FACTORS INFLUENCING THE ADOPTION PROCESS IN AN EMPLOYER DRIVEN HIV/AIDS SOCIAL MARKETING CAMPAIGN: A CASE STUDY OF INTERNATIONAL COMMITTEE OF THE RED CROSS

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DECLARATION

I, the undersigned, declare that this project is my original work and has not been submitted at any college, institution or university other than the University of Nairobi for Academic purposes.

Signed..... Date.....27/10/2005.....

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This research project has been submitted for examination with my approval as the University Supervisor.

Signed..... Date.....28-10-05.....

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ABSTRACT

HIV/AIDS is today acknowledged as a global health problem. Many organisations today acknowledge the challenge posed by the pandemic to their profitability and to the productivity of their employees. In response, many organisations have put in place policies to reduce the impact of the threat that HIV/AIDS poses. In ICRC, the organisation has adopted the use of social marketing campaigns to promote behaviour change and to encourage people to speak openly about HIV/AIDS. It was considered important to conduct a study to determine the factors that influence the adoption rate among the employees of ICRC. The objectives of the research were to establish the adopter categories of ICRC employees, determine the relative factors that influence adoption in an employer driven HIV/AIDS campaign among employees in ICRC and establish whether these factors vary according to the hierarchical level and geographical location of the employees.

This was a survey research which sampled a total of 125 employees of International Committee of the Red Cross (ICRC). They were selected from the staff records using stratified random sampling. A semi structured questionnaire was used whereby 47 staff members completed the questionnaire. Data was analyzed using mean scores, standard deviation and percentages.

It was concluded that promotion, price and information were the main influencers of adoption of new behaviors. These were followed closely by product, place and motivation. Culture was found to have the least influence. The staff indicated varying extents to which various measures influence the adoption of new behaviors. Most of the variables had high standard deviations indicating notable variations across groups. The findings indicate that that several factors influence behavior change to a large extent. These include:- benefits of new behavior, HIV/AIDS workshops, anticipated feelings of pride and joy from new behavior, increased understanding of the dangers of current behaviour, lunch time talk shows, video-shows, fear of death and educational pamphlets.

It can also be concluded that while the factors vary with hierarchical level and geographical location of staff. The variation was not significant. Of the two hierarchical level was found to be more of a discriminator than location. Most of the challenges were related to staff resistance to change, peer educators competence-dishonesty, educators lack role awareness, lack of resources and lack of support from expatriate staff.

It was recommended that ICRC should increase the level of promotion element to create awareness on the need to change. Staff segmentation in the social marketing was recommended to be more effective in targeting. Peer educators need to be educated on the need to be educated to show empathy to staff. The researcher suggested future research on measure effectiveness and impact of promotions, track actual behaviour and experimental research to find out the best approaches. Research covering expatriate employees and qualitative research were also recommended.

CHAPTER ONE
INTRODUCTION

1.1 Background

According to (OECD, 2000), poverty is a major concern of governments all over the world and countless poverty-alleviation programmes and campaigns have been developed over time and across regions. Yet poverty continues to be a key impediment to human development and economic progress. About half of Kenya's population was below poverty line in 1992, a proportion that was unchanged since 1982 (World Bank, 1995). Kenya's gross domestic product attained a growth rate of -0.3% in 2000 down from 1.4% in 1999 (Kippra, 2000). This implies that per capita growth continued to fall and poverty must have risen during that period. The slow down in activity was reflected in most key sectors of the economy and was attributed to drought, poor infrastructure, inefficient telecommunications services, mismanagement of farmers' institutions, insecurity in the country and decline in agricultural growth (Kippra, 2002).

Access to health care has long been considered as pivotal in helping people acquire core capabilities that permit them to escape poverty. Public health institutions in Kenya are characterized by long queues of patients and are generally inaccessible to the poor. Access to health services by the poor – meaning availability, affordability and physical accessibility of drugs and consultation services – has been limited owing to factors ranging from cost sharing to long distances to health facilities (Kippra, 2002).

Since Independence, one of the principal goals of Kenya's development effort has been to reduce poverty. The government has pursued this through various development strategies emphasizing economic growth, employment creation and provision of basic social services (Kippra, 2002). HIV/AIDS has compounded the poverty problem further. The overriding poverty related HIV/AIDS concerns are the AIDS orphans, population size and growth, cost of health care and child mortality. This is likely to create a huge strain on the coping ability of the social system of the poor, in addition to the burden at the extended family level (GoK, 1994).

Current estimates show that more than two million Kenyans are infected with HIV/AIDS (UNAIDS, 2000). If the current trend continues, HIV/AIDS will have a devastating effect on the structural and long term performance of the economy. This challenge requires an effective partnership involving the government, the private sector, communities, non governmental organisations, donors and the international community. There is need for HIV/AIDS policy and programmes to intensify educational campaigns to increase awareness of the disease and the importance of preventive measures (Kippra, 2002).

1.1.1 HIV/AIDS in the work place

HIV/AIDS was first reported in San Francisco, Los Angeles and New York in late 1980 and early 1981 where a rare pattern of illnesses started to be evident among homosexual men (Schilts, 1988). The illnesses included chest infection, a rare skin cancer, pneumonia, and Meningitis. Tests performed on these patients revealed that their immune systems were greatly weakened. Doctors could not identify the cause of the weakened immune system of homosexual men presenting these symptoms. As the initial cases were among homosexual men and it was initially given the name Gay Related Immune Deficiency. Later researchers began to see similar symptoms among other non-gay population groups. That realization heralded in earnest the search for the culprit pathogen, later identified as a retro-virus we now know as Human Immune-deficiency Syndrome or AIDS (Wader, 1987). The identification of HIV as the causal factor of the noticed immune deficiency led to perfection of a blood test, ELISA (Wader, 1987), that helped in the categorisation of the global spread of the virus (Bartlett, 1993).

In Africa, HIV/AIDS was first diagnosed in the Central African Congo Republic. This quickly spread to Tanzania and Uganda following wars, civil strife and guerrilla activities (Muraah and Kiarie, 2001). The first case of AIDS in Kenya was reported in September 1984 in the East African Medical Journal. This was a 34 year old Ugandan journalist who had died in May 1994 at Kenyatta National Hospital with all the signs and symptoms of AIDS (Obel, 1984).

HIV/AIDS is today acknowledged as a global health problem. It is estimated that between 34 and 46 million people are now living with HIV/AIDS with 4.2 to 5.8 million

new infections and 2.5 to 3.5 million AIDS deaths in 2003 (UNAIDS, 2003). Over two thirds of the total infections are in sub Saharan Africa. The long run economic costs of AIDS are almost certain to much higher than studies have estimated and possibly devastating. In parts of Africa, if effective action is not taken to combat the spread of the epidemic, HIV/AIDS could result in "economic collapse" (UNAIDS, 2003).

