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Correlates of Health Choices in View of Emerging Lifestyle Diseases Among Seventh-day Adventist Church Members in Eldoret West, Kenya

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CORRELATES OF HEALTH CHOICES IN VIEW OF EMERGING LIFESTYLE DISEASES AMONG SEVENTH-DAY ADVENTIST CHURCH MEMBERS IN ELDORET WEST, KENYA

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ABSTRACT

The study determined the relationship between SDA church members' health choices and their demographics, attitudes towards the Adventist health message, cultural beliefs on health, and knowledge of lifestyle diseases. Attitudes towards the Adventist health message, educational level, and monthly income emerged to have a significant relationship with health choices.

Keywords: Health choices, attitudes towards the Adventist health message, knowledge of lifestyle diseases, cultural beliefs on health, Kenya

Introduction

Noncommunicable or lifestyle diseases are the leading causes of death globally, 80% of these deaths occurring in low- and middle-income countries. These diseases are rising rapidly in African nations and it is projected that these will be the most common causes of death by 2030 (WHO, 2011). There is a surge of lifestyle diseases in Kenya, with a worrying number of cases being reported among younger people (Broadway, 2016).

The risk factors of lifestyle diseases are the pervasive aspects of economic transition, rapid urbanization, and 21st century lifestyles, which are modifiable behaviors such as use of tobacco and alcohol, physical inactivity, and unhealthy diet (WHO, 2018). The head of the division of noncommunicable diseases of the Ministry of Health in Kenya emphasized that lifestyle changes are the cornerstone of prevention and treatment of lifestyle diseases (Mugo,

2017). An effective health strategy is an individual's responsibility to work towards a healthy lifestyle, which involves choices about diet, exercise, use of harmful substances, among others.

The Seventh-day Adventist (SDA) church recognizes that God created man a free moral agent, to think and to act according to his enlightened conscience. The church teaches that the choice of healthy lifestyle is an offering acceptable to God's service (Secretariat, General Conference of SDA Church, 2016).

There is a limited number of studies regarding the health and lifestyle of SDA church members in developing countries. Although the church promotes a healthy lifestyle, little is known about the church members' knowledge on the Adventist health message and how knowledge and attitude influence lifestyle practices (Galvez et al., 2020).

Research Objectives

This study has two objectives:

1. To determine SDA church members' health choices, knowledge of risk factors of lifestyle diseases, knowledge of preventive measures of lifestyle diseases, cultural beliefs on health, and attitudes towards the Adventist health message.
2. To ascertain the association between church members' health choices and demographics (age, education level, monthly income, and years of church membership), knowledge of risk factors of lifestyle diseases, knowledge of preventive measures of lifestyle diseases, cultural beliefs on health, and attitudes towards the Adventist health message.

Research Methodology

Research Design

This cross-sectional study employed descriptive-correlational research design to describe the variables under investigation and determine the association between these variables.

Sampling

The stratified random sampling technique was used to identify the participating churches based on location. In Eldoret West station of the Greater Rift Valley Conference of the SDA Church, there are 126 churches, 7 churches are located in the urban areas, 8 churches are in semi-urban areas, and 111 churches are in rural areas. It was decided that a total of 13 churches (10% of the total number of churches) be involved in the study. One church each was randomly selected from the churches located in urban and semi-urban areas. Eleven churches were systematically selected from the list of churches located in the rural areas.

Inclusion Criteria

The study involved baptized members of the church aged 18 years and older who were available during data collection and willing to participate.

Sample Size

There were 237 members from the 13 churches who met the inclusion criteria.

Research Instrument

The main instrument used for data collection was a self-administered researcher-constructed questionnaire with 6 sections:

A. Demographic Profile of the Respondents

B. Health Choices

C. Knowledge of Risk Factors of Lifestyle Diseases

D. Knowledge of Preventive Measures of Lifestyle Diseases

E. Cultural Beliefs on Health

F. Attitudes towards the Adventist Health Message

Content Validity

The content validity of the questionnaire was ensured through proper conceptualization and operationalization of the study variables from review of literature and through expert validation of the research supervisors and nursing lecturers.

Reliability

To establish the reliability of the questionnaire, a pilot study was done in 3 churches in Eldoret, which are not part of the study. The data from the pilot study was used to obtain the Cronbach's alpha reliability coefficients of the five sub-scales of the questionnaire, which range from .708 to .800. The questionnaire is both valid and reliable, thus psychometrically sound to measure the variables being studies.

Data-gathering Procedures.

The research proposal was submitted to the Ethics Review Board of the University of Eastern Africa, Baraton for clearance. The Director of Graduate Studies and Research of UEAB endorsed the ethically approved proposal to the National Commission for Science, Technology, and Innovation of Kenya for issuance of a research permit. The researcher sought audience with the administrative board of the Greater Rift Valley Conference of the Seventh-day Adventist Church to clarify the purpose of the study and seek authorization. The executive secretary of GRVC wrote a letter of authorization, which enabled the researcher to approach the station pastors and church elders to set a schedule to gather data from the members of the selected

churches. The questionnaires were administered to church members, 18 years and older who were willing to participate in the study, during a forum on a scheduled Sabbath afternoon.

Description of Research Participants

Of the 237 church members who participated in the study, 60% are males and 40% are females. Majority (71%) are married, 25% are single, and 4% are divorced/separated. All age groups were represented: 34% are aged 18 to 30 years old, 20% are between 31 to 42 years old, and 46% are 43 years old and older.

