows no signs of the infection. This person is a carrier and is infectious.

The second stage is characterised by recurring illnesses. Early signs of the disease include: weight loss, sweating at night, persistent diarrhoea, swelling of lymph nodes, chronic fatigue, fever and persistent cough.

During the third stage, the person's immune system is completely destroyed. At this stage any little infection will make the person ill. Infected persons may suffer from tuberculosis, pneumonia, parasitic infection of the lungs, skin cancer causing sores and skin infections (*kaposis sarcoma*), fungal infection causing mouth ulcers and sores (Maruti 1999, 13).

However, it is important to note that different people go through these stages at different times depending on their health. Some may fall sick within one to two years and not improve whereas others may fall sick after ten years (MAP International 1996a, 8). Generally patients in stage three experience the following: 50% die within 18 months, 70% die within 2 years, all die within 5 years (ibid., 13).

AIDS Treatment

There is yet no cure for AIDS. Therefore, people suffering from AIDS and those taking care of them need to take the following into consideration in order to lengthen the life span of the patient: nutritious diet, exercises, good rest, good emotional and spiritual well being and prompt treatment of any infection (ibid., 9). The emotional, psychological and spiritual well-being of a person has a big impact on the progress of AIDS. To be accepted and loved, to be at peace with God, family and oneself, helps to slow down the disease (ibid., 9).

Behaviour Change

It is important to note that there is more to HIV/AIDS than factual knowledge. "By itself, information increases knowledge but does not change behaviour" (Sabatier 1989, 56). Many people may have full information about AIDS but still no change can be manifested in their lives. Therefore, in carrying out AIDS campaigns, AIDS educators should be careful to give something more than information.

It is important that AIDS educators understand and confront people's fears (ibid., 57). When people get the full information about AIDS, they are often overwhelmed with the information and this instigates fear in them. To overcome this fear, AIDS educators must take time and counsel with the people and help them address and deal with those fears.

It is important that the source of AIDS information must be trustworthy (ibid., 57). This will help solve the problem of people propagating wrong ideas about AIDS and causing unwarranted confusion.

Educators themselves must overcome denial. Some people still deny that AIDS is real and is killing many people. Such people should not educate others concerning HIV/AIDS.

AIDS information must take account of actual sexual behaviour. Many people still practise risky sexual behaviour, for example having multiple partners. Therefore, the information given to people must address such behaviour and encourage correct behaviour, that is, abstinence before marriage and faithfulness in marriage. Sabatier cites a case in Tanzania "when a 35-year-old Lenika Savorek read a poster explaining that to avoid infection with AIDS he should 'have sex with only one faithful partner' he burst into laughter. 'What am I going to do with my other wives?'" (Sabatier, 59). The poster did not take into account Lenika's situation. Therefore, there is need to recognise the existence of polygamous families; they should be encouraged only to practise sex within their marriages.

We should realise that religion and culture are powerful in shaping attitudes toward AIDS (ibid., 59). Some Christians have declared AIDS a curse from God. They view visiting an AIDS patient as trying to interfere with God's plan. Therefore, it is important that those handling an AIDS campaign hold an enlightened religious cultural perspective. This will help avoid spreading wrong religious views and condemning people before God.

Current State of HIV/AIDS in Kenya

> In Kenya, the first indigenous AIDS case was described in 1984 and by the end of that year, seven cases had been identified. The Kenyan government responded by forming the National AIDS Council (NAC) in 1985 to control the spread of the virus. Despite this and other efforts, the epidemic continued unabated and by the end of 1995, 63,179 AIDS cases had been reported to the National AIDS/STD Control Programme (NASCP) (Baltazar et al. 1996, 11).

In 1999 HIV/AIDS was declared a 'national disaster' in Kenya. Research statistics show that thousands of Kenyans are dying of AIDS and many millions are infected. According to Ojanji, "More than 2.2 million Kenyans are infected with HIV, with 240,000 dying every year from AIDS" (*Daily Nation* [Nairobi], 16 November, 2000). Muganda quoting Kiarie says that "29 Kenyans are dying of AIDS every hour" (*Daily Nation* [Nairobi], 7 June, 2001). These high rates of infections have immense effects on the society.

Hospitals in Kenya are filled with people living with HIV/AIDS (PLWHAs), creating lack of space for many other people who also need attention. "Already more than 40% of hospital beds in large

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urban hospitals are filled by patients with AIDS infection. The care for the sick and dying is overwhelming Kenya's national health system" (Mbugua 2000, 13).

Against this mosaic of human suffering is the grim reality that there is no cure for AIDS. So far, medical research has invented drugs that can control the effects of AIDS, thereby giving PLWHAs a longer life. However, these drugs are too expensive for the majority of Kenyans. It is estimated that "only 1000 out of the 2.2 million affected can afford these drugs" (*Daily Nation* [Nairobi], 7 June, 2001). Therefore, many Kenyan PLWHAs die within a short period of ailing due to lack of access to low-cost AIDS drugs.

The other repercussion of HIV/AIDS is the high rate of orphans being left behind by parents who die of AIDS. An AIDS orphan is defined as "...a child under the age of 15 who has lost the mother to AIDS" (AIDS Control Unit, 15). It is projected that, "...the number of AIDS orphans has probably reached over 900,000 today and will increase to 1.5 million by 2005" (ibid., 15). As a result, many homes and families are being depleted of parents, leaving children alone to take care of themselves and their grandparents. Relatives adopt some but others head their families. Some are taken to orphanages where they are offered care.

> While the extended family in Kenya has traditionally taken in the orphaned children, the traditional structures are increasingly burdened by the growing number of children needing care.... In many cases, grandparents are caring for young children. In some cases, Kenyan families are headed by children as young as 10 to 12 years old. In yet other cases, the children are living completely outside of any family structure, either in orphanages or on the street" (Saoke, Mutemi and Blair 1996, 45-46).

Furthermore,

> The burden will increase on society, both in the community and in the nation to provide services for these children, including orphanages, food, health care and school fees. Many children go without adequate health care and schooling, which will increase the burden on the society in the future years. The number of urban street children may also increase (AIDS Control Unit, 15).

The impact of HIV/AIDS on the family structure is also noteworthy. There is loss of income in families where the breadwinner has succumbed to AIDS. The cost of caring for PLWHAs is an added burden to the family. Also, in most cases the children become caregivers themselves for the sick parents rather than attending school and receiving care from their parents. Furthermore, it is sometimes difficult for these children to go to school even if there are other caregivers. The financial strain caused by AIDS leaves no money for school fees. When the parents die, the children often are left without supervision, and they eventually drop out of school. In the African setting, the woman plays a major role in meeting

the family needs. Therefore, "When a woman dies, family food security is threatened, particularly when families depend primarily on women's labour for food production..." (Kusimba et al. 1996, 29).

HIV/AIDS has affected Kenya in several sectors including health, education, transport, military, and communications and information. The effects on the macroeconomy are significant and can be grouped into five basic categories:

- Reduction in investment and savings due to higher health care expenditures;
- Decline in labour productivity due to worker absenteeism;
- Decline in labour productivity due to loss of experienced workers;
- Changes in labour market supply and demand;
- Changing demand for government services (Hancock et al. 1996, 115).

Current State of HIV/AIDS in Kenyan Public Universities

The Kenyan public universities are comprised primarily of students aged between 19 to 27, the high risk bracket in HIV/AIDS. A survey carried out in three Kenyan Universities showed that:

> Almost 83% of university students reported ever having sex. Sixty one % [sic] of university students are sexually active, with half of those being very active. Sixty-one % [sic] of students who have ever had sex have used a contraceptive. Seventh-one % [sic] of those currently using contraceptive are using condoms as the method (Otieno 1995b, iii).

These factors make it necessary for us to look into some of the reasons that contribute to this trend of immorality. First of all, it is important to mention that peer pressure is a prevalent source of threat to the students in campuses. Students from different backgrounds come with different behaviours that easily influence each other. During leisure time, there is a lot of drinking alcohol and drug taking among the non-Christian students. Some students become drunkards, drug addicts and drug vendors. Some end up in sexual promiscuity, which sets their lives at risk. During a conference held by university students in 1995, one of the issues identified was a lack of peer education and counselling (Otieno 1995a, 5). The conferees agreed that young people are hardly counselled, yet these counselling strategies are effective in many societies. A number of young people are involved in risky behaviour patterns, multiple sexual partners, rape cases, early sex and pregnancies and generally, there is a high level of infection among young people. This calls for attention, hence the need to educate them about the dangers of such behaviours and also counsel them and show them the right way.

A second issue of concern was that there is lack of access to accurate information on sex and sexuality. In most cases the information received by young people is inaccurate and lacks relevant

details. In some cases, parents or schools prohibit access to literature on sex and sexuality. Furthermore, there is misinformation on facts about HIV/AIDS. "Barriers to this information come from parents, schools, religious groups, community leaders and Government among others" (Otieno 1995a, 5).

A third reality is that discrimination and the stigmatisation of PLWHAs greatly impact young people. They fear revealing their status or even going for AIDS tests. In addition, the stigma that is laid on HIV/AIDS causes a lot of fear among those people with HIV/AIDS. There is generally fear/failure to reveal their sero-status, fear/failure to know one's own sero-status, inappropriate mandatory testing and restriction and denial of opportunity support. The PLWHAs say, "We realise that people suffer as a result of stigmatisation terminology in media and elsewhere, as well as the restriction and denial of opportunity, support and care as a result of their serostatus" (Otieno 1995a, 6). In this case, most young people who suspect infection avoid AIDS testing. Those who already know that they are HIV positive, hide their condition to avoid rejection.

Fourthly, students are economically hard pressed and struggling to survive. They look for sources of income. Female students commonly engage in commercial sex to make ends meet. The cost is unwanted pregnancies and sexually transmitted diseases. Some end up as single parents when the men decide to abandon them. To some extent this has affected the Christian Unions whereby some Christian ladies have yielded to such behaviour.

Due to economic hardship, some students are forced to live off campus since they are unable to pay accommodation fees. In their search for cheaper housing, some end up living in risky areas where rape is prevalent.

Fifth, political and social instabilities within the campuses further affect the life of students. In the recent past, there have been many demonstrations. During some of these demonstrations, some ladies are raped, resulting in exposure to HIV/AIDS. When the police come to resolve the conflict, they, in most cases, end up beating the students, shooting them and raping the female students. This is an alarming threat in the Kenyan universities.

Finally, academic work is another source of stress to the students. Sometimes there are mass failures in the examinations, which make students re-do their exams, repeat classes or drop out of campus. In such situations, some students end up in self-destructive habits, which put their lives at risk.

Sexuality and HIV/AIDS Information Sources for the Youth

"Research on transmission has found that young people from ages 15 to 25 are at greatest risk for getting the virus" (Morgan 2000, 44). One reason youth are adversely affected is because they do not hear about sex in the right place. Most of them gain their knowledge from the secular world and the media. This is illustrated by the results of a research carried out in 1995 as shown in table 1.

Table 1. Source of Information on Sexual Issues for the Youth

Source	Frequency	Percentage
1) Radio	174	55.8%
2) Friends	149	47.8%
3) Newspaper	147	47.1%
4) Television	136	43.6%
5) Teacher	115	36.9%
6) Parents	98	31.4%
7) Pastor	96	30.8%
8) Girl friend	87	27.9%
9) Youth leader	71	22.8%
10) Boy friend	69	22.1%
11) Parent's friends	43	13.8%
12) Aunties [sic]	36	11.5%
13) Uncles	25	8.0%

(Source: Makau, et al. 1995, 19).

The most common sources of information on sexual matters are the mass media and friends. This could be one reason for youth having wrong information about sex. In addition, they develop unhealthy attitude toward sexual issues, because they are rarely discussed in church or by their parents. The church and other Christian organisations must educate the youth on sexual matters so that they can have the correct information and develop right attitudes.

During the same research, when the youth were asked how regularly such sex-related issues were discussed in the church, their responses were as shown in table 2. From the results we see that approximately half of the youth reported that sexuality, boy/girl relationships and AIDS matters were often or sometimes discussed in church. However, there is still more to be done with the other 50% of the youth. These are crucial issues among the youth since they are at a critical stage in their development.

Table 2. Response of Youths on how Sex-Related Issues are discussed in Church

Topic	Often	Sometimes	Rarely	Never	Other
1) Sexual matters	20.5%	29.5%	19.9%	15.4%	14.7%
2) AIDS matters	22.1%	26.0%	20.1%	16.3%	15.5%
3) Boys and girls	22.1%	27.6%	21.5%	12.8%	16.0%
4) Parents and youth	36.5%	33.0%	17.0%	7.4%	6.1%

(Source: ibid., 21).

It is necessary to help the youth understand what abstinence means instead of just telling them to abstain from sex.

> Sex education in the church means more than teaching young people to say no to premarital sex; our training must also provide things for them to say yes to. We need to give kids permission to be sexual beings in ways that are pleasing to God.... Young people need to be taught that sex is a beautiful, powerful, exciting experience *within marriage* (Parris and Parris 1995, 18 -19).

According to Christie's report, 8 out of 10 males and 7 out of 10 females have had intercourse while in their teens. Fifty percent of all sexually active 19-year-old males had their first sexual experience between the ages of 11 and 13 (Christie 1997, 24). Though this is from a western context, it reveals that teenagers are seriously in need of correct sexual information since they are in the high risk group. The earlier this education is given to them the better, as it will enable them to know the precautions and protective measures to take.

Christian Response to HIV/AIDS Epidemic in Kenya

Given the high percentage of professing Christians in Kenya, it is important to explore how they have responded to the epidemic. "Christians comprise 70 to 80 percent of the Kenyan population. The church clearly has an important role to play in the AIDS epidemic" (Kiiti and Dortzbach 1996, 129). The impact is not only on the strength of numbers but on the fact that "Churches are at the grassroots, integral part of the community life. Churches promote beliefs that guide behaviour with either an implicit or explicit system of accountability" (ibid., 130).