In Kenya, approximately 2.1 million people are living with HIV (UNAIDS, 2000). This is approximately 14% of the people between 15 and 49 years and 7% of the entire population of 28.8 million. With less than 0.5% of the global population, Kenya has 6% of the world's HIV positive people (Muraah, 2001). By the end of 2001, Kenya had about 2.5 million people living with AIDS, 890,000 children orphaned by AIDS and an adult prevalence rate of 15% (UNAIDS, 2001), It is estimated that by 2005 Kenya will have lost 15% GDP to the scourge (UNAIDS, 2002).

The HIV/AIDS pandemic poses one of the greatest challenges to business development in Africa. HIV related absenteeism, loss of productivity and the cost of replacing workers lost to AIDS threaten the survival of a number of businesses in the increasingly competitive world market. The ILO (2001) estimates that the labour force in over 30 countries will be 10-35% smaller by 2020 than it would have been without AIDS. Employers are losing skilled, experienced workers. Recruitment and retraining costs are soaring at the same time as insurance payments and health benefits (ILO, 2001). In high prevalence countries, individual business operations have established a direct link between HIV/AIDS, declining productivity, rising production costs and declining profits. A USAID funded study of a transport company in Zimbabwe in 1998 estimated that the total cost to the company arising from HIV/AIDS was equal to 20% profits. In this case, over half the costs incurred were due to higher health related costs (UNAIDS, 2002).

With the rising prevalence of HIV/AIDS, businesses are increasingly concerned about the impact of the disease on their organisations. HIV/AIDS affects the cost of doing business by increasing costs of health, life and safety insurance; shortening the period of retirement savings; increasing the cost of providing medical care and health benefits; increasing costs of recruitment, training and retraining of staff.

Organisations record reduced productivity due to increased absenteeism, staff turnover, declining morale, loss of technical skills and experience (Rau, 2002).

In cases where companies provide health care, the costs of this service increases significantly with rising HIV/AIDS rates. A UNAIDS study carried out in 2000 of a commercial agro-estate in Kenya showed that medical expenditure as a result of AIDS rose to over 400% above that of projected expenditure without AIDS. Considerable costs are also incurred by businesses in meeting funeral costs of employees. The increased funeral costs are largely as a result of the high mortality due to HIV/AIDS (UNAIDS, 2002).

Early investments in education and prevention campaigns can considerably help reduce the spread of the epidemic among workers, their families and surrounding communities. Health care provision, such as treatment of sexually transmitted infections can reduce the infection rates. Provision of Anti retroviral therapy, though costly, can help prolong the lives of employees hence provide long-term benefits to the company. Not responding at all may result in related costs increasing exponentially (UNAIDS, 2002).

1.1.2 Employer driven social marketing campaigns

Kotler et al (2002) defined social marketing as the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify or abandon a behaviour for the benefit of individuals, groups or society as a whole. According to Savitz and Unmble (2002), social marketing offers employers an effective approach to maintaining a healthy workforce and reducing long-term health care expenditures. The goal of social marketing is to increase awareness of health risks, diagnostic capabilities, available treatments, safe practices and behaviours or improved health status in order to elicit a desired behaviour change. Employers often choose to couple social marketing campaigns with supportive human resource policies. They may offer financial incentives to adopt healthy behaviours such as reduced health premiums. They may also provide prizes to employees with exemplary safety records as they comply with occupational health and safety standards.

An example is General Motors (USA), which has implemented 'lifesteps' a comprehensive wellness program for all employees, retirees and dependants coping with diabetes. The national program raises awareness and educates employees through booklets, health risk appraisals, news letters, a toll-free personal health advisor line and a web-site (Savitz and Umble, 2002).

One of the ways in which an organisation may positively promote behaviour change is by practising social marketing. Social marketing campaigns have been used to promote behaviour change all over the world. In the US for example, the Kansas Health Foundation used social marketing to create an environment that puts children first, so they can grow up to be caring, contributing, thoughtful, tolerant and healthy adults. It was dubbed 'Take it outside campaign' (Kansas Health Foundation, 2003). The Henry Kaiser Family Foundation started a "Know HIV/ AIDS" campaign with the purpose of using the power of media to educate and compel people to act – to protect themselves and to get tested for the HIV virus (Viacom and Kaiser Family foundation, 2003) . In Australia, social marketing campaigns have been used to encourage a smoking free environment in the prisons (Stevens, Greene and Primavera: 1982). These campaigns have been effective in encouraging behaviour change.

For social marketing campaigns to be more effective there is need for the change agents to understand the behaviour of the target adopters so that appropriate marketing mixes can be designed. Given that several factors would influence ones ability to adopt an innovation or a new behaviour, it would be important for an organization to first and foremost identify the factors that influence the adoption process among the target group. To succeed in marketing social ideas and practices, requires being able to predict how the target adopters will behave. Prediction requires knowing the processes that guide and determine the behaviour of target adopters (Kotler and Roberto, 1989).

1.1.3 Background of the International Committee of the Red Cross (ICRC)

The International Committee of the Red Cross (ICRC) is an International Humanitarian organisation whose mission is to help all victims of war and internal

armed violence. The ICRC was founded in 1863 as the International Committee for Relief to the wounded and later became the International Committee of the Red Cross (ICRC). The idea began with a Swiss Business man, Henry Dunant, after witnessing the sufferings of those wounded in armed conflict during the battle of Solferino in 1954, in Northern Italy. With its Headquarters in Geneva Switzerland, ICRC has 53 Delegations all over the world (ICRC, 1996).

In Kenya the ICRC opened the offices in 1974 to cater for the Great Lakes region. This includes Uganda, Somalia, Djibouti, Rwanda, Burundi and the Congo. Since then the organisation has grown and currently has a workforce of 351 staff in Nairobi and 430 staff in Lokichoggio. ICRC Nairobi is the second largest office for the ICRC after the headquarters in Geneva. ICRC's work in the region mainly involves transporting food, medicine and other supplies to the affected areas and populations, providing water and sanitation in conflict areas, training the police and military on International Humanitarian Law and the Geneva Conventions and providing support to other offices in Africa.