Most of the research participants (64%) earn a monthly income of less than KSh 5,000 (approximately US$50), 25% earn between KSh 5,000 to 25,000 monthly, and only 11% earn higher than KSh 25,000 a month.

25% of the participants have secondary level education or lower, 51% have college education, and 24% have university or post-graduate education. 56% of the participants had been members of the church for over 20 years, 29% for 11 to 20 years, and 15% had been church members for 10 years or less.

Results

Health Choices

The questionnaire measured the health practices of church members on a scale of 1 (never) to 5 (all the time). The health choices comprise practices related to water intake, exercise, sleep, sunlight, diet, air, temperance, and regular medical check-ups. The overall mean for health choices is 3.30, which is interpreted as good. The mean ranges of 88% of the respondents lie between categories of good and very good.

- Specifically, the practice that almost all of the participants (86%) do all the time or usually do is “ensuring that their house and rooms are well-ventilated with open window during the day.
- Generally, intentional exercise and taking morning sunlight are sometimes practiced.
- On average, the research participants usually sleep to a maximum of 7 to 8 hours a day and do things in life in moderation.
- Moreover, drinking at least 8 glasses of water a day is also sometimes practiced and this is complicated by the fact that only 37% of the respondents avoid taking tea leaves and coffee beverages even if they know that these can be harmful to health.
- They also usually try to eat a balanced diet although eating between meals is practiced by 33% of the participants and 23% have issues in controlling their dietary intake of sugar, salt, and fat.
- Only 11% go for regular medical check-ups with 42% not doing so at all.

Knowledge of Risk Factors and Preventive Measures of Lifestyle Diseases

In general, 70% of the research participants know the risk factors of lifestyle diseases and 81% have knowledge of their preventive measures.

- More than three-quarters were able to identify correctly the risk factors and preventive measures of hypertension and depression.
- 71% know both the risk factors and prevention of cancer.
- 85% know the preventive measures of obesity but only 62% know its risk factors.
- Similarly, more respondents know the preventive measures of diabetes and heart diseases (83%) than those who know their risk factors, 68% and 70%, respectively.

Cultural Beliefs on Health

The influence of culture on health is vast. It affects perceptions of health, illness and death, beliefs about causes of disease, approaches to health promotion, how illness and pain are experienced and expressed, where patients seek help, and the types of treatment patients prefer. Literature suggests that Africans, Kenyans in particular, have many cultural beliefs that affect their health security (Rashed & Hussien, 2015).

The questionnaire measured the degree of agreement or disagreement of church members to cultural beliefs on health on a scale of 1 to 4. With a mean of 1.87 and a standard deviation of .501, the respondents generally disagreed to the cultural beliefs comprising the causes and prevention of lifestyle diseases. Only 13% are on the agreement side.

- It is interesting to note that more or less than 15% of the respondents are in agreement to the beliefs that lifestyle diseases are associated with the way elders are treated, that they are inherited such that it is a waste of time and money treating or preventing them, and that they are due to failure to pray.
- 21% believe that it is a shame to suffer from lifestyle diseases so no one should know about it.
- 23% of the participants believe that prayer is the only way through which illnesses can be healed and 22% believe that the traditional herbs they inherited from their parents are the best form of medication.
- 21% agree that it is better to give milk when someone asks for water with 16% believing that sugarless drink at home is a sign of lack of money.

Attitude Towards the Adventist Health Message.

On average, the research participants have moderately positive attitude towards the Adventist health message, with 80% on the positive continuum.

Correlations

Health choices were found to be significantly and directly related to attitudes towards Adventist health message (r = .179), monthly income (r = .172). This implies that church members who have positive attitude towards the Adventist health message and have higher income tend to have positive health choices. However, the significant relationship with education level (r = -.254) is inverse, which means that church members with higher level of education tend to have poorer health choices. This is surprising. It should be noted, though, that time constraints prevent individuals from adopting healthy choices, which is common among educated people. Although it is expected that people who are educated and knowledgeable about healthy practices are more likely to opt for healthy choices, it still depends on whether the individual is able to apply their knowledge (Pheasant, 2008).

Regression

Multiple regression analysis was used to test if the independent variables studied significantly predict church members' health choices. Educational level, income, and attitude towards the Adventist health message entered the regression and these account for 11.4% of the variance in individual health choices. 5.2% is accounted for by educational level, 3.6% by income, and 2.6% by attitude towards the Adventist health message. The F-value is 9.908 showing that the regression model is significant at p-value less than .001.

Conclusions

From the findings of the study, the following conclusions were drawn:

1. The health choices of majority of the SDA church members in Eldoret West, Kenya range from good to very good.
2. Majority of the church members know the risk factors (70%) and preventive measures (81%) of lifestyle diseases.
3. Most SDA church members do not accept the cultural beliefs on health.
4. Church members who have positive attitudes towards the Adventist health message tend to have good health choices.
5. Church members with lower educational level and those with higher income have better health choices than their counterparts.
6. Educational level, income, and attitudes towards the Adventist health message are significant predictors of health choices accounting for 11.4% of the variance in individual health choices.

Recommendations

The health ministries department of the church needs to…

1. continue its education and promotion of Adventist health message for the purpose of encouraging church members to adopt positive health choices.
2. conduct seminars on risk factors of lifestyle diseases, particularly of obesity, for church members.

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