The church in Kenya has responded in two different ways. Some Christians have responded by extending a *helping hand* through offering care to the PLWHAs. Others have responded with a *closed fist* and rejected those with HIV/AIDS, causing them to keep their distance (ibid., 131).

On the positive side, churches and Christian organisations in Kenya have responded by conducting AIDS awareness workshops, offering counselling and providing training on HIV/AIDS-related issues.

Through community development projects, traditional media such as songs, health services, literature, mass media, research, and symposiums, there has been a considerable effort to address HIV/AIDS. Some key organisations in this effort are Christian Health Association of Kenya (CHAK), Norwegian Church Aid (NCA), World Vision Kenya, Kenya Catholic Secretariat (KCS) and MAP International (ibid., 131-132).

Nonetheless, it is sad that a number of churches and Christian organisations in Kenya still have not taken the initiative to respond to this scourge, instead they have kept silent or condemned those infected. Some Christians tend to stigmatise PLWHAs and do not associate with them. This inadequate response to HIV/AIDS is due to several factors such as lack of correct information, a strong belief that AIDS is God's judgement on the immoral, lack of discussion about sexuality, and a general lack of church policy on HIV/AIDS (ibid. 32-133). "Too often issues are not discussed at all and informal policies develop out of suspicion and fear rather than from accurate information, such as clergy refusing to bury persons who have died of AIDS, or failing to provide pastoral care for someone with AIDS or his or her family" (ibid., 133).

Negative Response to HIV/AIDS Epidemic

Negative response can be summarised in three aspects: denial, alienation and accusation. First, some Christians have denied the reality of AIDS. It is sad that "Christians are denying the facts and misery of AIDS. The only approach is being self-righteous in condemning those who live with AIDS" (Makhulu quoted in Morgan 2000, 40). In denying the reality of HIV/AIDS, some Christians have been sceptical about the whole issue, taking no responsibility in the counteraction of the epidemic. In essence "The church has missed the opportunity to be a leader on AIDS..." (Odallo quoted in Morgan 2000, 40). This has then left the secular world to take a lead in this area.

Secondly, most PLWHAs are stigmatised and left on their own. Christians hardly interact with them because they perceive them as sinners, hence no need to associate with them. This means that many who are infected have been left on their own and no love of Christ extended to them.

Thirdly, PLWHAs face the challenge of accusation, especially from their fellow Christians. The question normally raised is how one can be a Christian yet be infected. A case in hand is a bishop in Uganda who is HIV positive. The origin of his infection with HIV/AIDS is not established. He says, "'I was not a virgin when I got married and yes I had sex before I got saved but I cannot trace back to my

encounter.' In fact he also says that he had a blood transfusion at some point in his life" (Kaakaabaale 2000, 7). Sadly he has faced so much opposition and rejection from Christians. Kaakaabaale writing about him says, "In fact the greater discouragement for Gideon has been from fellow Christians. Is he really infected? How can he say he is a Christian and yet he has AIDS?" (ibid., 7). When Gideon attended a meeting in one of the churches, and was called upon to give a testimony, he was rejected and people refused to listen to him on the basis of "What kind of testimony did a Christian with AIDS have to give?" (ibid., 7).

How Christians can Respond to the HIV/AIDS Epidemic

There are various ways in which Christians can look at this epidemic and help in the reduction of its spread and also be of support to those infected. There is need for Christians to recognise the holistic nature of the gospel. The Gospel has no boundaries as to who should hear it or not and what problem it should address or not. It is absolute and relevant at all times. Christians should realise that, "The gospel is a total package: deliverance, healing, and preparation of the soul for hope beyond the grave. The total package includes HIV-AIDS" (Banda quoted by Morgan 2000, 43).

The church should provide the training, care and leadership that is required by the community. It is also a healing community, practising healing in various ways but mostly through a sense of caring and a strong belief in hope for this life and the life to come. Ruth Kasuki, a Kenyan who died of AIDS in 1993, when asked what she would like to communicate to churches in Kenya said, "The first thing is that church leaders must understand this thing! And after they have understood this disease, then they must have an interest" (Kiiti and Dortzbach 1996, 130).

Some of the ways in which Christians can respond to the HIV/AIDS epidemic are to foster awareness, involvement in HIV/AIDS activities, and interaction with PLWHAs.

Awareness

Christians have the responsibility to mobilise other members of the Christian community and also the society at large to respond to this scourge. The church and individual Christians should realise that they have a major role to play in eradication of this epidemic. The fact is that there is no cure but

something can be done to sort out this mess. "Since we don't have a cure, we have to create awareness, to sensitize" (Morgan 2000, 38).

Indeed the church should warn the people to live a moral life, otherwise the probability of people getting AIDS is high. "But as we inform people of the facts of the dreaded disease, we must remember that AIDS education must be moral, not merely factual" (Clarke 1994, 120). The church should proclaim clearly the only effective way of prevention, that is, abstaining from sexual relations before marriage and remaining faithful to one's spouse if married. It is true that "Sexual purity will not give a person automatic immunity from AIDS. But proper use of sex, in the context of a monogamous marriage, is the best preventative [sic]" (ibid., 121).

Furthermore, the church should speak out how God views immorality. For example there is need to give the biblical teaching about prostitution, adultery, and fornication. The Bible warns that these activities can lead to premature death.

Church leaders should lead classes and seminars in biblical sexuality. These classes and seminars should target those who are already engaged to provide them with alternatives to the world's corrupt sex education. Preventive counselling should be provided to the young people to help stop the spread of AIDS. They should be encouraged to abstain from sex before marriage and avoid acts that will easily lead them to commit sin. In addition, they should be encouraged to be faithful to their spouses in marriage. The following topics should be handled:

How to abstain from sex and wait for marriage;
How to resist the temptations to commit immoral sex;
How to prepare for marriage;
How to find the right mate;
How to behave in courtship; and
God's plan for sex in marriage (Clarke 1994, 126).

The Church should seek to be at the forefront in the creation of AIDS awareness. In this respect, Christians should seek to know the facts about AIDS, seek to disseminate the correct information and also encourage change of behaviour in people's lives.

Involvement in HIV/AIDS Activities

The church should seek to be actively involved in HIV/AIDS activities in various ways. There is need for the church to start training Christians to lead PLWHAs to Christ. This is because some of the

PLWHAs have no personal relationship with Christ and this could be a channel to reach them with the gospel. These Christians should be trained in both hospital and home evangelistic visitation.

Apart from visitations, the church should establish HIV/AIDS counselling centres. These centres should go beyond mere presentation of facts about AIDS to give alternatives that will seek to change behaviour. It is a big fallacy to believe that information alone will change behaviour and stop the spread of the virus. Indeed, "...in biblical counselling, we must do more than present new information. We must lead the AIDS patient to change his behaviour and his attitudes" (Clarke 1994, 123).

The church should also be actively involved in reaching out to the many who have been left as orphans and widows due to loss of their loved ones with HIV/AIDS. In many places the extended family has stopped caring for family members or relatives due to fear of contracting the virus, hence the children are left in misery. As Clarke says, "Christians have a moral obligation to reach out and care for the orphans.... Christians must be willing to care for such children and take them in. Where the extended family fails to give compassion, Christians must open their homes to the homeless: morally, it is the right thing to do" (Clarke 1994, 124).

Most women who are left by their spouses suffer. Traditionally, the society has no place for the widows hence they are treated as outcasts. However, the church should realise that widows have a special place before God, hence the need to arise and defend the cause of widows. The Church should assist widows and seek to meet their physical, social, spiritual and emotional needs. In James 1:27, God accepts pure and faultless religion, which is to look after orphans and widows in their distress.

Interaction with PLWHAs

Christians can interact with PLWHAs in various ways. First, they should show acceptance to PLWHAs. This can be done at two levels – accepting the fact that AIDS is real and accepting those who are infected. Christians need to accept the reality that many people are being affected by the repercussions of the epidemic. They need also to accept that some fellow Christians are also suffering from the disease. Christians are either infected or affected. Accepting this reality would help the way Christians perceive and respond to PLWHAs.

Christians should also extend godly acceptance to PLWHAs, instead of stigmatising and condemning them. As Dortzbach says, "If we could only realize that at the cross we may not be HIV positive, but all of us are sin positive. No one is more righteous than anyone else" (Dortzbach quoted in

Morgan 2000, 39). We need to "accept those with HIV/AIDS as Jesus accepts them, they need compassion and kindness" (Kaakaabaale 2000, 8).

The second way Christians can interact with PLWHAs is by expressing love and compassion to them. Kaakaabaale says that "... as Christians we are called to compassion and love and to encourage and support those in our midst who are infected with the virus and in addition to physical pain have to suffer untold emotional turmoil" (Kaakaabaale 2000, 8). Through the compassionate ministry of the church, Christians can give food, clothing, comfort, and care to PLWHAs and their families. In this, the church will be obeying Jesus' command to his disciples in Matthew 25: 34-36, 40.

Thirdly, there is a need for Christians to offer support to those who are members of the family and are struggling in various ways as they care for their relatives. One of the challenges families are facing is due to the fact that Christians have kept silent and stopped following Christ's example to care for the sick and offer servant leadership (John 13: 1-17). If Christians rose and extended a helping hand, families would be helped too. After caring and watching her mother, sister and niece die, an 18-year old girl reflected, "Although it pains to have relatives with AIDS, I have realised these relatives need our help. We must be positive, full of love, kindness and compassion for them. We should encourage them to forget their former sins but to look at the cross. We need to lead them to Jesus Christ as their saviour and pray with them so that when they die they will die in the Lord!" (Akinyi 1999, 11).

Realising that there are so many ways Christians can be involved, it is important to mention that this can only be done when the perception Christians hold towards the HIV/AIDS is changed. Christians are called upon to take a different perception as far as this disease is concerned. "AIDS is here with us, the greatest challenge about it is yes the fact that it spells D-E-A-T-H but also that it is a highly stigmatised disease. We may not change the fact that AIDS is a killer but we can change the way we relate with people with AIDS" (Editor *Relate* 2000, 9). The fact is that "We can do more. We can do better. We can do it now" (Morgan 2000, 43).

Methodological Literature Review

Paul Leedy defines a method as, "a way of accomplishing an end result. It is how one operates, a way to get the job done" (Leedy 1983, 137). Borg and Gall suggest the following methods to collect data: use of questionnaire, the use of individual interview, the use of available records, files, registers and the use of telephone interview (Borg and Gall 1989, 418). Best and Kahn highlight the following

instruments for collecting data: observation, questionnaire, and interview which they call oral questionnaire (Best and Kahn 1989, 275-332).

The mailed questionnaire is the most popular instrument for collecting data. This instrument can contain both open-ended questions or closed response questions. In the open-ended questions, the respondent is free to use his or her own words in responding to the questions, hence they are not structured or restrictive (Peter 1994, 76). The closed response questions are restrictive and structured. They are described as questions that call for short, check-mark responses (Best and Kahn 1989, 182). The respondent is required to follow instructions given by the researcher. Various codes are used to get the answers and this could be done by ticking, circling or underlining the correct response. However, according to Peter, questionnaires have the lowest rate of return (Peter 1994, 64).

Interview or oral questionnaire is another way of collecting data from the respondent. It gives the interviewer an opportunity to explain explicitly the questions to the interviewees and is able to see the real reaction of the interviewees as they respond to the questions asked. The researcher can immediately give any needed clarification to the interviewees, helping secure relationship between the interviewer and interviewee. Hence, certain confidential reports may be given which an individual was not willing to put in writing (Best and Kahn 1989, 201). This method is time consuming and the most difficult to use successfully and therefore requires a high level of expertise (ibid., 203).

CHAPTER THREE

METHODOLOGY

Every scientific study should be "a disciplined form of inquiry and the process of systematic investigation" (Frey et. al. 1992, 3). This can be provided by a research methodology which Leedy defines as "a procedure which we attempt to find systematically, and with the support of demonstrable facts, the answer to a question or the resolution to a problem" (Leedy 1989, 5). The researcher is called upon to identify and use a method that is suitable for the research at hand, depending on the goals and purpose of the proposed study and the amount of money available to conduct the research (Wimmer and Dominick 1991, 24).

Given time and financial constraints, the descriptive research design was used in this study to help the researcher gain an insight into the factors affecting the response of Christian Union students towards the HIV/AIDS epidemic. Although the approach has some limitations, which will be discussed later in this chapter, this approach seemed to be the most suitable for this study.

This chapter focuses on the preliminary requirements that the researcher needed to collect the required data. These include the following:

Entry

This is the process through which initial contact between the researcher and the source of data is established. The respondents need to be approached in order to notify them of the intended study, the purpose of conducting it and the person who will be conducting the study. This process serves to prepare the respondents beforehand to receive the researcher (Mann 1985, 145-149).

To facilitate effective data collection, the researcher got a letter of introduction from the Deputy Vice-Chancellor for Academic Affairs at Nairobi Evangelical Graduate School of Theology. This letter was taken to the General Secretary of the Fellowship of Christian Unions (FOCUS) who needed to be aware of the intended study. The researcher also obtained another letter of introduction to the Christian Unions from the General Secretary of FOCUS. These two letters are appended to the

thesis. Thereafter, the researcher had meetings with the leaders of the selected Christian Unions to introduce herself and explain what she was planning to do. She also personally approached the sampled Bible study leaders from each selected Christian Union and requested them to participate in the research by responding to the questionnaire.