ICRC began to realise the need to put in place a HIV policy in 1997. At this time the organisation had lost 8 employees to HIV/AIDS in a period of two years, medical costs for employees seeking treatment for opportunistic illnesses were very high with an average of two admissions a month. The funeral costs, high medical costs, and absenteeism coupled with recruitment costs, training costs and loss of trained employees awakened the organisation to the seriousness of the impact of HIV/AIDS in the work place. In 2000, Medical check ups carried out on a group of fifty truck drivers who were going to work in the Middle East on short missions revealed that almost 50% of those tested were HIV positive. Although the organisation realised that truck drivers were a high risk group, the organisation realised that HIV/AIDS was an external threat to the organisation which needed to be addressed urgently if the organisation was to continue to achieve desired outcomes in terms of productivity.

The ICRC implemented a HIV/AIDS workplace policy in 2003. Prior to this there was no clear effort on the organisations part to tackle the HIV/AIDS problem. ICRC also realised that producing a policy document was not enough to achieve behaviour change, reduce infection rates and better quality life for those already infected. In

addition to the policy paper it was necessary to come up with a strategy on how the HIV/AIDS problem would be tackled in order to achieve the desired outcomes.

In 2003, a campaign dubbed Maisha^{+} to signify positive living was launched. The program borrowed heavily from social marketing in the approach toward 'selling' the idea and encouraging behaviour change. It encompasses Voluntary Counselling and Testing with incentives to encourage the staff, pre and post test counselling, Anti Retroviral medication, regular check ups, condom distribution, Nutritional counselling, continuous communication through posters, videos, talk shows, literature, workshops, peer education. Further, staff are assured that their jobs will not be at risk because they are ailing, instead the organisation is willing to adjust their work schedules and allow them time off when they need to seek constant medical attention. This facility is extended to the dependants.

1.2 Statement of the problem

Many organisations today acknowledge the challenge posed by the HIV/AIDS pandemic to their profitability and to the productivity of their employees. In response, many organisations have put in place policies to reduce the impact of the threat that HIV/AIDS poses. In ICRC, the organisation has adopted the use of social marketing campaigns to promote behaviour change and to encourage people to speak openly about HIV/AIDS. Despite these campaigns there has been a mixed response. Although some employees have responded positively, some are still reluctant while others are taking up the idea slowly. This is evident through medical records that show that less than 20 employees have so far come forward to seek for assistance.

Studies on HIV/AIDS by Waita (2003) and Muraah (2003) mainly focussed on the strategic response of large private manufacturing companies and pharmaceutical companies to the HIV/AIDS pandemic in Nairobi respectively. Murambi (2001) studied Human Resource policy responses to the HIV/AIDS pandemic. Studies carried out in social marketing include Mbugua (1994) on usage of social marketing strategies in changing public behaviour; Odiko(1994) on factors influencing social marketing in the reproductive health sector in Kenya and Warinda (2003) on Social marketing in an era of increased competition. None of these studies looks at the adoption of social marketing ideas and innovations and why the target adopters will

accept or reject an idea or product or why they will take long to change their behaviour to the desired behaviour. It would have been necessary to carry out such a study to establish the factors that would influence the adoption process among the employees of ICRC prior to launching the social marketing campaign. Since it is not known whether such a study was conducted, it would be important to conduct a study to determine the factors that influence the adoption of new behaviour among the employees of ICRC. The findings may enable the organisation to offer specialised HIV/AIDS services to each significantly different adopter category.

This study was in response to the above need and sought to answer the following questions:-

i) To which adopter category do the employees of ICRC belong?

ii) What factors influence adoption in an employer driven HIV/AIDS campaign among the employees of ICRC and their relative importance?

iii) Do these factors vary according to the hierarchical level and geographical location of the employees?

1.3 Objectives of the Study

The objectives of this study were:-

i) To establish the adopter categories that ICRC employees belong to.

ii) To determine the relative factors of the factors that influence adoption in an employer driven HIV/AIDS campaign among employees in ICRC.

iii) To establish whether these factors vary according to the hierarchical level and geographical location of the employees.

1.4 Importance of the study

The results of this study will be of importance to the following:-

i) Management of ICRC as they may be able to develop new strategies to deal with the HIV/AIDS challenge in the work place.

ii) Employers in both the NGO and private sector who may draw useful lessons from the challenges ICRC has faced in the implementation of a HIV/AIDS campaign.

iii) The Kenya Government and the Ministry of Health in formulating policies and HIV/AIDS campaigns.

iv) Scholars and researchers in various disciplines as a source of reference.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

In this chapter social marketing and target adopters are defined. The different adoption processes are also looked at in greater detail. In this chapter the difference between social marketing and commercial marketing is also addressed. Target adopters and the different adoption processes are also explained. Finally the factors that influence the adoption process are discussed.

2.2 Social Marketing – meaning and importance

The concept of social marketing resulted from a blending of principles from social marketing with the public healthy arena's desire to promote healthy behaviours. According to William and Wilkins (1996), the leading causes of death shifted from infectious diseases to chronic diseases such as cancer, heart disease and stroke. A definite link was also found between chronic diseases, individual lifestyles and specific health behaviours. As this change in causes of mortality occurred, public health professionals questioned whether health communication programs might be used to educate the public to accept greater responsibility for their individual health choices (Walsh et al, 1993). The term social marketing was first introduced in 1971 by Kotler and Zaltman to describe the use of marketing principles and techniques to advance a social cause, idea, or behaviour. This promotion of 'ideas' was termed as social marketing, and public health professionals gained a new tool in attempting to change the perception, attitudes and opinions that underlie an individual's health behaviours.

Kotler (1996) advances that all marketing is the marketing of an idea, whether it be the general idea of brushing your teeth or the specific idea that crest provides the most effective decay prevention. However, when is focussed on social ideas such as public health, campaigns to reduce smoking, alcoholism, drug abuse and overeating and other campaigns such as family planning, human rights and racial equality, it is referred to as social marketing and it includes the creation and implementation of programs seeking to increase the acceptability of a social idea, cause or practise within targeted groups.

Kotler et al (2002) defines social marketing as the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify or abandon behaviour for the benefit of individuals, groups or society as a whole. Andreasen (1995) defines social marketing as the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of society. Cravens et al (1996, defined social marketing as the design, implementation and control programs aimed at increasing the acceptability of a social idea, cause or practice a target group. Glanz et al (1997), defined social Marketing as the application of commercial marketing technologies to the analysis, execution and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society. From the aforesaid, Social Marketing can be defined as the use of marketing principles and techniques to influence behaviour change. It is aimed at improving the social well being of the target group and that of the society at large.