Research Design

"Research design is the plan, structure, and strategy of investigation conceived so as to obtain answers to research questions and to control variance. The *plan* is the overall scheme or program of the research" (Kerlinger 1973, 300). A descriptive research design was chosen to help the researcher gain an insight into the views Christian students have towards HIV/AIDS epidemic in selected Kenyan public universities. The type of descriptive research design used in this study was a survey. The survey was chosen so as to get the Christian students' attitudes, opinions and response towards HIV/AIDS. According to Best,

> A descriptive study describes and interprets what is. It is concerned with conditions or relationships that exist, opinions that are held, processes that are going on, effects that are evident, or trends that are developing. It is primarily concerned with the present, although it often considers past events and influences as they relate to current conditions (Best 1981, 93).

Therefore, this design was helpful to the researcher, since she was interested in knowing the current state of Christian Unions with regard to their response to the HIV/AIDS epidemic. The information was gathered from the respondents through a questionnaire. The data was gathered mainly from Christian students in the four selected campuses by means of a questionnaire. Three research questions were raised to guide the study. The first question sought the response of Christian students towards the HIV/AIDS epidemic. The second research question sought the factors affecting the response of these students towards the HIV/AIDS epidemic. The third research question sought Christian students' ideas on improving their response to the HIV/AIDS epidemic.

To establish the factors that affect the response of these students, four research hypotheses were generated. These hypotheses were tested using the frequency tables and the Chi-Square test.

Population

This study examined population set drawn from both the leaders and members of the Christian Union. At the time, there were approximately seven thousand Christian Union members in the public universities. These were young adults between eighteen and twenty-six years of age and were of mixed gender. However, some students were over twenty-six years old due to mature entry programmes in some institutions such as Egerton University and Chepkoilel campus. Other students were older due to repeating classes and starting schooling late. Furthermore, some courses such as Medicine and Engineering take longer than others, and this caused the students to stay longer on campus.

Sampling

Sampling is usually done to minimise financial costs and duration where the population for study is large (Nachmias and Nachmias 1996, 179). It is crucial for the researcher to ensure that the sample size is representative of the whole population. There are many ways of selecting a sample population, depending on the research goal. A sample size depends on: project type, project purpose, project complexity, amount of error willing to be tolerated, time constraints, financial constraints, and previous research in the area (Wimmer and Dominick 1991, 74).

In this study, a multi-stage sampling method was used. In the first stage, a purposeful sampling method was used to select four campuses. This method was chosen because the campuses had the variables the researcher was interested in and for convenience purposes. There was limited time and money hence the research could not be carried out in all the campuses. In the second stage, simple random sampling was used to select Bible study groups required in each campus to form the needed sample size. All elements selected in the group participated in the research.

At the time of this study, there were sixteen public university campuses in Kenya, as shown in table 3. In each campus there was a Christian Union comprised of Christian students from that campus. The research focused on Christian Union members rather than the entire campus.

Table 3. Public University Campuses in Kenya

Name of University	Campuses
Egerton University	1. Njoro, 2. Laikipia, 3. Kisii
Jomo Kenyatta University of Agriculture and Technology	1. Jomo Kenyatta University of Agriculture and Technology
Kenyatta University	1. Kenyatta University
Maseno University	1. Maseno University
Moi University	1. Main, 2. Faculty of Health Sciences, 3. Chepkoilel campus
University of Nairobi	1. Main, 2. Kikuyu, 3. Upper Kabete, 4. Lower Kabete, 5. Chiromo, 6. Parklands, 7. Medical School

The Christian Unions were divided into two major categories, based on their location. The categories were urban and peri-urban (table 4). Urban Christian Unions were those located within or in close proximity to large urban centres i.e. Nairobi. Peri-urban Christian Unions are located outside major urban centres.

Table 4. Categories of Christian Unions

Urban	Peri-urban
University of Nairobi - Main campus, Kikuyu, Upper Kabete, Lower Kabete, Parklands, Chiromo and Medical School	Moi University - Main and Chepkoilel
Kenyatta University	Maseno University
Moi University - Faculty of Health Sciences	Egerton University - Njoro, Laikipia and Kisii

The researcher selected four Christian Unions, two from each of the categories and on the basis that these four CUs formed a representative sample of all the Christian Unions. The selected CUs were also a reasonable and manageable sample size. The sampled campuses were University of Nairobi – Upper Kabete (urban), University of Nairobi – Parklands (urban), Moi University – Main (peri-urban) and Maseno University (peri-urban). However, the researcher discovered that University of Nairobi – Upper Kabete students were doing exams hence she could not conduct the research there. She then chose University of Nairobi – Medical School as a replacement.

The researcher obtained Bible study group lists from the selected Christian Unions. From the Bible study lists, the number of registered Christian Union members was established. Initially the researcher calculated 10% of the total population to get the required sample size. However, after pilot testing the questionnaire she realised that the attendance rate of the Bible study groups was low hence she increased it to 25%. From the sample size, the number of Bible study groups required to form the required sample was determined. For example, in Moi University Main Campus there were eighty-seven Bible study groups, each with eight members on average. The researcher therefore chose twenty-two Bible study groups (comprising 25% of the Christian Union members).

The procedure for random sampling was as follows: For each CU, the researcher placed the names of all the Bible study group leaders in a container and selected an element at a time, then returning the names in the container, up to 25% of the leaders. This was done to ensure that all elements were given equal chance for selection. All members in the selected Bible study groups were expected to participate in the research. To help achieve this, the researcher arranged with the Christian Union leaders so that the questionnaire was filled during the Bible study group meeting time.

Instrument Design

The researcher developed a questionnaire containing both open-ended and closed-ended questions. The closed-ended questions were used to gather factual information. The open-ended questions were designed to give the respondents freedom to express themselves using their own words.

The researcher consulted people working with AIDS-related issues (World Relief AIDS), people working among university students (FOCUS), and the literature on HIV/AIDS. The consultations were to help the researcher get information on issues that affect the response of Christian students towards HIV/AIDS. The following factors emerged as affecting the response of Christian students towards HIV/AIDS: a lack of correct information on HIV/AIDS, a lack of AIDS awareness activities, lack of practical involvement with people living with HIV/AIDS (PLWHAs), a lack of AIDS programmes in churches and Christian Unions, and incorrect interpretation of Scriptures in matters related to HIV/AIDS.

The questionnaire had twenty-two questions in six parts (see Appendix A) designed to establish the relationship between the above factors and the response of Christian students towards HIV/AIDS. Part one collected the demographic information on the respondent. Part two measured the attitude of the

students towards HIV/AIDS. Part three measured the respondent's factual knowledge about HIV/AIDS. Part four dealt with AIDS awareness. Part five examined the respondent's interaction with PLWHAs Part six examined general response to HIV/AIDS epidemic. Items seven to eleven, and eighteen were helpful in answering Research Question 1. Items thirteen, fourteen, sixteen, seventeen, twenty and twenty-one were helpful in answering Research Question 2. Items twelve, fifteen, nineteen and twenty-two sought to answer Research Question 3.

Pilot Testing

The questionnaire was pre-tested at the Lower Kabete Campus (University of Nairobi) Christian Union to help the researcher know whether the questions were clear or they needed to be changed. The Christian Union was chosen because the researcher was well acquainted with the Christian Union leaders and the FOCUS staff working there. The researcher first talked with the Christian Union leaders to explain the purpose of the study and reason for pre-testing the questionnaire. Random sampling was used to select the Bible study groups that participated in the study. All elements in the selected groups participated in the research. The researcher had a session with the leaders from the selected Bible study groups to explain the purpose of the research, and their role in the study and how to administer the tool during their meeting and explain to the members the purpose of the research. She also attended the Bible study groups and explained further about the research. The researcher made clarifications where necessary and collected the questionnaire after the meeting. She got written comments on the questionnaire, which helped her in improving the tool. After pre-testing, corrections were made to ensure that the questionnaire would be clearly understood by the respondents. Apart from a comment on adding one more question there were not many corrections since all the items seemed manageable by the respondents. The extra question was included before the instrument was used in the field.

Administering the Instrument

The researcher administered the questionnaire to the respondents through the leaders of the selected Bible study groups in each selected Christian Union. To ensure the smooth running of this administering process, the researcher held a meeting with the leaders to train them on how to administer the instrument. The training involved explaining the purpose of the study, clarifying items in the

questionnaire, and answering any questions from the leaders. The leaders read through the questionnaire and were given a chance to ask the researcher for any clarification. The questionnaires for each selected CU were left with the Bible study co-ordinator who distributed them to the Bible study leaders of the sampled groups. The leaders in turn gave the members of their groups the questionnaire to fill in during Bible study meeting time; both leaders and members were expected to fill in the questionnaire. After the questionnaires were completed, the leaders collected and brought them back to the Bible study co-ordinator who in turn sent them to the researcher.

Method of Data Analysis

"*The nature of data analysis dictates methodology.* If the data is verbal, the methodology is *qualitative*, if it is numerical, the methodology is *quantitative*" (Leedy 1993, 139). In this research both qualitative and quantitative methodologies were used. The closed-ended questions were analysed quantitatively, whereas the open-ended items were analysed qualitatively and discussed. The analysis is reported in chapter four after the returns of the questionnaire.

In seeking to evaluate the students' opinions, the researcher adapted the Likert Scale technique to collect questionnaire items eleven and twenty. The researcher computed the total scores for each respondent and then analysed the inherent attitudes.

A combination of frequency tables, Chi-square tests and open-ended responses were used to test the hypotheses. For example, Hypothesis 1 (H_0:1) was tested through the use of frequency table of the responses to item 7 on the questionnaire. If a respondent ranked HIV/AIDS among the first four social issues of critical concern, this implied the respondent had a high priority level for HIV/AIDS. The researcher would then use the priority level to infer that the respondent had a positive response towards HIV/AIDS. Otherwise, if the respondent did not rank HIV/AIDS among the first four social issues then the researcher inferred that the respondent had a low priority level for and hence a negative response towards HIV/AIDS. This means that response is measured in terms of cognitive response (priority level ranking).

The rest of the hypotheses were tested using the Chi-Square Test. The researcher used a computer programme, *SPSS 10.0 for Windows Student Version*, to key in and analyse the data. The researcher developed appropriate codes to help in keying in of the data. After keying the data, the programme performed all the necessary calculations and produced the required frequency tables. The SPSS

programme was used to do all the necessary Chi-Square tests, based on the Pearson's method of analysis, on the various data variables. The researcher chose .05 level of significance to reject or not reject the null hypotheses. If the Chi-Square (χ^2) value is equal to or greater than the critical value required to reject the hypothesis at the chosen level of significance, then the hypothesis is rejected; if it is less, then it is not rejected. The level of significance is chosen prior to actual data analysis to avoid the error of rejecting a true hypothesis.

CHAPTER FOUR

DATA ANALYSIS

This study sought to find out the factors that affect the response of Christian students towards HIV/AIDS. A total of two hundred and ninety-nine questionnaires were administered in four Kenyan public universities. To determine the factors that affect the response of Christian students towards HIV/AIDS, the researcher generated three research questions. To enable the respondents to answer these questions, the researcher used both open-ended and closed-response questions.

Questionnaire Returns

A total of 299 questionnaires were distributed to the students and 229 were accepted for analysis. The researcher rejected 70 questionnaires because they were blank since not all the Bible study group members were available to fill them in. Some of the reasons given for the unavailability of the members were sickness, laxity, or some had signed up but did not actually attend Bible study groups hence were not members of the Christian Union. The valid respondents are shown in table 5.

Table 5. Questionnaire Returns

	Distributed	Returned	% Returned
Moi University Main Campus	176	129	73.3%
Maseno University	80	57	71.3%
Parklands Campus	21	21	100%
Medical School	22	22	100%
Total	299	229	76.6%

General Response of Christian Students towards HIV/AIDS

The researcher first sought to gauge the general response of Christian students towards HIV/AIDS. This was to answer the following research question:

Research Question 1 What is the response of Christian students towards HIV/AIDS epidemic?

Hypothesis 1

H_0: 1 Generally, the response of Christian students towards HIV/AIDS epidemic is negative.

Item 7 of the questionnaire was used to test this hypothesis. The priority level ranking of HIV/AIDS was used as a measure of the respondent's response towards the epidemic. If HIV/AIDS was ranked among the first 50% of the listed issues, the respondent had a high priority level for HIV/AIDS, and hence a positive response towards HIV/AIDS. If the ranking was among the last 50%, this indicated a low priority level and hence a negative response towards HIV/AIDS. The results are in table 6.

Table 6. Priority Level Ranking of HIV/AIDS
by Christian Students

	Frequency	Percent
Low	21	9.2
High	205	89.5
Total	226	98.7
Missing data	3	1.3
Total	229	100.0

From the results, out of the 229 respondents, 21 (9.2%) indicated a low priority for HIV/AIDS epidemic whereas 205 (89.5%) indicated a high priority for HIV/AIDS. Taking the priority level as an indicator of response, it can be interpreted that in general the Christian students have a positive response towards HIV/AIDS epidemic. That is, they reckon that HIV/AIDS is a very critical issue in Kenya. However, whether this positive response is attested by the other variables measured in the research will be seen after analysis in the subsequent sections.

Factors Affecting the Response of Christian Students towards HIV/AIDS

Research Question 2

What are some of the factors that affect the response of Christian students towards HIV/AIDS epidemic?

The researcher identified five main factors that possibly affect the response of Christian students towards HIV/AIDS. These were gender, locality, factual information about HIV/AIDS, level of involvement in AIDS awareness, and interaction with PLWHAs. Hypotheses were cast in relation to these factors.

Gender of Christian Students and Response towards HIV/AIDS

The researcher sought to find out whether the gender of respondents affected their response towards HIV/AIDS. This was to test the following hypothesis:

H_0: 2 There will be no significant difference between male and female Christian students in their response towards HIV/AIDS epidemic.