According to Kotler and Roberto (1989), social marketing utilizes concepts of market segmentation, consumer research, product concept development and testing, directed communication, facilitation, incentives and exchange theory to maximize the target adopter's response. Target adopters are the individuals, groups and populations who are intended to be the consumers of the campaigns products. They are called target adopters because they are the specific people whose acceptance and adoption of a social product will fulfil the objectives of the campaign.

Social marketers can pursue different objectives. They might want to produce understanding (knowing nutritional value of different foods) or trigger a one time action (joining in a mass communication campaign), they might want to change behaviour (discouraging drunk driving) or a basic belief (convincing employers that handicapped people can make strong contributions in the work force). (Kotler and Armstrong, 1996). In designing effective social change strategies social marketers go through the normal marketing planning process. First they define the social change objective, next they analyze the attitudes, beliefs, values and behaviour.

They consider communication and distribution approaches, develop a marketing plan and build a marketing organisation to carry out the plan. (Kotler, 1996)

2.3 Social Marketing vs. Commercial Marketing

Kotler and Armstrong (1996) define marketing as the business function that identifies customer needs and wants, determines which target markets the organization can serve best and designs appropriate products, services and programs to serve the markets. They further define it as a social and managerial process by which individuals and groups obtain what they need and want through creating and exchanging products and value with others. It means managing markets in order to bring about exchanges for the purpose of satisfying human needs and wants. Churchill and Peter (1995), define marketing as the process of planning and executing the conception, pricing, promotion and distribution of ideas, goods and services to create exchanges that satisfy individuals and organisational goals.

According to Kotler et al (2002), the differences between social marketing and commercial marketing include:- *The type of product sold.* In commercial marketing, the marketing process revolves primarily around the selling of goods and services. In the case of social marketing the marketing process is used to sell behaviour change. *The primary aim.* The primary aim in commercial marketing is financial gain. The primary aim in social marketing is individual or societal gain. Hence the former chooses target markets that will provide the greatest volume of profitable sales while in the latter segments are made based on prevalence of the social problem. *Competitors.* Commercial marketers identify competition as other organisations offering similar goods and services or that satisfy similar needs. In social marketing, because the focus is on selling behaviour, the competition is most often the current or preferred behaviour of the target market and the perceived benefits associated with that behaviour.

Despite these differences, there are some similarities between social and commercial marketing. In both the marketer knows that the offer must appeal to the target audience, the consumer must perceive benefits that equal or exceed the perceived costs, marketing research is used throughout the process, markets must be

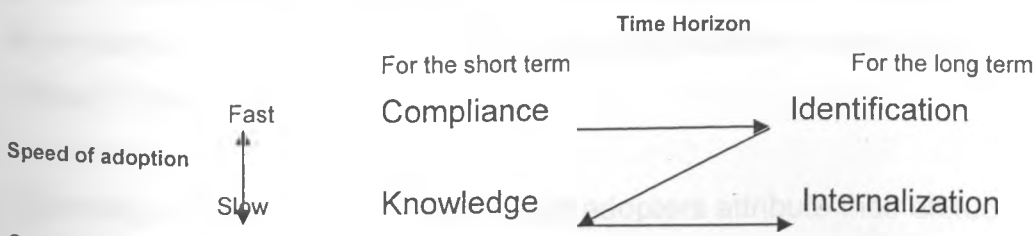
segmented, all 4 p's (product, price, place and promotion) are considered and results are measured and used for improvement (Kotler et al, 2002).

2.4 Target Adopters

Adopting a new idea means adopting or modifying either a belief, an attitude or a value. According to Rokeach (1966), A belief is any proposition conscious or unconscious, inferred from what a person says or does capable of being preceded by the phrase "I believe that". An attitude on the other hand is a relatively enduring organisation of beliefs around an object or object predisposing one to respond in some preferential manner. A value is a type of belief, centrally located in ones total belief system about how one ought or ought not to behave or about some end-state of existence worth or not worth attaining. Social marketers can think of their task as converting a non-belief to a belief, a belief to an attitude or an attitude into a value.

Adopters may accept a particular idea or practise for different reasons. Katz (1960) and Kelman (1961), site the example to the oil crisis in the 1970's whereby some people joined car pools because their companies requested them to comply or gave them an incentive to comply. This is compliance adoption. In some cases laws are passed to secure compliance. Other people joined carpools because people who they admired and with whom they identified had joined car pools. This is identification adoption. Still others joined car pools because this action seemed to be a reasonable adjustment under the new circumstances. This is knowledge based adoption. Yet others joined the car pools because they believed that it was the right thing to do. It was not just personally sensible, it made sense to everyone. They internalized a new norm, or standard, or behaviour. This is internalized adoption.
The four adoption behaviours can be classified according to their speed (slow versus quick) and the time horizon (immediate versus long term).

Four styles of adoption behaviour



Source: Kotler and Roberto (1998) , Strategies for changing Public Behaviour, The Free press Pg 132.

2.5 Adoption processes

Social marketers have identified four different models of how target adopters can be moved to the final decision to adopt an idea, behaviour or tangible product. These models are Learn-feel-do adoption, do-feel-learn adoption, learn-do-feel adoption and Multipath adoption (Ray, 1982).

Learn- Feel-do process

Adoption, in this case, will not take place unless the target adopters first learn about and then develop an attitude toward the social product. According to Robertson, Zielinski and Ward (1984), this leaning model is the most widely used and researched model for influencing the behaviour of target adopters. This model gets the best results when two conditions are present: potential target adopters are highly involved in the adoption objective and they perceive clear differences between adoption and its alternative (Rice & Paiseley ,1981).

In the learn-do-feel process, target adopters first are made aware, then are led to take an interest in and to like the innovation, and then are moved to try it and adopt it. Information to heighten their awareness of and attraction to the social product needs to be communicated effectively (Kolter & Roberto, 1989).

Do-feel learn process

In this process, the target adopters proceed in the reverse of the normal learning sequence. First they adopt an idea or practice on a tentative basis; next they change their attitude as a result of the trial-adoption experience; and then, they push they push their attitude toward a final step of better learning. This model has two theoretical bases: cognitive dissonance theory and attribution theory. According to cognitive dissonance theory, when target adopters are in a situation of forced choice between closely similar alternatives, their choice will be followed by an improved attitude toward the idea or practice. Thus target adopter will gather information that is favourable to the choice they made and unfavourable to the choice they avoided (Kotler & Roberto, 1989).

According to the attribution theory target adopters attribute their attitude toward an idea or practise to their behaviour toward the idea or practise. Hence if they have not

adopted the idea or practise, they attribute this choice to the absence of a positive attitude. But if they have adopted it, they conclude that they must have had a positive attitude. Following the decision to adopt an idea or practise, target adopters then select information that reinforces their attitude, resulting in the do-feel-learn sequence (Kotler & Roberto, 1989).