To test this hypothesis, the researcher tested for any significant differences between male and female students in terms of their HIV/AIDS priority level, HIV/AIDS factual knowledge, level of involvement in AIDS awareness activities, care of PLWHAs, and those who had done an AIDS test.

First, the relationship between gender and HIV/AIDS priority level was examined (table 7). Out of the 224 respondents, 130 (58%) were male and 94 (42%) were female. The fact that there were more male respondents than female reflects the gender ratio among university students in general. The results showed that 9 (9.6%) female respondents indicated a low HIV/AIDS priority level compared to 11 (8.5%) male respondents; whereas 85 (90.4%) female respondents had a high HIV/AIDS priority level compared to 119 (91.5%) male respondents. This revealed that there was very little difference between the genders in their HIV/AIDS priority level.

Table 7. Gender and HIV/AIDS Priority Level

			Gender		
			Female	Male	Total
HIV/AIDS Priority Level	Low	Count	9	11	20
		%	9.6%	8.5%	8.9%
	High	Count	85	119	204
		%	90.4%	91.5%	91.1%
Total		Count	94	130	224
		% of Total	42.0%	58.0%	100.0%

N = 224 $\chi^2 = 0.083$ df = 1

A Chi-square test was performed and the Chi-square value of **0.083** was far less than the critical value (**3.841**) necessary to reject the null hypothesis at .05 level of significance. Thus the null hypothesis was not rejected. In other words, there was no statistically significant difference between male and female students in their priority level of HIV/AIDS. A majority of both male and female students perceived HIV/AIDS as a critical issue.

The relationship between gender and the level of HIV/AIDS factual knowledge was then examined (table 8). The HIV/AIDS factual knowledge level was based on how correctly the respondents answered each of the ten questions in questionnaire items 9 and 10. Each correct response was awarded 10%. Based on this, the researcher developed four HIV/AIDS factual knowledge levels: Very High (100% correct), High (80-90% correct), Average (60-70% correct), and Low (50% and below correct). Of the 227 respondents, 25 (11%) scored Very High level, a majority of the respondents 154 (67.8%) were of High level, 47 (20.7%) respondents were Average, and only 1(0.4%) respondent had Low level. This shows that generally these Christian students have a high level of HIV/AIDS factual knowledge.

Table 8. Gender and HIV/AIDS Factual Knowledge Level

			Gender		
			Female	Male	Total
HIV/AIDS Factual Knowledge Level	Very High	Count	11	14	25
		%	11.5%	10.7%	11.0%
	High	Count	61	93	154
		%	63.5%	71.0%	67.8%
	Average	Count	24	23	47
		%	25.0%	17.6%	20.7%
	Low	Count		1	1
		%		.8%	.4%
Total		Count	96	131	227
		% of Total	42.3%	57.7%	100.0%

N = 227 $\chi^2 = 2.698$ df = 3

The Chi-square test was performed and the Chi-square value of **2.698** was less than the critical value **(7.815)** necessary to reject the null hypothesis at .05 level of significance. Thus, the hypothesis was not rejected. This means that there was no statistically significant difference between male and female respondents in their level of HIV/ADS factual knowledge.

The researcher then tested for any significant relationship between gender and the level of involvement in AIDS awareness activities (table 9). From the results, 74 (34.4%) male respondents had been involved in AIDS awareness compared to 43 (20.0%) female respondents and 52 (24.2%) male respondents had not been involved compared to 46 (21.4%) female respondents. Overall, 117 (54.4%) respondents had been involved in AIDS awareness compared to 98 (45.6%) who had not.

Chi-square test done gave a value of **2.281** which was less than the critical value (**3.841**) required to reject the null hypothesis at .05 level of significance. Thus, the hypothesis is not rejected. In other words, there is no statistically significant difference between male and female Christian students in their level of involvement in AIDS awareness activities as a measure of response towards HIV/AIDS.

Table 9. Gender and Involvement in AIDS Awareness

			Gender		
			Female	Male	Total
Have you been involved in AIDS awareness?	No	Count	46	52	98
		%	51.7%	41.3%	45.6%
	Yes	Count	43	74	117
		%	48.3%	58.7%	54.4%
Total		Count	89	126	215
		% of Total	41.4%	58.6%	100.0%

N = 215 $\chi^2 = 2.281$ df = 1

The relationship between gender and care for PLWHAs was then explored (table 10). It was observed that 41 (43.6%) of the female respondents had not cared for PLWHAs compared to 67 (51.9%) male respondents, and 53 (56.4%) female respondents had cared for PLWHAs compared to 62 (48.1%) male respondents. From these observations, there was no significant difference between the male and female respondents.

Table 10. Gender of Christian Students and Caring for PLWHAs

			Gender		
			Female	Male	Total
Have you Cared for PLWHAs?	No	Count	41	67	108
		%	43.6%	51.9%	48.4%
	Yes	Count	53	62	115
		%	56.4%	48.1%	51.6%
Total		Count	94	129	223
		% of Total	42.2%	57.8%	100.0%

N = 227 $\chi^2 = 1.507$ df = 1

A Chi-square test established this fact. The Chi-square value of **1.507** was lower than the critical value of **3.841** expected to reject the null hypothesis at .05 level of significance. Therefore, the

hypothesis was not rejected. There is therefore no statistically significant difference between male and female Christian students in their care for PLWHAs.

Finally the relationship between gender and those who have done an AIDS test was examined (table 11). It was observed that of the 225 respondents, only 31 (13.8%) had done an AIDS test; they comprised of 16 (17.0%) female and 15 (11.5%) male respondents. This compared to 78 (83.0%) female and 116 (88.5%) male respondents who had not. There was no significant difference between the genders. However, it is sad that a majority of the respondents had not done an AIDS test. A Chi-square test was performed and the Chi-square value of **1.430** was less than the critical value of **3.841** required to reject the null hypothesis at .05 level of significance. Thus, the hypothesis was not rejected. This implies that, considering the respondents who had done an AIDS test and those who had not, there was no statistically significant difference between male and female Christian students. Overall, few male and female students had done the test.

Table 11. Gender Versus Students Who Have Done AIDS Test

			Gender		
			Female	Male	Total
Have you done AIDS test?	No	Count	78	116	194
		%	83.0%	88.5%	86.2%
	Yes	Count	16	15	31
		%	17.0%	11.5%	13.8%
Total		Count	94	131	225
		% of Total	41.8%	58.2%	100.0%

N = 225 $\chi^2 = 1.430$ df = 1

In conclusion, hypothesis 2 was not rejected. That is, the results showed that there was no statistically significant difference between male and female Christian students in their response towards HIV/AIDS.

Locality of Christian Unions and Response Towards HIV/AIDS

The researcher sought to find out whether the locality of the Christian students affected their response towards HIV/AIDS. This was to test hypothesis 3:

H_0: 3 There will be no significant difference between Christian students from urban Christian Unions and those from peri-urban Christian Unions in their response towards HIV/AIDS epidemic.

To test this hypothesis, the responses of Christian students from urban Christian Unions and those from peri-urban Christian Unions were observed in terms of their HIV/AIDS priority level, amount of HIV/AIDS factual information, level of involvement in AIDS awareness activities, care or interaction with PLWHAs, and those who had done an AIDS test.

First, the relationship between the CU locality and respondents' HIV/AIDS priority level was examined (table 12). From the results, 43 (19.0%) respondents were from urban CUs and 183 (81.0%) from peri-urban CUs; 3 respondents did not indicate their HIV/AIDS priority level hence were treated as missing data. Furthermore, an overwhelming majority had a high HIV/AIDS priority level. A Chi-square test was used to examine the relationship. The Chi-square value of **1.357** was less than the required value (**3.841**) to reject the null hypothesis at .05 level of significance. Hence, the hypothesis was not rejected. In other words, there was no statistically significant difference between Christian students from urban and peri-urban CUs in their priority level of HIV/AIDS. Majority of the students perceived HIV/AIDS as a critical issue irrespective of the location of their CU.

Table 12. Locality of Christian Union and HIV/AIDS Priority Level

			Locality of CU		
			Urban	Peri-urban	Total
HIV/AIDS Priority Level	Low	Count	2	19	21
		%	4.7%	10.4%	9.3%
	High	Count	41	164	205
		%	95.3%	89.6%	90.7%
Total		Count	43	183	226
		% of Total	19.0%	81.0%	100.0%

N = 226 $\chi^2 = 1.357$ df = 1

The researcher then examined the relationship between the CU locality and respondents' level of HIV/AIDS factual knowledge (table 13). It was observed that a higher percentage (41.9%) of respondents from urban CUs had very high level compared to only 3.8% from peri-urban CUs. Furthermore, only 2 (4.7%) respondents from urban CUs had average level compared to 46 (24.7%)

respondents from peri-urban CUs. Thus there was some significant difference between respondents from urban and those from peri-urban CUs.

Chi-square test performed to verify this difference produced the value of **54.959** which was by far greater than the critical value (**7.815**) necessary to reject the null hypothesis at .05 level of significance. Thus, the hypothesis was rejected. In other words, there was a statistically significant relationship between the students' CU locality and their level of HIV/AIDS factual knowledge. Comparatively, students from urban CUs demonstrated a higher level of HIV/AIDS factual knowledge.

Table 13. Locality of Christian Union and HIV/AIDS Factual Knowledge

			Locality of CU		
			Urban	Peri-urban	Total
HIV/AIDS Factual Knowledge Level	Very High	Count	18	7	25
		%	41.9%	3.8%	10.9%
	High	Count	23	132	155
		%	53.5%	71.0%	67.7%
	Average	Count	2	46	48
		%	4.7%	24.7%	21.0%
	Low	Count		1	1
		%		.5%	.4%
Total		Count	43	186	229
		% of Total	18.8%	81.2%	100.0%

N = 229 $\chi^2 = 54.959$ df = 3

The researcher also tested for any significant relationship between CU locality and the respondents' level of involvement in AIDS awareness activities (table 14). It was noted that there was no significant difference in the percentage of respondents from urban CUs and those from peri-urban CUs in their involvement in AIDS awareness: 20 (47.6%) respondents from urban CUs had not been involved compared to 78 (44.8%) from peri-urban CUs, and 22 (52.4%) respondents from urban CUs had been involved compared to 96 (55.2%) from peri-urban CUs. From the Chi-square test, the value of **0.106** was less than the critical value (**3.841**) required to reject the null hypothesis at .05 level of significance. Therefore, the hypothesis was not rejected. There is no statistically significant difference between Christian students from urban CUs and those from peri-urban CUs in their level of involvement in AIDS awareness activities.

Table 14. Locality of CU and Students' Involvement in AIDS Awareness

			Locality of CU		
			Urban	Peri-urban	Total
Have you been involved in AIDS awareness?	No	Count	20	78	98
		%	47.6%	44.8%	45.4%
	Yes	Count	22	96	118
		%	52.4%	55.2%	54.6%
Total		Count	42	174	216
		% of Total	19.4%	80.6%	100.0%

N = 216 $\chi^2 = 0.106$ df = 1

The researcher then tested for any significant relationship between locality of CU and the student's likelihood of caring for PLWHAs (table 15). From the results, a higher percentage (51.6%) of peri-urban respondents had not cared for PLWHAs compared to 34.9% urban respondents. Conversely, a lower percentage (48.4%) peri-urban respondents had cared for PLWHAs compared to 65.1% urban respondents. The Chi-square value of **3.914** was slightly higher than critical value (**3.841**) expected to reject the null hypothesis at .05 level of significance. Therefore, the hypothesis was rejected. It means there was a statistically significant difference between Christian students from urban CUs and those from peri-urban CUs in their care for PLWHAs. Slightly more students from urban CUs cared for PLWHAs compared to those from peri-urban CUs.

Table 15. Locality of CU and Students Who Have Cared for PLWHAs

			Locality of CU		
			Urban	Peri-urban	Total
Have you Cared for PLWHAs?	No	Count	15	94	109
		%	34.9%	51.6%	48.4%
	Yes	Count	28	88	116
		%	65.1%	48.4%	51.6%
Total		Count	43	182	225
		% of Total	19.1%	80.9%	100.0%

N = 225 $\chi^2 = 3.914$ df = 1

Finally, the relationship between CU locality and students who have done an AIDS test was examined (table 16). The results show that a significantly higher percentage (91.3%) of peri-urban respondents had not done an AIDS test compared to 65.1% of urban respondents. Conversely, a higher percentage (34.9%) of the respondents from urban CUs had done an AIDS test compared to only 8.7%

from peri-urban CUs. From the Chi-square test, the value of **20.272** was far greater than the critical value **(3.841)** required to reject the null hypothesis at .05 level of significance. Thus, there was statistically significant relationship between the locality of CUs and the students' likelihood to do an AIDS test. Comparatively, more urban-CU students are likely to have done AIDS test.

Table 16. Locality of CU and Students Who Have Done AIDS Test

			Locality of CU		
			Urban	Peri-urban	Total
Have you done AIDS test?	No	Count	28	168	196
		%	65.1%	91.3%	86.3%
	Yes	Count	15	16	31
		%	34.9%	8.7%	13.7%
Total		Count	43	184	227
		% of Total	18.9%	81.1%	100.0%

N = 227 $\chi^2 = 20.272$ df = 1

Overall, hypothesis 3 produced mixed results. Students from urban CUs exhibited a higher level of factual knowledge and care for PLWHAs, and were more likely to take an AIDS test compared to those from peri-urban CUs. However, there was no statistically significant difference in their HIV/AIDS priority level and level of involvement in AIDS awareness activities. Perhaps the difference in factual knowledge was due to the fact that urban students have greater access to information and organisations working on HIV/AIDS tend to be based in urban centres. Therefore, it can be said that the CU locality affects to some appreciable extent the response of Christian students towards HIV/AIDS.