Learn-do feel process

Target adopters select an idea or practise only on the basis of familiarity with it, usually from heavy repetitive media communications. They have not formed any attitude toward it. If they are in a situation in which they have to make a choice, they select the social product even when they have little involvement with it. Afterwards they may change their attitude if their experience has been satisfying (Kotler & Roberto, 1989).

Multipath process

This model synthesizes the other models. It draws on important conceptual distinctions among belief or cognition (the learn effect), affect (the feel effect) and volition (the do effect). A target adopter may respond with a lower-order or a higher-order belief or other effect.

A target adopter acquires a lower-order belief when he or she is uncertain about the association between a desired attribute and the social product to be adopted and finds the information on the product to be acceptable only at low levels. This lower-order belief results in a low effect, "too weak to register in commonly used attitude scales" in social marketing surveys (Smith and Swinard, 1982).

A target adopter gains a higher-order belief when he or she experiences an adoption objective either directly through trial adoption or indirectly through a vicarious experience. This experience provides a higher certainty of association and more acceptable information and forms a much stronger belief base since it is processed directly through the senses. Higher-order beliefs generate higher-order affects "possessing sufficient strength to control" adoption or other relevant behaviours. (Smith and Swinyard,1982).

2.6 Factors influencing the adoption process

Adoption of new behaviour is triggered by various components. The four P's in social marketing – product, promotion, place and price greatly influence whether the target adopters will adopt the new behaviour or not. Other factors that influence adoption of new behaviour include culture, knowledge and motivating factors.

Product. The product in social marketing is the desired behaviour and the associated benefits of that behaviour. It is the benefits the target adopters will experience when they perform the behaviour, benefits they say are most valuable to them. It includes any tangible objects and services developed to support and facilitate the target audience's behaviour change (Kotler et al, 2002). There are three levels of the product. The core product, which is the benefits of the desired behaviour, the actual product which is the desired behaviour and the augmented product which is the tangible objects and services to support behaviour change. In the case of HIV/AIDS prevention the core product could be prevention of HIV/AIDS infection, the actual product may be use of a condom and the augmented product may be condoms with different colours and easy access to them. The target adopters must perceive a benefit in buying the product.

Price. The price of a social marketing product is the cost that the target market associates with adopting the new behaviour. Adoption costs may be monetary and non monetary in nature. Monetary costs are most often related to tangible objects and services associated with adopting the new behaviour. Non monetary costs are more intangible but are just as real for the target audience. These costs are associated with time, effort and energy to perform the behaviour; psychological risks and losses that might be perceived or experienced and any physical discomforts that may be related to the behaviour (Kotler et al, 2002).

The adopter's beliefs about the outcomes or consequences of adopting a new idea or practice can determine his or her attitudes towards a practice yet to be accomplished (Fishbein and Ajzen, 1975). For example, smokers consider what the outcome would be and how significant those consequences are to them. For the target adopter to adopt the new behaviour, the benefits offered must be equal to or greater than what they will have to give (Kotler & Andreasen, 1991).

If social marketers know what specific feelings and beliefs exert the most influence on the attitude they wish to shape, they can target communications more precisely. In Roberto and Valbuena's study of men's attitudes toward using condoms, the dominant belief was that 'using a condom is being a responsible husband'. The social marketing program then launched a condom-communication campaign that stressed 'the image and sense of responsibility which accrue to the person using condoms for family planning' (Roberto and Valbuena, 1976).

There may be exit costs associated with abandoning the old behaviour (e.g nicotine withdrawal), as well entry costs associated with adopting new behaviour (e.g getting up early to exercise) (Porter, 1998). The social marketer must seek to decrease the costs of adopting new behaviour, those associated with exiting the current behaviour and entering the new one as well as increase the benefits of adopting the new behaviour (Kolter et al, 2002).

Place. This is where the target market will perform the desired behaviour, acquire any related tangible objects and receive any associated services (Kotler et al, 2002). The target audience will evaluate the convenience of our offer to other exchanges in their lives. The social marketer must make it as convenient and pleasant as possible for the target audience to perform the desired behaviour, acquire tangible objects and receive any services. They must also do anything possible to make the competing behaviour seem less convenient (Kolter et al, 2002). To achieve this it is important to make the location closer, make the location more appealing, be there at the point of decision making and make the desired behaviour more attractive than the competing behaviour.

Promotion. Promotion is perhaps the marketing mix tool that is relied on most to move target adopters to the next stage of behaviour change (Kotler et al 2002). Promotion involves creating persuasive communications designed and delivered to highlight the following, the product benefits, features and associated tangible objects and services; pricing strategies, including an emphasis on value relative to the competition, as well as any incentives, recognition and rewards; place components that offer convenience of access. The communicators job is to ensure that the target

audience knows about the offer, believes they will experience the stated befits and are inspired to act. The message must be meaningful – pointing out the benefits that make the product desirable, believable – the product must deliver on the promised benefits and distinctive – how is it a better choice than competing behaviours (Kotler and Armstrong, 1996).

In executing a promotional strategy, the message may contain rational elements, emotional elements, moral elements and non verbal elements. Rational elements focus on delivering straight forward information and facts. The messages could be either one sided or two sided. One sided messages usually present a major benefit, but do not directly address any major drawbacks. Two sided messages address both benefits and drawbacks (Siegel and Doner, 1998). One sided messages appear to work best with people who are already favourably predisposed to the idea or practise and who have a low level of education while two sided messages work best when people are not predisposed to the idea and have a higher level of education (Kotler and Roberto, 1989).

According to Kotler and Roberto (1989), emotional elements are designed to elicit some negative feeling (fear, guilt, shame) or positive emotion (humour, love, pride, joy) that will motivate the desired behaviour. Negative messages work better when social product presents a real solution to a real problem, while positive messages are appropriate to social products that offer a means of satisfying a personal goal or objective. They emphasize however, that each situation will be unique and that it will be important to determine whether a particular segment is more responsive to appeals of fear or to positive messages. Humorous messages are more effective when they represent a unique approach for the social issue, become stale if repeated too frequently and are not as appropriate for complex messages. Fear based messages on the other hand work best when accompanied by solutions that can be easily implemented, are most persuasive to those who have been previously unconcerned about a particular issue and may be more effective when directed toward someone who is close to a potential target adopter and when a credible source is used for endorsement (Kotler and Roberto, 1989). Davar (1991), advances that though fear is a negative motive, it is a powerful one. He further states that the most basic instinct of a human being is self preservation. A person would do

anything to preserve himself or to guarantee his safety. Possible fears including fear of death, fear of loss, fear for the future must be ascertained to enable the social marketer sell his idea effectively.