HIV/AIDS Factual Knowledge Level and Response Towards HIV/AIDS

The researcher sought to find out whether the students' level of HIV/AIDS factual knowledge affected their response towards HIV/AIDS. This was to test the following hypothesis:

H_0: 4 There will be no significant difference between Christian students with different levels of HIV/AIDS factual knowledge in their response towards HIV/AIDS epidemic.

The responses were evaluated to see whether there were any significant statistical differences between those who had high HIV/AIDS factual information and those who did not in terms of their HIV/AIDS priority level, involvement in AIDS awareness activities, care or interaction with PLWHAs, and those who had done AIDS test.

First, questionnaire item 8 was used to find out when the respondents first heard about AIDS (table 17). From the results, the respondents had heard about AIDS between 1984 and 1998; with the mean year being 1990.65. In other words, the respondents had heard about AIDS, on average, since about 1991. This implied that the respondents had heard about HIV/AIDS for a reasonable duration.

Table 17. Year Students First Heard of AIDS

When did you first hear about AIDS?	Frequency	Percent
1984	2	.9
1985	5	2.2
1986	2	.9
1987	12	5.4
1988	21	9.4
1989	28	12.6
1990	56	25.1
1991	17	7.6
1992	29	13.0
1993	13	5.8
1994	24	10.8
1995	7	3.1
1996	5	2.2
1997	1	.4
1998	1	.4
Total	223	100.0
Missing System	6	
Total	229	

Of special interest was how the respondents were able to define correctly HIV/AIDS, since the researcher considered this a basic factual knowledge (table 18).

Table 18. Christian Students and HIV/AIDS Definition

	Frequency	Percent
Only HIV correct	8	3.6
All Wrong	18	8.2
All Correct	73	33.2
Only AIDS correct	121	55.0
Total	220	100.0
Missing data	9	
Total	229	

From the results, it was significant that only 18 (8.2%) respondents could not define HIV/AIDS at all compared to 73 (33.2%) who got the definition correct. It was notable though that many of the respondents 121 (55.0%) could define AIDS only but not HIV.

The researcher then examined the respondents' reactions and attitudes towards certain statements about HIV/AIDS (table 19).

Table 19. Students' Reactions to Some Statements about HIV/AIDS

	Strongly agree	Agree	Not sure	Disagree	Strongly Disagree
AIDS is not real (N=228)	8 3.5%	0 0%	1 0.4%	12 5.3%	207 90.8%
AIDS is a myth (N=226)	2 0.9%	0 0%	5 2.2%	16 7.1%	203 89.8%
AIDS is a punishment from God (N=221)	34 15.4%	60 27.1%	65 29.4%	26 11.8%	36 16.3%
AIDS is a creation of the West (N=225)	4 1.8%	15 6.7%	82 36.4%	43 19.1	81 36.0%
Only immoral people contract AIDS (N=227)	3 1.3%	6 2.6%	5 2.2%	87 38.3%	126 55.6%
Christians should not talk about AIDS and sexual issues (N=226)	3 1.3%	0 0%	2 0.9%	14 6.2%	207 91.6%
Christians cannot get AIDS (N=227)	4 1.8%	3 1.3%	2 0.9%	34 15.0%	184 81.0%

The results show that an overwhelming majority of respondents either disagreed or strongly disagreed with the statement that AIDS is not real (96.1%) and AIDS is a myth (96.9%). Similarly, a very high majority either disagreed or strongly disagreed with the statements that only immoral people contract AIDS (93.9%), Christians should not talk about AIDS and sexual issues (97.8%), and Christians cannot get AIDS (96%). These findings demonstrate that the respondents have a good attitude towards HIV/AIDS as far as the above issues are concerned. However, a small percentage (28.1%) disagreed or strongly disagreed that AIDS is a punishment from God. Also slightly over half of the respondents (55.1%) either disagreed or strongly disagreed that AIDS is a creation of the West. These two findings suggest that AIDS educators need to address clearly these issue among Christian students.

The relationship between the respondents' level of HIV/AIDS factual knowledge versus HIV/AIDS priority level was then examined (table 20). It can be seen that majority or 205 (90.7%) of the respondents indicated a high priority level irrespective of their level of factual knowledge.

Table 20. HIV/AIDS Factual Knowledge and HIV/AIDS Priority Level

			HIV/AIDS Factual Knowledge Level				
			Very High	High	Average	Low	Total
HIV/AIDS Priority Level	Low	Count	1	16	4		21
		%	4.0%	10.5%	8.5%		9.3%
	High	Count	24	137	43	1	205
		%	96.0%	89.5%	91.5%	100.0%	90.7%
Total		Count	25	153	47	1	226
		% of Total	11.1%	67.7%	20.8%	.4%	100.0%

N = 226 $\chi^2 = 1.214$ df = 3

The Chi-square value of **1.214** was less than the required value (**3.841**) to reject the null hypothesis at .05 level of significance. Therefore the hypothesis was not rejected. In other words, there was no statistically significant relationship between the Christian students' level of HIV/AIDS factual knowledge and their priority level of HIV/AIDS. Most of the Christian students had a high HIV/AIDS priority level irrespective of their level of HIV/AIDS factual knowledge.

The researcher then examined the relationship between the student's HIV/AIDS factual knowledge level and their level of involvement in AIDS awareness (table 21).

Table 21. HIV/AIDS Factual Knowledge and Involvement in AIDS Awareness

			HIV/AIDS Factual Knowledge Level				
			Very High	High	Average	Low	Total
Have you been involved in AIDS awareness?	No	Count	12	67	18	1	98
		%	50.0%	45.6%	40.9%	100.0%	45.4%
	Yes	Count	12	80	26		118
		%	50.0%	54.4%	59.1%		54.6%
Total		Count	24	147	44	1	216
		% of Total	11.1%	68.1%	20.4%	.5%	100.0%

N = 216 $\chi^2 = 1.768$ df = 3

The results show that out of the 24 respondents who had very high level of HIV/AIDS factual knowledge, 12 (50%) had been involved in AIDS awareness and 12 (50%) had not. Almost a similar margin is seen with those who had high level of HIV/AIDS factual knowledge, where 80 (54.4%) were involved in AIDS awareness compared to 67 (45.6%) who were not. Thus, the respondents' level of HIV/AIDS factual knowledge did not significantly affect their involvement in AIDS awareness activities.

Chi-square test performed to examine this relationship produced the value of **1.768** which was far lower than the critical value of **7.815** necessary to reject the null hypothesis at .05 level of significance. Thus, the hypothesis was not rejected. This means that there was no statistically significant relationship between the students' level of HIV/AIDS factual knowledge and their involvement in AIDS awareness.

The relationship between the student's level of HIV/AIDS factual knowledge and their care for PLWHAs was then examined (table 22). From the results, 16 (66.7%) respondents with very high level of HIV/AIDS factual knowledge had cared for PLWHAs compared to 8 (33.3%) who had not. However, more respondents 80 (52.6%) who had a high level of factual knowledge had not cared for PLWHAs compared to 72 (47.4%) who had. Thus, it is difficult to see any clear trend from the observed frequencies.

Table 22. Students' HIV/AIDS Factual Knowledge and Care for PLWHAs

			HIV/AIDS Factual Knowledge Level				
			Very High	High	Average	Low	Total
Have you Cared for PLWHAs?	No	Count	8	80	20	1	109
		%	33.3%	52.6%	41.7%	100.0%	48.4%
	Yes	Count	16	72	28		116
		%	66.7%	47.4%	58.3%		51.6%
Total		Count	24	152	48	1	225
		% of Total	10.7%	67.6%	21.3%	.4%	100.0%

N = 225 $\chi^2 = 5.208$ df = 3

From Chi-square test performed to examine the relationship, the value of **5.208** was slightly lower than the critical value (**7.815**) expected to reject the null hypothesis at .05 level of significance. Therefore, the hypothesis was not rejected. In other words, there was no statistically significant difference in the level of HIV/AIDS factual knowledge among Christian students who had cared for PLWHAs and those who had not. Their level of HIV/AIDS factual knowledge did not really affect whether they cared for PLWHAs or not. Also it could imply that caring or not caring for PLWHAs does not seem to determine the level of HIV/AIDS factual knowledge. It is important to point out that in the context of this research, caring for PLWHAs was taken to mean active involvement with the PLWHAs such as visiting; it does not mean to simply show concern. This point was clarified when the questionnaires were being administered.

Finally, the relationship between the level of HIV/AIDS factual knowledge and those who have done an AIDS test was examined (table 23). It was noted that a consistently higher percentage of respondents had not done AIDS test right across the various HIV/AIDS factual knowledge levels.

Chi-square test was done and the Chi-square value of **2.680** was lower than the critical value **(7.815)** required to reject the null hypothesis at .05 level of significance. Thus, the hypothesis was not rejected. There was no statistically significant relationship between the Christian students' HIV/AIDS factual knowledge level and their having done or not done an AIDS test. In other words, the few Christian students who had done an AIDS test had varying HIV/AIDS factual knowledge level.

Table 23. HIV/AIDS Factual Knowledge and AIDS Test

			HIV/AIDS Factual Knowledge Level				
			Very High	High	Average	Low	Total
Have you done AIDS test?	No	Count	19	134	42	1	196
		%	76.0%	87.6%	87.5%	100.0%	86.3%
	Yes	Count	6	19	6		31
		%	24.0%	12.4%	12.5%		13.7%
Total		Count	25	153	48	1	227
		% of Total	11.0%	67.4%	21.1%	.4%	100.0%

N = 227 $\chi^2 = 2.680$ df = 3

In conclusion, hypothesis 4 was not rejected. That is, there was no statistically significant relationship between the Christian students' level of HIV/AIDS factual knowledge and their response towards HIV/AIDS. This attests to the fact in the literature review that AIDS education must go beyond HIV/AIDS factual information to behaviour change. The implication is that though emphasis should be put on passing correct HIV/AIDS information to students, a lot more needs to be done in seeking to change their attitudes and behaviour.

Involvement in AIDS Awareness and Response towards HIV/AIDS

The researcher sought to find out whether a student's involvement in AIDS awareness affected their response towards HIV/AIDS. This was to test the hypothesis:

H_0: 5 There will be no significant difference between Christian students who are personally involved and those who are not personally involved in HIV/AIDS awareness in their response towards HIV/AIDS epidemic.

This hypothesis was tested by examining any significant statistical differences between respondents involved in AIDS awareness and those not involved in terms of HIV/AIDS priority level, HIV/AIDS factual knowledge level, care for PLWHAs, and those who had done AIDS test.

The first test explored whether there was any significant relationship between the respondents' level of involvement in AIDS awareness and their HIV/AIDS priority level (table 24).

Table 24. Involvement in AIDS Awareness and HIV/AIDS Priority Level

			Have you been involved in AIDS awareness?		
			No	Yes	Total
HIV/AIDS Priority Level	Low	Count	9	10	19
		%	9.2%	8.5%	8.8%
	High	Count	89	107	196
		%	90.8%	91.5%	91.2%
Total		Count	98	117	215
		% of Total	45.6%	54.4%	100.0%

N = 215 $\chi^2 = 0.027$ df = 1

It was observed that a majority of the respondents ranked HIV/AIDS high irrespective of whether they had been involved in AIDS awareness or not. A Chi-square test was done and the Chi-square value of **0.027** was far less than the required value (**3.841**) to reject the null hypothesis at .05 level of significance. Thus, the hypothesis was not rejected. That is, there was no statistically significant difference between the Christian students who are involved and those not involved in AIDS awareness in terms of their HIV/AIDS priority level. A majority of the students had high HIV/AIDS priority level whether or not they had been involved in AIDS awareness.

Questionnaire item 14 further asked those respondents who had been involved in AIDS awareness what activities they had been involved in. The activities were numerous and varied, therefore the researcher chose to list only the top five activities according to frequency (table 25).

Table 25. AIDS Awareness Activities that Christian Students are Involved in

Activity	**Frequency**
Giving AIDS talks (in churches and schools)	68
AIDS Panels, workshops and seminars	16
AIDS counselling i.e. Peer Counselling	16
Open discussions with friends	10
Drama and poetry on HIV/AIDS	10

The variety of the activities is commendable and should be encouraged. A majority of the respondents were involved in giving HIV/AIDS talks. Therefore, training students on how to give good AIDS talks should be a priority.

The researcher also sought for the reasons given by respondents who had not been involved in AIDS awareness. Again these were numerous and varied, hence only the top five reasons are listed here (table 26). The majority were not involved because they lacked opportunity. AIDS educators should therefore seek to help students identify these opportunities. The results also highlighted the fact that a number of the respondents had not seriously considered being involved in AIDS awareness. This seems to be an attitude problem, which needs urgent attention.

Table 26. Reasons for Non-Involvement in AIDS Awareness by Christian Students

Reason	**Frequency**
Lack of opportunity to be involved	56
Lack of interest	11
Simply never thought about it	9
Lack of time or priority for AIDS awareness	8
Lack of exposure to and adequate information about HIV/AIDS	6

The researcher then examined whether there was any relationship between the respondents' level of involvement in AIDS awareness and their level of HIV/AIDS factual knowledge. This has already been discussed under hypothesis 4 (table 21), where it was concluded that there was no statistically significant relationship between the respondents' HIV/AIDS factual knowledge level and their level of involvement in HIV/AIDS awareness.

Another test was whether there was a relationship between the level of involvement in AIDS awareness and likelihood of caring for PLWHAs (table 27). The results show that of the respondents who had been involved in AIDS awareness 61.5% had cared for PLWHAs compared to 38.5% who had not. However, among the respondents who had not been involved in AIDS awareness, 39.2% had cared for PLWHAs compared to 60.8% who had not. A Chi-square test was performed and the Chi square value of **10.617** was much higher than the critical value **(3.841)** required to reject the null hypothesis at .05 level of significance. Hence, the hypothesis was rejected. In other words, there was a statistically significant difference between the Christian students who are involved in AIDS awareness and those who are not in terms of their caring for PLWHAs. Those who were involved in AIDS awareness were likely to care more for PLWHAs than those who were not involved.

Table 27. Involvement in AIDS Awareness and Caring for PLWHAs

			Have you been involved in AIDS awareness?		
			No	Yes	Total
Have you Cared for PLWHAs?	No	Count	59	45	104
		%	60.8%	38.5%	48.6%
	Yes	Count	38	72	110
		%	39.2%	61.5%	51.4%
Total		Count	97	117	214
		% of Total	45.3%	54.7%	100.0%

N = 214 $\chi^2 = 10.617$ df = 1

The researcher then examined whether there was a significant relationship between the respondents' level of involvement in AIDS awareness and their having done an AIDS test (table 28). It was noted that 87.8% of those who had not been involved in AIDS awareness had not done an AIDS test while 12.2% had done the test. Also 84.6% of those who had been involved in AIDS awareness had not done an AIDS test compared to 15.4% who had done the test. In other words, a majority had not done an AIDS test whether or not they had been involved in AIDS awareness.

Table 28. Involvement in AIDS Awareness and Doing an AIDS Test

			Have you been involved in AIDS awareness?		
			No	Yes	Total
Have you done AIDS test?	No	Count	86	99	185
		%	87.8%	84.6%	86.0%
	Yes	Count	12	18	30
		%	12.2%	15.4%	14.0%
Total		Count	98	117	215
		% of Total	45.6%	54.4%	100.0%

N = 215 $\chi^2 = 0.438$ df = 1

From the Chi-square test the value of **0.438** was far below the critical value (**3.841**) required to reject the null hypothesis at .05 level of significance. Therefore, the hypothesis was not rejected. There is no statistically significant difference between students who are involved in AIDS awareness and those who are not in terms of their having done an AIDS test. That is, whether a student had been involved in AIDS awareness or not did not significantly affect their likelihood to take an AIDS test.

Also examined was whether there was any significant difference between respondents from CUs which organised AIDS awareness activities and those from CUs which did not, in relation to their level of involvement in AIDS awareness (table 29). Out of the respondents who had not been personally involved in AIDS awareness 76% indicated that their CUs organised AIDS awareness compared to 24% whose CUs had not. For those who had been involved in AIDS awareness, 83.8% indicated that their CUs had organised AIDS awareness compared to 16.2% whose CUs had not.

Table 29. Involvement in AIDS Awareness Versus CU Organises AIDS Awareness

			Have you been involved in AIDS awareness?		
			No	Yes	Total
Has CU organised AIDS awareness?	No	Count	23	19	42
		%	24.0%	16.2%	19.7%
	Yes	Count	73	98	171
		%	76.0%	83.8%	80.3%
Total		Count	96	117	213
		% of Total	45.1%	54.9%	100.0%

N = 213 $\chi^2 = 1.985$ df = 1

The Chi-square value of **1.985** was less than the critical value (**3.841**) required to reject the null hypothesis at .05 level of significance. Thus, the hypothesis was not rejected. This implies that whether or not CUs organised AIDS awareness did not seem to bear any significant relationship to students' involvement in AIDS awareness.

Finally, the researcher tested whether there was any significant difference between respondents from home churches which organised AIDS awareness activities and those from churches which did not, in terms of their involvement in AIDS awareness (table 30). It was observed that of the respondents from churches that had not organised AIDS awareness, 36.9% had been involved in AIDS awareness compared to 61.7% who had not. Of the respondents from churches that had organised AIDS awareness, 63.1% had been involved in AIDS awareness compared to 38.3% who had not.

The Chi-square value of **12.501** was far greater than the critical value (**3.841**) required to reject the null hypothesis at .05 level of significance. Therefore the hypothesis was rejected. In other words, there was a statistically significant difference between students from churches which organised AIDS awareness activities and those from churches which did not, in terms of their level of involvement in AIDS awareness. Students from churches which reportedly organised AIDS awareness activities were

more likely to be involved in AIDS awareness than their counterparts from churches which did not. This suggests that the church has a major influence on students and therefore there should be more AIDS awareness organised in churches.

Table 30. Involvement in AIDS Awareness Versus Church Organises AIDS Awareness

			Have you been involved in AIDS awareness?		
			No	Yes	Total
Has church organised AIDS awareness?	No	Count	58	41	99
		%	61.7%	36.9%	48.3%
	Yes	Count	36	70	106
		%	38.3%	63.1%	51.7%
Total		Count	94	111	205
		% of Total	45.9%	54.1%	100.0%

N = 205 $\chi^2 = 12.501$ df = 1

In conclusion, hypothesis 5 produced mixed results. There was significant difference between students who are involved in AIDS awareness activities and those who are not in terms of their caring for PLWHAs. Also, students from churches which organised AIDS awareness showed a higher personal involvement in AIDS awareness than students from churches which did not. However, there was no statistically significant difference between students who were involved in AIDS awareness and those who were not in relation to their HIV/AIDS priority level and factual knowledge.

It therefore could be said that overall there was a significant difference between students who are involved in AIDS awareness and those who are not involved, in terms of their response towards HIV/AIDS. Therefore, Christian students who are already involved in AIDS awareness should be encouraged and trained so that they are better equipped to spread the awareness. It was also noted that home churches which regularly organise AIDS awareness had a significant impact in motivating students to be involved in AIDS awareness. Therefore, churches should be encouraged to organise AIDS awareness regularly.

Interaction with PLWHAs and Response towards HIV/AIDS

The researcher sought to find out whether a respondent's interaction with PLWHAs affected his/her response towards HIV/AIDS. This was to test hypothesis 6:

H_0: 6 There will be no significant difference between Christian students who interact and those who do not interact with people living with HIV/AIDS (PLWHAs) in their response towards HIV/AIDS epidemic.

To test this hypothesis, the researcher evaluated whether there were significant differences between respondents who had cared for or visited PLWHAs and those who had not in terms of HIV/AIDS priority level, HIV/AIDS factual information, involvement in AIDS awareness activities, and those who had done AIDS test.

First, the respondents were asked whether they knew any CU members and/or non-CU members who are living with AIDS (table 31). The results show that only 4 respondents knew of CU members who are PLWHAs compared to 38 respondents who knew of non-CU members who are PLWHAs. Of the known students who are living with AIDS, 3 were CU members and approximately 100 were non-CU members. These findings underscore the fact that there are students in the universities who are living with AIDS. However, a number are yet to publicly declare their status, hence the relatively low number of known PLWHAs. Also this might indicate that Christian students are not interacting as much with the rest of the students to really get to know those who are living with AIDS.

Table 31. Students Who Know CU and Non-CU Member Living with AIDS

Question	Response	Statistic	Value
Do you know a CU member living with AIDS?	Yes	Count	4
		%	1.8%
	No	Count	216
		%	98.2%
Do you know a non-CU member living with AIDS?	Yes	Count	38
		%	17.3%
	No	Count	182
		%	82.7%

The researcher then explored whether there was any significant relationship between caring for PLWHAs and HIV/AIDS priority level (table 32). From the results we see that 115 (51.8%) of the respondents had cared for PLWHAs and 107 (48.2%) had not. Furthermore, majority of the respondents had high HIV/AIDS priority level irrespective of whether they had cared for PLWHAs (90.45%) or not (91.6%). The number of respondents who had cared for PLWHAs was higher than the ones who had indicated they knew of CU and non-CU members who are PLWHAs (from table 31). Perhaps this shows that most of the respondents had cared for PLWHAs outside campus – at home, in hospitals, etc.

Table 32. Caring for PLWHAs Versus HIV/AIDS Priority Level

			Have you Cared for PLWHAs?		
			No	Yes	Total
HIV/AIDS Priority Level	Low	Count	9	11	20
		%	8.4%	9.6%	9.0%
	High	Count	98	104	202
		%	91.6%	90.4%	91.0%
Total		Count	107	115	222
		% of Total	48.2%	51.8%	100.0%

N = 222 $\chi^2 = 0.090$ df = 1

The Chi-square test gave a value of **0.090** which was much lower than the critical value **(3.841)** required to reject the hypothesis at .05 level of significance. Thus, the hypothesis was not rejected. There was no statistically significant difference between students who had cared for PLWHAs and those who had not in terms of their HIV/AIDS priority level. Whether a student had cared for a PLWHAs or not, they viewed HIV/AIDS as a critical issue in Kenya. HIV/AIDS educators and policy-makers should therefore make greater use of this general positive attitude towards HIV/AIDS among Christian students.

The relationship between respondents who had cared for PLWHAs and their HIV/AIDS factual knowledge level was also examined. This has already been discussed (see table 22) and it was concluded that there was no statistically significant difference between students with high factual knowledge level of HIV/AIDS and those with low level in terms of caring for PLWHAs.

The other relationship examined was between respondents who have cared for PLWHAs and their level of involvement in AIDS awareness. This has also been discussed under hypothesis 5 (see table 27), where it was concluded that there was a statistically significant difference in the level of involvement in AIDS awareness between Christian students who cared for PLWHAs and those who did not. More students who had cared for PLWHAs tended to be involved in AIDS awareness compared to those who had not.

The researcher then explored whether there was any significant difference between respondents who cared for PLWHAs and those who did not in terms of their likelihood to have done an AIDS test (see table 33). From the results, 89% of the respondents who had not cared for PLWHAs indicated that they had not done an AIDS test. This compares very closely to the 84.3% of the respondents who had cared for PLWHAs, yet indicated that they had not done an AIDS test. Thus there was very little

difference between those who had cared for PLWHAs and those who had not in terms of those who had done an AIDS test.

Table 33. Caring for PLWHAs versus Doing an AIDS Test

			Have you Cared for PLWHAs?		
			No	Yes	Total
Have you done AIDS test?	No	Count	97	97	194
		%	89.0%	84.3%	86.6%
	Yes	Count	12	18	30
		%	11.0%	15.7%	13.4%
Total		Count	109	115	224
		% of Total	48.7%	51.3%	100.0%

N = 224 $\chi^2 = 1.040$ df = 1

The Chi-square value of **1.040** was lower that the critical value (**3.841**) required to reject the null hypothesis at .05 level of significance. Therefore, the null hypothesis was not rejected. No statistically significant difference was found between students who cared for PLWHAs and those who did not, in their likelihood of doing an AIDS test. Of the students who had not done an AIDS test, an equal number had cared for PLWHAs compared to those who had not cared for PLWHAs.

The reaction/feelings of the respondents who had cared for PLWHAs was also examined (table 34). Of the respondents who had cared for PLWHAs, 53.8% said they were afraid and 13.4% were overwhelmed. This implies that AIDS education ought to aim at addressing the practical concerns and fears of those who are involved in caring for PLWHAs. Perhaps these concerns could be the reason why a number of respondents are not involved in caring for PLWHAs. Also from the results, 66.9% prayed for, 36.1% befriended and 46.2% cared for the PLWHAs. Christian students should be trained and further equipped on how to offer hope and show acceptance to the PLWHAs.

Table 34. Reaction of Christian Students who Cared for PLWHAs

Reaction	**Frequency**	**Percentage**
Afraid	64	53.8%
Prayed for the person	79	66.9%
Befriended the person	43	36.1%
Cared for the person	55	46.2%
Overwhelmed	16	13.4%
Not bothered	0	0%

The researcher was also interested in knowing why some of the respondents had not cared for PLWHAs. The reasons given were varied and so only the top five are listed here (table 35). A majority indicated that they did not know anybody living with HIV/AIDS. This is perhaps because many PLWHAs still fear stigmatisation, or due to lack of initiative on the part of the respondents to reach out to PLWHAs.

Table 35. Reasons why Christian Students had not Cared for PLWHAs

Reason	Frequency
Did not know anybody living with HIV/AIDS	52
Lacked opportunity or chance to care for PLWHAs	26
Fear of PLWHAs	5
Lack of time	2
Not bothered or not interested	2

In conclusion, it can be said that hypothesis 6 had mixed results. There was no significant difference between Christian students who had interacted with PLWHAs and those who had not, in their response towards HIV/AIDS. The only exception was with regard to their involvement in AIDS awareness where it was seen that students who had cared for PLWHAs tended to be more involved in AIDS awareness than students who had not. More efforts should be made to enable students to interact more with PLWHAs.

Improving the Response of Christian Students towards HIV/AIDS

Research Question 3

In what ways do Christian students think their response towards HIV/AIDS epidemic could be improved?

There is no hypothesis for this research question since it is a survey of the Christian students' opinions in terms of what they think should be done to improve their response.

In response to this, the researcher developed four open-ended questions for the respondents to give their ideas on what they hope should be done. Items twelve, fifteen, nineteen and twenty-two on the instrument helped to answer this research question. Some of their responses to these questions are reported below.

How to Improve Flow of Correct HIV/AIDS Information

Item 12 in the questionnaire was used to get the respondents' views on this. The top ten suggestions are shown in table 36.

Table 36. How to Improve the Flow of Correct HIV/AIDS Information

How to improve flow of correct HIV/AIDS information	Frequency
Public talks about HIV/AIDS	80
Using mass-media – radio, television, newspapers and posters	76
Incorporating HIV/AIDS in curriculum of primary schools, secondary schools and colleges	53
Discussing AIDS in churches	44
Organising HIV/AIDS seminars	38
Inviting PLWHAs to share their experiences	21
Use of HIV/AIDS literature – books, booklets, pamphlets and handouts	19
Organising video and film shows featuring PLWHAs	18
Have people with correct HIV/AIDS information doing the work	18
Discussing AIDS at family level	14

A majority of the respondents proposed that there should be public talks about HIV/AIDS, use of mass media and incorporating HIV/AIDS into the education curriculum. Discussing AIDS issues in churches and organising HIV/AIDS seminars were also proposed. It was commendable for the respondents to have mentioned the need to invite PLWHAs to share their experiences. AIDS educators therefore need to evaluate their current methods of disseminating HIV/AIDS information and where possible incorporate these proposals.