Moral elements are directed to the audience's sense of what is right and proper (Kotler and Andreasen, 1991) while Nonverbal elements rely on visual cues, graphic images, symbols and on the body language of the actors and models including vocal expressions, body movement, eye contact, spatial distance and physical appearance (Kotler and Roberto, 1989).

Information. Target adopters must have access to information about the idea or practise to be adopted. Their learning, then, is a function of the kind of sources that provide the data that adopters use to make decisions. There are three important sources of information personal sources, non-personal sources and the adoption experience itself (Kotler & Roberto, 1989). Information that is obtained through personal communication is often more effective in influencing people than is information obtained through the mass media (Katz and Lazarsfeld, 1955). Although social change programs use both sources, personal communications usually take the lead role. Personal sources become more significant to target adopters as they move from the awareness stage of the adoption process to the succeeding stages (Williams, 1982). According to Robertson et al (1984), the target adopters' search for information is typically limited both in the number of alternative products to consider and in the amount of information actually used to make the decision. Thus, social marketers must carefully consider the type and amount of information they provide to target adopters.

Motivating factors. The need for excitement and novelty, the need to be accepted and loved, the need for catharsis and acting out and the need to imitate and match are motivational forces that can influence adoption (Kolter and Roberto, 1989). In a community program to reduce the risk of coronary heart disease by encouraging people to change their behaviour, the participants received personal instruction that generated real involvement. To encourage exercising behaviour, the target adopters were presented with new or increased exercise activities which each adopter could decide to join. The reinforcement of behaviours was provided through

encouragement from instructors and spouses, group support and progress reports. Because these programs met the target adopters' need for novelty and excitement, they have been successful (Meyer; 1980). Robertson et al (1972) advances that the need to be accepted and loved is another powerful motivator of adoption behaviour.

Adopters often express a positive feeling toward a product because some respected or significant others feel that way (Kotler and Roberto, 1989). Stevens et al (1982), in their study, found that the most significant predictor of successful smoking cessation for male smokers was the absence of other smokers in the household.

Adopters may undertake trial adoption because of a need to manage a perceived risk, or their involvement with a social marketing product predisposes them to adopt it tentatively after an overwhelming repetition of the adoption message (Kotler and Roberto, 1989). Target adopters are most satisfied when they can allay their concerns about the potential risks of adopting a social product by means of trial adoption (Reselius, 1971). According to Gumenden (1985), target adopters perceive five type of risks - Is it socially acceptable to people whose opinion I care about; Will it yield its promised benefit; Does it have any side effects? Could it be harmful?; Will it do what it is said to do?; Will it be worth what I spent for it.

Culture. The most fundamental determinant of a person's wants and behaviour are naturally culture. Whilst in animals, their behaviour is generally triggered by instinct, in case of human beings behaviour is normally learned. As a child grows, he is influenced by various things that happen around him and is exposed to certain values, preferences and behaviour patterns which involve his family and the society he operates in. This exposure results in certain type of behaviour. These factors influence the way consumers behave hence influencing the adoption of new behaviour (Davar, 1991).

In summary, understanding the target adopters and the adoption processes is very key in social marketing campaigns. The adoption processes can be catogorized in four broad categories and the target adopters would be inclined to wither one of the four processes. By understanding the adoption processes, the marketer is able to design campaigns that will achieve the desired outcome. The adoption processes is

greatly influenced by the 4 p's of marketing – product, promotion, price and place. Other factors that significantly influence adoption of new behaviour include information that the target adopters have access to, motivating factors and cultural influence.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter focuses on research methodology. It outlines the research design, population of interest, sample frame and sampling design, data collection methodologies and data analysis. It gives a clear picture of how the study was conducted.

3.2 Research Design

This study was a descriptive study aimed at determining the factors influencing adoption of new behaviour among the employees of ICRC. A descriptive study aims at determining the what, where and how of a phenomenon (Cooper and Schindler, 1998). Nganga (2004) and Njoroge (2003) have used the design in related studies.

3.3 Population

The population of interest in this study included all non expatriate employees of ICRC in Nairobi and Lokichoggio. This is because the expatriates within ICRC are sent to Kenya on short missions ranging from 6 months to 1 year. Though in certain cases this is renewed to last longer, they are not foreseen to be in one place for a long duration. Hence they are not the target group in the Social Marketing Campaign.

3.4 Sample frame

The complete list of all employees in ICRC as at 01 April 2005 was obtained from the Human Resources records. From these records there were 351 non expatriate employees in Nairobi and 430 in Lokichoggio. They constituted of 20 employees in top management, 40 in middle management, 328 skilled workers and 393 semi skilled and unskilled employees, giving a total of 781 employees. These staff categories are as defined by the organisations' management.

3.5 Sample and sampling design

A target sample of 100 employees was studied. In previous studies, Nganga (2004) in a study of 2,772 employees used a sample size of 125 employees. Since the staff in each category are homogenous this would be an adequate representation of the

entire population. Proportionate stratified sampling was used to ensure proper representation on the population. The stratification was done as detailed below:-

Table 1: Sample Structure

Staff Category	Total Number	Proportion (%)	Number in target sample	Effective sample	Proportion (%)
Top Management	20	3	3	4	8
Mid – management	40	5	5	5	10
Skilled employees	328	42	42	21	45
Semi skilled and	393	50	50	17	36
Total	781	100	100	47	100

Simple random sampling method was used to select the sample members. The researcher achieved an effective sample of 47 which gives a response rate of 47% or 6% of the total population of interest. It is comparable to other return rates of between 30% and 85% that several researchers have reported in their work (Matseshe, 1999; Njoroge, 2003).

3.6 Data collection

Primary data was collected using a semi structured questionnaire (See Appendix 3.1). A research assistant, worked closely with the administrator in Lokichoggio, was trained and dispatched to Lokichoggio to collect the data. In Nairobi, the questionnaire was dropped to the respective offices and collected by the researcher. Pre-testing of the questionnaire was done to determine the clarity of the questions. The questionnaire was divided into four parts. Part A consisted of general information questions, part B has 5 point Likert scale questions aimed at identifying the factors that influence adoption in the employer driven social marketing campaign at ICRC, part C aimed to identify the adoption category that the employees belonged to. Part D determines the challenges encountered in promoting adoption within ICRC. This section was only to be answered by peer educators and members of the HIV committee as they are in the front line of promoting behaviour change.