How CUs and Churches Could Improve AIDS Awareness Activities

Item 15 on the questionnaire was used to get the respondents' views on improving AIDS awareness activities in CUs and churches. The top ten suggestions are shown in table 37. Many respondents suggested HIV/AIDS seminars and workshops as a key way to improve AIDS awareness. They also proposed the use of video and film shows, AIDS talks, AIDS awareness campaigns, and open discussions about AIDS as some other key ways. Once again the respondents suggested the need for PLWHAs to share about AIDS. AIDS educators therefore need to seriously consider these suggestions and especially aim for interactive sessions.

Table 37. How CUs and Churches Could Improve AIDS Awareness Activities

How to improve AIDS awareness activities	Frequency
Through seminars and workshops	67
Through video shows and films about AIDS	54
Through AIDS talks	54
AIDS awareness campaigns	51
Open discussions on AIDS	41
Inviting PLWHAs to share about AIDS	32
Visiting and caring for PLWHAs	22
Through mass media	11
Avoid over-spiritualising and condemning PLWHAs	8
AIDS panels	6

How to Improve Interaction with PLWHAs

Item 19 on the questionnaire was used to get the respondents' views on how to improve interaction with PLWHAs. The suggestions are shown in table 38.

Table 38. How to Improve Interaction with PLWHAs

How to improve Interaction with PLWHAs	Frequency
To love, encourage and give hope to PLWHAs	62
Avoid stigmatising PLWHAs	48
Educating people on facts about HIV/AIDS	41
Accepting PLWHAs	27
Visiting PLWHAs	25
Inviting and involving PLWHAs in our activities	25
Caring for PLWHAs	24
Praying for PLWHAs	9

The respondents recognised the need for loving, encouraging and giving hope to PLWHAs. They also listed the need to avoid stigmatising PLWHAs. Educating the public on basic HIV/AIDS facts was also ranked high and the respondents said this would especially enable people to get rid of the myth that they can become infected through interaction with PLWHAs. Acceptance of PLWHAs was also highlighted.

Ways to Improve the Christian Students' Response towards HIV/AIDS Epidemic

Item 22 in the questionnaire was used to get the respondents' views on improving Christian students' response towards HIV/AIDS epidemic. The top ten suggestions are shown in table 39. It was

observed that AIDS education and interaction with PLWHAs ranked very high in the respondents' suggestions. The respondents also noted that Christians need to accept the fact that HIV/AIDS is real and Christians also contract AIDS. This suggestion implies that there is still a bit of denial among Christians which needs to be addressed. Other suggestions included participating in AIDS awareness activities, openly preaching and discussing HIV/AIDS issues in church, using audio visual channels to pass the HIV/AIDS message, accepting PLWHAs, teaching about abstinence and faithfulness in marriage, and change of attitude towards HIV/AIDS and PLWHAs. These are very poignant suggestions which demand the earnest attention of all AIDS educators, if the response of Christians towards HIV/AIDS is to be improved.

Table 39. How to Improve the Response of Christians towards HIV/AIDS Epidemic

How to improve response towards HIV/AIDS epidemic	Frequency
Educating people about HIV/AIDS	41
Visiting and caring for PLWHAs	36
Accepting HIV/AIDS is real and Christians can also get AIDS	30
Participating in AIDS awareness activities	24
Discuss HIV/AIDS openly in church (i.e. preaching)	21
HIV/AIDS seminars	19
Video shows, films and drama on HIV/AIDS	16
Accepting the PLWHAs	15
Teaching good morals (abstinence and faithfulness)	13
Change of attitude towards HIV/AIDS and PLWHAs	7

Overall Analysis and Discussion

First, the general response of Christian students towards HIV/AIDS was examined. Hypothesis 1, generated to test this, was rejected. Therefore, the research established that in general Christian students have a positive response towards HIV/AIDS, using their priority level of HIV/AIDS as an indicator. A majority of Christian students placed HIV/AIDS on a high priority level, thus recognising it as a critical issue in Kenya. This implies that the students are generally positively inclined towards HIV/AIDS issues.

Second, the factors affecting the response of Christian students towards HIV/AIDS were examined. Following is a summary of the research findings:

The first factor examined was gender. Hypothesis 2 was not rejected, hence it was concluded that gender was not a statistically significant factor in the response of Christian students towards HIV/AIDS. Both male and female respondents generally responded in the same way. This therefore implies that

both male and female Christian students should be addressed equally in the fight against HIV/AIDS. Perhaps the findings reflect the general shift towards gender equality whereby both male and female students in the universities are equally exposed to the same issues.

The second factor examined was locality and hypothesis 3 used to test this was rejected. Thus the locality of the CU was found to be a significant factor affecting the response of Christian students towards HIV/AIDS. Compared to Christian students from peri-urban CUs, students from urban CUs exhibited a higher level of HIV/AIDS factual knowledge, more had cared for PLWHAs and done the AIDS test. However, there was no significant difference in their HIV/AIDS priority level and involvement in AIDS awareness. Overall it was seen that the locality of the CU affects the Christian students' response towards HIV/AIDS. It seems that the students from urban CUs have greater access to HIV/AIDS information than those from peri-urban CUs. This could be due to the high technology available in the urban centres, easy flow of information in the urban centres and the fact that most of the organisations dealing with HIV/AIDS are located in the urban centres.

The third factor was HIV/AIDS factual knowledge. A majority of the respondents (78.8%) had very high or high level of HIV/AIDS factual knowledge. This showed that the students generally had good understanding of basic HIV/AIDS facts. This was further attested by the students' reactions to certain statements about HIV/AIDS. They viewed AIDS as real, not a myth, and affecting not only immoral people but also Christians. However, the sizeable percentage of respondents were uncertain as to whether AIDS is God's judgement or a creation of the West. AIDS educators therefore need to address carefully these two issues. Hypothesis 4 was not rejected, implying that there was no statistically significant difference between respondents who had varying levels of HIV/AIDS factual knowledge in their response towards HIV/AIDS. It seems that there are other underlying issues other than factual knowledge affecting the response towards HIV/AIDS.

The fourth factor was involvement in AIDS awareness. A slight majority of the respondents was involved in AIDS awareness. Those involved were involved in giving AIDS talks in churches and in seminars. Those who were not involved cited lack of opportunity as the main factor. It was also established that Christian students who had been personally involved in AIDS awareness activities cared more for PLWHAs than students who had not. Furthermore students from churches which organised AIDS awareness tended to be more involved in AIDS awareness compared to students who were from churches which did not. However, there was no significant difference in terms of the students'

HIV/AIDS priority level, care for PLWHAs and doing an AIDS test. Overall, hypothesis 5 was rejected. In other words, involvement in AIDS awareness was a significant factor in the response towards HIV/AIDS.

The last factor considered was interaction with PLWHAs. It was shown that few respondents knew of other students who were living with HIV/AIDS. However, it was encouraging that over 50% of the respondents indicated that they had cared for PLWHAs. It was also noteworthy that over 50% of those who had cared for PLWHAs indicated fear as a reaction towards the PLWHAs. As for those who had not cared for PLWHAs, a number said this was because they did not know anybody living with HIV/AIDS. Hypothesis 6 produced mixed results, but overall, it was not rejected.

The researcher finally explored how the response of Christian students towards HIV/AIDS could be improved. The respondents showed openness about the fact that they have been silent about the epidemic and were able to give insights into how to improve their response. The variety of the suggestions further attests to the positive attitude among the respondents. They seem eager to improve their response and in some way have an impact in the fight against HIV/AIDS.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

A survey was done in this study to find out some of the factors that affect the response of Christian students towards HIV/AIDS epidemic. The summary of the findings, conclusions and recommendations for further research are presented in this chapter.

Statement of the Problem

HIV/AIDS is a national disaster in Kenya. University students are among the most affected by the epidemic. Christian students form a sizeable population in the Kenyan universities; therefore they have a great potential in the fight against HIV/AIDS epidemic. The research problem was to determine some of the factors that affect the response of Christian students towards HIV/AIDS epidemic in Kenyan public universities.

Significance of the Study

The study will serve as resource material for those who are addressing the HIV/AIDS epidemic among university students. Furthermore, it might enable curriculum planners to develop a training manual for those working among Christian students in Kenyan public and private universities.

Purpose of the Research

The aim of the study was to find out the factors affecting the response of Christian students towards HIV/AIDS epidemic. The research questions that guided the focus of this study were:

1. What is the response of Christian students towards HIV/AIDS epidemic?
2. What are some of the factors that affect the response of Christian students towards HIV/AIDS epidemic?

3. In what ways do Christian students think their response towards HIV/AIDS epidemic could be improved?

Design of the Study

The instrument used to gather the data was a questionnaire having both open-ended and closed-ended questions. The research questions and hypotheses were generated from the literature review and after consulting those working with AIDS-related issues and those working among university students.

Summary of the Findings

General Response of Christian Students towards HIV/AIDS

RQ. 1 What is the response of Christian students towards HIV/AIDS epidemic?

H_0: 1 Generally, the response of Christian students towards HIV/AIDS epidemic is negative.

This hypothesis was rejected since the research revealed that a high majority (89.5%) of the Christian students had a high priority level for HIV/AIDS, thus recognising it as a critical issue in Kenya. Therefore, generally Christian students have a positive response towards HIV/AIDS epidemic.

Factors Affecting the Response of Christian Students Towards HIV/AIDS

RQ. 2 What are some of the factors that affect the response of Christian students towards HIV/AIDS epidemic?

To answer Research Question 2, five null hypotheses were generated and tested. The hypotheses and results are stated below.

H_0: 2 There will be no significant difference between male and female Christian students in their response towards HIV/AIDS epidemic.

This hypothesis was not rejected since the research revealed that a majority of both male and female Christian students had high HIV/AIDS priority level and HIV/ADS factual knowledge level. Furthermore, there was no difference in their involvement in HIV/AIDS awareness, caring for PLWHAs and having done an AIDS test. The gender of Christian students did not affect their response.

H_0: 3 There will be no significant difference between Christian students from urban Christian Unions and those from peri-urban Christian Unions in their response towards HIV/AIDS epidemic.

Overall, this hypothesis was rejected. The research showed that more Christian students from urban CUs exhibited a higher HIV/AIDS factual knowledge level, cared more for PLWHAs and had done the AIDS test, compared to those from peri-urban CUs. However, majority of Christian students from both urban CUs and peri-urban CUs had high level of HIV/AIDS priority and involvement in AIDS awareness activities. Therefore, the locality of the CU affected the response of Christian students towards HIV/AIDS.

H_0: 4 There will be no significant difference between Christian students with factual knowledge and those without factual knowledge about HIV/AIDS in their response towards HIV/AIDS epidemic.

This hypothesis was not rejected since the research revealed that the students' level of HIV/AIDS factual knowledge did not affect their HIV/AIDS priority level, HIV/AIDS factual knowledge level, involvement in AIDS awareness, care for PLWHAs and having done an AIDS test or not. HIV/AIDS factual knowledge level did not affect the response of Christian students towards HIV/AIDS.

H_0: 5 There will be no significant difference between Christian students who are personally involved and those who are not personally involved in HIV/AIDS awareness in their response towards HIV/AIDS epidemic.

This hypothesis was partly rejected since the research showed that Christian students who had been personally involved in AIDS awareness activities cared more for PLWHAs than students who had not been involved. Furthermore students from churches which organised AIDS awareness tended to be more involved in AIDS awareness compared to students who are from churches which did not organise AIDS awareness. However, the hypothesis was partly not rejected since there was no significant difference between Christian students who were involved in AIDS awareness and those who were not in relation to their HIV/AIDS priority level, HIV/AIDS factual knowledge and having done an AIDS test.

H_0: 6 There will be no significant difference between Christian students who interact and those who do not interact with people living with HIV/AIDS (PLWHAs) in their response towards HIV/AIDS epidemic.

Overall, this hypothesis was not rejected. No statistically significant difference was observed between Christian students who had interacted with PLWHAs and those who had not, in their response towards HIV/AIDS. However, it was seen that students who had cared for PLWHAs tended to be more involved in AIDS awareness than students who had not.

Improving the Response of Christian Students towards HIV/AIDS

RQ. 3 In what ways do Christian students think their response towards HIV/AIDS epidemic could be improved?

There was no hypothesis for this research question. The following were suggestions made by the students:

1. To improve the flow of correct HIV/AIDS information, a majority of the students proposed public talks on HIV/AIDS, the use of mass media, incorporating HIV/AIDS into the education curriculum, discussing AIDS issues in churches, organising HIV/AIDS seminars and inviting PLWHAs to share their experiences.
2. To improve AIDS awareness in CUs and churches, the students suggested HIV/AIDS seminars and workshops, use of video and film shows, having AIDS talks, AIDS awareness campaigns, open discussions about AIDS and inviting PLWHAs to share about AIDS.
3. To improve interaction with PLWHAs, the students suggested loving, encouraging and giving hope to PLWHAs, the need to avoid stigmatising PLWHAs, educating the public on basic HIV/AIDS facts, and the need to accept PLWHAs.
4. To improve the response of Christian students towards HIV/AIDS epidemic, the students suggested the need for AIDS education, interaction with PLWHAs, Christians accepting the reality of HIV/AIDS, participating in AIDS awareness activities, openly preaching and discussing HIV/AIDS issues in church, using audio visual channels to pass the HIV/AIDS message, accepting PLWHAs, teaching about abstinence and faithfulness in marriage, and change of attitude towards HIV/AIDS and PLWHAs.

Conclusions

1. Among the several issues facing Kenya, Christian students view HIV/AIDS as a highly critical issue in Kenya. This is an admission that the HIV/AIDS epidemic is real and needs urgent attention. Therefore, this offers a good starting point for AIDS educators.
2. From the fact that there was no significant difference between the response of male and female Christian students, it could be concluded that there is no bias in terms of exposure to HIV/AIDS information, involvement in AIDS awareness and interaction with PLWHAs.
3. It seems that Christian students from CUs in peri-urban locations have less access and exposure to HIV/AIDS information and involvement compared to those from CUs in urban location. This could be due to the fact that most organisations dealing with HIV/AIDS are concentrated in urban centres.
4. The amount of HIV/AIDS factual knowledge is not being translated into practical response towards HIV/AIDS. There will be those who will not respond even if they have all the information. It seems that a personal concern to address the HIV/AIDS epidemic is very crucial. Therefore factual knowledge should not be seen as the panacea for the fight against HIV/AIDS.
5. The research showed that involvement in AIDS awareness positively influenced the students towards further involvement with PLWHAs. Therefore more students should be encouraged to be involved and this could be achieved by helping the students identify opportunities for AIDS awareness involvement.
6. Christian students from churches which organised AIDS awareness activities were more likely to be involved in AIDS awareness than those from churches which did not. Therefore, more churches should be encouraged to have AIDS awareness activities.
7. Many students indicated that they had not interacted with PLWHAs because they did not know any PLWHAs. Either the students had not gone out of their way to identify and reach out to PLWHAs with a *helping hand* rather than a *closed fist*, or a number of PLWHAs have not publicly declared their status, most likely because they fear the response they would get – stigmatisation, denial and rejection.

8. A number of Christian students who had cared for PLWHAs indicated that they were afraid and overwhelmed. These are issues that AIDS educators need to address so that students can get involved with PLWHAs without fear or sense of inadequacy.
9. The very helpful suggestions on how to improve the students' response towards HIV/AIDS are positive indication of their willingness to see a change in the way students have responded to HIV/AIDS. The researcher hopes that if some of these ways can be adopted, then there will be a more active input from Christian students towards HIV/AIDS eradication. Their strategic placement in the universities is very key and therefore their role as models and pace-setters will help disseminate correct information and better reach this high-risk group.

Recommendations

From the foregoing conclusions, the researcher made the following recommendations to improve the response of Christian students towards HIV/AIDS.

First, the researcher expected that students who had a higher level of factual knowledge would have a better response towards HIV/AIDS compared to those with low factual knowledge. However, this was not the case. Therefore, there is need to find out why the level of factual knowledge a student has does not seem to affect their response. In addition, the HIV/AIDS educators should seek to empower the students with more than head knowledge, the sort that translates into change of behaviour, thus affecting the heart and the individual holistically.

Secondly, despite there being no difference between female and male Christian students in their response, it is important to note that female students on campus are more vulnerable (i.e. from rapes during the frequent riots, pressure to offer sex for money, etc.) than their male counterparts. Therefore AIDS educators need to help female students develop survival tactics against these vulnerabilities.

Thirdly, it was striking that only a few students knew of fellow students who are living with HIV/AIDS. The researcher expected that there would be more students who are living with HIV/AIDS than the 4 CU members and approximately 100 non-CU members living with AIDS who were known by the respondents. Christian students should therefore be helped to avoid stigmatising PLWHAs and to accept them as all other persons. This could be done by inviting PLWHAs to share their experiences and encouraging students living with HIV/AIDS to be known and cared for. Students living with AIDS

should also be encouraged to declare their status as this would help the other students fully recognise that HIV/AIDS is real and a major issue on campus.

A fourth striking observation was that most of the students were uncertain whether HIV/AIDS is God's judgement or a creation of the West. The researcher recommends the need for HIV/AIDS educators to address this specifically. This will help eradicate some of the misconceptions students have concerning the reality of HIV/AIDS.

A fifth issue is the finding that Christian students from urban CUs had a better response towards HIV/AIDS compared to those from peri-urban CUs. It is therefore recommended that organisations working on HIV/AIDS should target peri-urban areas even if they are mostly based in the urban centres.

Finally, the use of mass media (television, radio, magazines and posters) and audio-visuals (videos and films) as a means of disseminating HIV/AIDS information among students should be encouraged. This is because students are very much into the media. These videos and articles should feature real testimonies of PLWHAs whom the students can identify with. The researcher recommends that the videos be more Kenyan instead of the predominantly Western and non-Kenyan videos currently in the market. This would help the students realise how critical the situation is and also be able to see the situation in Kenya and not view HIV/AIDS as a creation of the West.

Areas for Further Research

The researcher recommends that further research be done to establish clearly some of the reasons why the Christian students do not seem to fully translate factual information into concrete response actions.

The researcher would have expected more students to have done AIDS test than was actually the case. A number of students said they were confident about themselves and therefore did not see the need for a test. Further research could be done to establish why the students do not consider an AIDS test necessary.

A number of students who had cared for PLWHAs indicated that they struggled with fear and being overwhelmed. Further research could be done to establish exactly what are the fears. This would point further to what areas need to be addressed in HIV/AIDS education.

A study should be done among students who are living with AIDS to get their views on the HIV/AIDS epidemic. This could cover such areas as how they contracted HIV/AIDS, the attitude and

response of Christian students towards them, and ideas on how to fight respond towards HIV/AIDS. Such a research will serve to complement this one to give an overall understanding of the state of HIV/AIDS in the public universities and the role of Christian students in the fight against HIV/AIDS.

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APPENDIX A:

Questionnaire for Christian Students

Introduction

This is a research meant to enable the researcher to establish some of the factors that affect the response of Christian students towards HIV/AIDS epidemic. The aim of the researcher is to get information that will serve as a resource material to AIDS education curriculum developers and those working among university Christian students.

You have been chosen to fill this questionnaire through random sampling; in other words, there was no biased or suspicious methods used. There are over one hundred students from other universities in Kenya who are participating in this research.

Please kindly fill this questionnaire as honestly as possible. Use a tick [√] or supply needed information as appropriate. For the sake of confidentiality, do not write your name on this questionnaire.

Part One: General Information

1) Age: ______________________

2) Gender: [ ] F [ ] M (Tick [√] one)

3) Marital status: [ ] Married [ ] Single Other (specify)____________

4) Degree of study: ________________________________ (Specify)

5) Year of study : [ ] 1st [ ] 2nd [ ] 3rd [ ] 4th Other (specify)_____

6) How long have you been a Christian? (Tick [√] appropriately)

Less than one year	[ ]	6 - 10 years	[ ]
1 - 3 years	[ ]	10 - 20 years	[ ]
3 - 5 years	[ ]	Over 20 years	[ ]

Part Two: Cognitive Response towards HIV/AIDS

7. The following are some issues facing our society. Please rank the issues from the one you consider most critical (1) to the least critical (8).

Drug abuse	_____
Abortion	_____
Corruption	_____
HIV/AIDS	_____
Unemployment	_____
Unrest in schools and colleges	_____
Street children	_____
Poverty	_____

Part Three: Factual information about HIV/AIDS

8. When did you first hear about AIDS? _________ (indicate year)

9. What does HIV/AIDS stand for?

____

____

____

10. How is AIDS transmitted? (Please tick [√] as many as you think are correct)

Sex	[ ]
Breast feeding	[ ]
Sharing utensils	[ ]
Mosquito bites	[ ]
Sneezing	[ ]
Kissing	[ ]
Blood contact	[ ]
Sharing a room with an infected person	[ ]
Coughing	[ ]

11. Indicate (tick [√]) your reaction to each of following statements about HIV/AIDS.

	Strongly agree	Agree	Not sure	Disagree	Strongly Disagree
AIDS is not real					
AIDS is a myth					
AIDS is a punishment from God					
AIDS is a creation of the West					
Only immoral people contract AIDS					
Christians should not talk about AIDS and sexual issues					
Christians cannot get AIDS					

12. Suggest ways in which the flow of correct HIV/AIDS information could be improved?

____
____
____

Part Four: AIDS Awareness

13. Has your Christian Union and the church you regularly attend organised any AIDS awareness activities?

	Yes	No
Christian Union	[ ]	[ ]
Church	[ ]	[ ]

If Yes, what activities? (Tick [√] as many as are appropriate)

Activity	**Christian Union**	**Church**
AIDS Talk	[ ]	[ ]
Video show about AIDS	[ ]	[ ]
Visiting people living with AIDS	[ ]	[ ]
Presentation by a person living with AIDS	[ ]	[ ]
AIDS Seminar	[ ]	[ ]
Others (specify)		

14. Have you personally been involved in AIDS awareness? [ ]Yes [ ] No

If Yes, how?
____
____

If No, why? ______________________________________
____
____

15. How could the Christian Union and the church improve the AIDS awareness activities?

____
____
____
____

Part Five: Interaction with people living with HIV/AIDS

16. Do you know any student(s) who are living with HIV/AIDS?

	Yes	No
Christian Union member	[ ]	[ ]
Non-Christian Union member	[ ]	[ ]

If Yes, how many do you know? (do not indicate name of the person.)

_____ Christian Union members

_____ Non-Christian Union members

17. Have you ever cared for or visited someone living with HIV/AIDS?

[ ] Yes [ ] No

If yes, what was your initial reaction towards the person? (Tick as many as are appropriate)

Afraid	[ ]
Prayed for the person	[ ]
Befriended the person	[ ]
Cared for the person	[ ]
Overwhelmed	[ ]
Not bothered	[ ]
Other (specify)	

18. Have you ever done an HIV blood test? [ ]Yes [ ] No

If Yes, what was your status? [ ]Negative [ ] Positive

If No, why? ____
____
____

19. How could interaction with people living with HIV/AIDS be improved?

____
____
____
____

Part Six: Response to HIV/AIDS

20. To what extent would you consider the following factors as having negatively affected your response to the HIV/AIDS epidemic?

	Very great extent	Great extent	Small extent	Very small extent	Not at all
Lack of HIV/AIDS information					
Lack of HIV/AIDS awareness activities					
Lack of interaction with people living with HIV/AIDS					

21. What other factors do you think affect your response towards HIV/AIDS epidemic?
Positively: ____

____

____

____

Negatively: ____

____

____

____

22. Suggest possible ways of improving the response of Christians to the HIV/AIDS epidemic?

____

____

____

Any other comments.

____

____

____

Thank you very much for answering all the questions.

Mrs. Roseline Olumbe
Nairobi Evangelical Graduate School of Theology (NEGST)

APPENDIX B:

Letters of Permission for Research Work

NAIROBI EVANGELICAL GRADUATE SCHOOL OF THEOL

P.O. Box 24686, NAIROBI, KENYA
A Project of the Association of Evangelicals in Africa (AEA)

TEL : 254-2-882104/5
FAX : 254-2
E-Mail : NEGST@

18th Feb., 2002

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: RESEARCH WORK

The bearer of this letter, Mrs. Roseline Olumbe is a student at Nairobi Evangelical Graduate School of Theology and is doing research towards the completion of the Master of Arts in Christian Education programme. The research is on **"Factors Affecting the Response of Christian Students Towards HIV/AIDS Epidemic in Selected Kenyan Public Universities"**.

Any assistance that you can give to Mrs. Olumbe will be much appreciated.

Sincerely,

Victor B. Cole
Deputy Vice-Chancellor for Academic Affairs

VBC/mo.

FELLOWSHIP OF CHRISTIAN UNIONS (FOCUS)

FOCUS Student Centre, Kasarani Road (Next to Kasarani DO's Office)
P. O. Box 781 Ruaraka 00618, Kenya. Tel: 862022. Fax: 862037.
E-Mail: focus@focusctr.or.ke Web site: http://www.focusctr.or.ke/

Tuesday, 26 February 2002

Chairmen
Christian Unions
Colleges/Campuses in Kenya

Dear Brethren:

RECOMMENDATION FOR MRS ROSELINE OLUMBE

I am writing to introduce to you Mrs Roseline Olumbe who is currently a student at Nairobi Evangelical Graduate School of Theology and a former (1997/98) FOCUS STEM staff at Chepkoilel Campus of Moi University.

Roseline has shared with me her concern on the spread of AIDS/HIV in Kenya. As a student at NEGST, Roseline is doing research work towards the completion of Master of Arts degree in Christian Education. The research is on '**FACTORS AFFECTING RESPONSE OF CHRISTIAN STUDENTS TOWARDS HIV/AIDS EPIDEMIC IN SELECTED KENYAN PUBLIC UNIVERSITIES**'.

The results of her studies will greatly enhance our efforts in trying to combat this disease in our midst.

Please accord her all the assistance you can give.

Yours faithfully in Christ

Dr Timothy Wachira
GENERAL SECRETARY

VITA

PERSONAL DATA

Name:	Roseline Shimuli Olumbe
Date of Birth:	1st September 1974
Gender:	Female
Marital Status:	Married
Nationality:	Kenyan

EDUCATIONAL BACKGROUND

NEGST	Master of Arts in Christian Education	2000 – 2002
All Nations Christian College	Certificate in Biblical and Cross Cultural Studies	1998 – 1999
Moi University	Bachelor of Education (Arts)	1993 – 1997
Lugari Secondary School	Kenya Certificate of Secondary Education (KCSE)	1986 – 1990

PROFESSIONAL EXPERIENCE

Secretary – Counselling Committee	Karen Community Church	2002
First Aid Trainer	St. John Ambulance (Kakamega)	1999 – 2000
Campus Staff	Fellowship of Christian Unions (FOCUS)	1997 – 1998
Teacher	Kimilili Boys High School	1997
Secretary – Christian Union	Moi University	1996 – 1997
Teacher	Shieywe Secondary School	1995