3.7 Operationalizing target adoption dimensions

In order to operationalize the target adoption variables, the factors were defined as shown in the table below. The questionnaire used the 5 point Likert scale to

measure the factors influencing adoption of new behaviour among the employees of ICRC.

Table 2: Operationalizing the factors influencing adoption

Variable	Measures	QUESTIONS
Product	Condom distribution, Understanding of products offered	18, 19
Price	Effort needed to get the product Acceptance by peers Fear of side effects by the medication Fear of being HIV positive Fear of family members knowing my status Fear of death Fear of loosing the job or missing a promotion Fear of stigmatization by colleagues	11,12,13,14,15,16,17
Place	Accessibility to a VCT centre ambience of the VCT centre Accessibility to a peer educator	20,21,22
Promotion	Use of incentives Use of posters Use of lunch time talk shows Use of videos Use of workshops Use of pamphlets Understanding of benefits of new behaviour Understanding of dangers of current behaviour Elicit guilt, shame and fear Elicit pride, love and joy Appeal to sense of right and wrong	1,2,3,4,5,6,7,8,9,10,28
Information	Understanding of product offered and benefits Communication obtained directly Obtained through third party	23,24,25
Motivating factors	The need to feel accepted and loved Reinforcement	26,27
Culture	Beliefs Social norms Religious beliefs	29,30,31,32

3.8 Data Analysis

This being a descriptive study, descriptive statistics were used to analyze the data. Frequency tables was used to analyse part A ,C and D while data in part B was analysed by use of frequencies, mean scores and standard deviations. The data was then be presented on tables and charts.

CHAPTER FOUR
DATA ANALYSIS

4.1 Introduction

This chapter details the findings of the research study. The data is analyzed using mean scores, percentages and frequencies. These are subsequently presented in tables and charts. The analysis has been presented in four sections. The first section details data on the respondents' profiles. The second section is on factors affecting adoption of new behaviours in the ICRC HIV/AIDS campaign, then a section on adoption process and finally a section on challenges faced by peer educators in promoting behaviour change. The data is based on the 47 questionnaires that were completed out of the 100 that were dropped to the respondents. This gives a response rate of 47%. The respondents were reluctant to fill up questionnaires since they felt that the issues addressed are quite personal and even though they were assured of anonymity the cultural influence whereby some subjects are not discussed was found to be very strong.

4.2 Respondents Profiles

In this section, the respondents profile which includes grade, location, nature of work, level of education and length of service is analysed. The data is analysed using frequencies and percentages. Findings are presented in the table below.

Table 3: Respondents Profiles

Grade	Frequency	Percent
8-9	14	30
6-7	20	43
4-5	7	15
1-3	6	13
Total	47	100
LOCATION		
Nairobi	34	72
Lokichoggio	13	28
Total	47	100
NATURE OF WORK		
Office work	22	47
Field work	7	15
50% in the field 50% in the office	18	38
Total	47	100

EDUCATION		
Primary	10	21
Secondary	16	34
College	13	28
University	6	13
Post graduate	2	4
Total	47	100
LENGTH OF SERVICE		
Less than 5 years	10	21
5-10 years	24	51
More than 10 years	13	28
Total	47	100

Source : Research Data

In relation to grade, 14 of the respondents are in grade 8 and 9, 20 in grade 6 and 7, 7 fall into grade 4 and 5 while 6 fall into grades 1-3. This implies that majority of the respondents (73%) belonged to grade 6 and above. This compares well with the number of staff in these grades. In relation to geographical location, 34 of the respondents are based in Nairobi while 13 of the respondents are based in Lokichoggio. This implies that 72% were based in Nairobi which means that there was higher response from Nairobi office than Lokichoggio office. In terms of nature of work 47% were mainly do office work, 38% were do both office and field work while 15% indicated they only do field work. Majority of the respondents had at least some college education which means that they could give educated opinions. The level of education of the respondents varied from primary (21%), Secondary (34%), college (28%), university (13%) and postgraduate (4%). In relation to the length of service, 24 respondents have worked for between 5 to 10 years while 13 have worked for more than 10 years. This implies that majority of the respondents (79%) had served for at least five years while 21% had served for a shorter period. It can be concluded that the sample was fairly balanced and representative of employees of varied descriptions. Profile by seniority is presented in the sampling section.

4.3 Adopter Categories of respondents

Respondents were asked to describe their behavior when faced with a new product. The four adopter categories given were learn-do-feel the adopters learn about the product, try the product on a trial basis and then develop a liking for it . The second category was do-feel-learn whereby adopters try the product on a limited basis,

develop a liking for it and then learn more about it. In the, learn-feel -do the adopter first takes an interest in the product and then learns about it then develops a liking for it and tries the product. Lastly is the Multipath process where the adopters try to find the association between the desired benefit and the product before deciding to adopt it. The ICRC employees responded as shown in the table below.

Table 4: Adopter Categories

Adopter category	Frequency	%
Learn-do feel process	14	29%
Do-feel-learn process	6	14%
Multi path process	6	14%
Learn-feel do process	3	7%
No answer /Not sure	17	36%

The table above shows that 14 respondents (29%) are in the learn feel do adopter category, whereby the adopters first take an interest in the product and learn about it, then they develop a liking for it and try it. 28% of the respondents fall into the do-feel-learn category and the multipath process while 7% of the respondents fall into the learn-do-feel category; they first learn about the product then try the product on a trial basis before developing a liking for it. However, it is important to note that a sizeable 36% of the staff covered either did not respond to the question or indicated that they were not sure how they respond when faced with a new product.

4.4 Factors influencing adoption of new behavior in the Maisha+ campaign among ICRC employees

In this section the factors that influence the adoption of new behaviors in the ICRC HIV/AIDS (Maisha) campaign are considered.

The factors were categorized into price, promotion, place, product, information, culture and motivating factors. Data was analysed using mean scores and standard deviations. A mean score of 4.1 to 5 was considered to imply that the particular factor affect behavior change to a very large extent. A mean score that is 3.1 to 4 imply that the factor affect behavior change to a great extent. A mean score that is 2.1 to 3 imply that the factor affect behavior change to some extent. A mean score that is less than 2 but greater than 1.5 imply that the factor affect behavior change to a small

extent. A mean score that is less than 1.5 would imply that the factor affect behavior change to no extent at all.

The outcome as shown in the tables below can be interpreted using the value labels used to derive the mean score which had a minimum of 1 and a maximum of 5 depending on the extent of influence on behaviour change. For this reason it was found that none of the factors under study influence behavior change to a very large extent as none scored anything close to 5. This may mean that behavior change may be influenced to a very large extent by a combination of many factors but not isolated factors.

4.4.1 Factors Influencing By Key Variables

In this section the factors that influence the adoption of new behaviors in the ICRC HIV/AIDS (Maisha) campaign are considered. The factors were categorized into price, promotion, place, product, information, culture and motivating factors.

Product

The product variables which includes understanding the product offered and easy access to condoms within the workplace had a mean of 3.11 and 2.79 respectively. It had an overall mean of 2.95 meaning that it influences behaviour change to some extent. It had a standard deviation of 1.12 meaning that there was notable variation across respondents (Table 5).

Table 5 : Product variables

Product variables	Mean	SD
Understanding of the products offered	3.11	1.03
Easy access to condoms within the workplace	2.79	1.22
Product Overall	**2.95**	**1.12**

Price

In price the variables tested include fear of knowing if I am HIV positive which had a mean of 3.32 and a SD of 1.45; fear that family members will know my status if I am positive had a mean of 3.38; fear of death had a mean score of 3.64 meaning that it influenced behaviour to a large extent; fear that I may be put on medication that has side effects, fear of loosing my job, fear that I may be too wek to work and fear of

being discriminated by colleagues had each a mean score of 3.26, 3.23, 3.45 and 2.79 respectively. The price factors had an overall mean of 3.3 meaning that it influences behaviour change to some extent. They had a standard deviation of 1.48 meaning that there was a very notable variation across respondents. The only price measure that seemed to influence behaviour to a large extent was fear of death. All price variables had a standard deviation that is greater than 1 meaning that there was a very notable variation across respondents (Table 6).

Table 6 : Price Variables

Price variables	Mean	SD
Fear of knowing my status if I am HIV positive	3.32	1.45
Fear that family members will know my status if positive	3.38	1.53
Fear of death	3.64	1.45
Fear that I may be put on medication that has side effects	3.26	1.59
Fear of loosing my job	3.23	1.68
Fear that I may be too weak to work	3.45	1.46
Fear of being discriminated by colleagues	2.79	1.18
Price overall	**3.3**	**1.48**

Place

In place the variables tested include easy access to the VCT center and accessibility to a peer educator who can accompany me to the VCT center each with a mean score of 2.89 and 2.26 which means that they influence behaviour to a small extent. The atmosphere at the VCT center had a mean score of 3.13 meaning that it influences behaviour to some extent. The place factors had an overall mean of 2.76 meaning that it influences behaviour change to some extent. All place variables had a standard deviation that is greater than 1 meaning that there was a very notable variation across respondents (Table 7).

Table 7 : Place variables

Place variable	Mean	SD
Easy access to the VCT center	2.89	1.18
Accessibility to a peer educator who can accompany me to the VCT center	2.26	1.17
The atmosphere at the VCT center	3.13	1.33
Place	**2.76**	**1.23**

Information

The information variables tested include information that has been communicated to me directly with a mean score of 2.96 and information obtained from published material with a mean score of 2.87 meaning that they each influence behaviour to a small extent. Information obtained from colleagues had a mean score of 3.26 meaning that it influences behaviour to some extent. The information factors had an overall mean of 3.03 meaning that it influences behaviour change to a some extent. It had a standard deviation of 0.98 which is less than 1 which means that variation across respondents was not major and thus employees answered these questions in a similar manner (Table 8).

Table 8: Information Variables

Information variables	Mean	Std. Deviation
Information that has been communicated to me directly	2.96	1.10
Information obtained from colleagues	3.26	0.92
Information obtained from published material	2.87	0.92
Information	**3.03**	**0.983**

Promotion

The promotion factors had an overall mean of 3.5 meaning that it influences behaviour change to a large extent. It had a standard deviation of 1.07 which means that there were notable variations across the respondents. Two variables had a standard deviation that is less than one namely ; The HIV/AIDS workshops, and Increased understanding of the dangers of current behaviour. This means that the variation across respondents was not major and thus employees answered these two questions in a similar manner. The main promotion measures that seemed to influence behavior to a large extent were ; .Benefits of new behavior as highlighted

in the literature and sessions, The HIV/AIDS workshops, Anticipated feelings of pride and joy from new behavior and increased understanding of the dangers of current behaviour, these had a mean score of between 3.85 and 4.04. The promotion variables that influence behaviour to some extent include use of posters, lunchtime talk shows, video-shows on HIV/AIDS, use of educational pamphlets, realization of the need to adopt morally acceptable behaviour and feelings of guilt and shame from current behaviour. The promotion variable that has no influence on behaviour was free t-shirts and caps offered after visiting a VCT center with a mean score of 1.89. (Table 9).

Table 9 : Promotion Variables

Promotion variables	Mean	Std. Deviation
Use of posters	3.4	1.19
Lunch time talk shows	3.7	1.06
Video-shows on HIV/AIDS	3.64	1.03
Use of educational pamphlets	3.53	1.06
Benefits of new behavior as highlighted in the literature and sessions	4.04	1.04
The HIV/AIDS workshops	4	0.91
Increased understanding of the dangers of current behaviour	3.85	0.83
Realization of the need to adopt morally acceptable behavior	3.49	1.08
Feelings of guilt and shame from current behaviour	3.13	1.24
Anticipated feelings of pride and joy from new behaviour	3.87	1.19
Free T-shirts and caps offered when I visit a VCT center	1.89	1.15
Promotion	**3.50**	**1.07**

Motivating Factors

The motivating factors which include the need to fit in with and be accepted by colleagues and encouragement received from peer educators had a mean of 2.64 and 2.81 respectively and an overall mean of 2.73 meaning that motivating factors influence behaviour change to some extent. All motivating variables had a standard

deviation that is greater than 1 meaning that there was a very notable variation across respondents (Table 10).

Table 10 :Motivating Variables

Motivation variables	Mean	Std. Deviation
The need to fit in with and be accepted by my colleagues	2.64	1.17
The encouragement I have received from peer educators	2.81	1.25
Motivation	**2.73**	**1.207**

Culture Measures

The cultural factors which include use of condom, religion permitting multiple partners, w itchcraft a nd belief that t here i s n othing l ike H IV/AIDS a ll h ad a m ean score of between 1.32 and 1.98 with an overall mean of 1.54 meaning that culture influences behaviour change to a small extent. It had a standard deviation of 1.09 which is greater than 1 which means that there were major variations across respondents. C ulture had l ow s tandard deviations m eaning respondents a nswered them in a similar way (Table 11).

Table 11: Culture Measures

Culture variables	Mean	Std. Deviation
Its against my culture to use a condom	1.32	0.94
My religion permits multiple partners	1.36	0.94
There is nothing like HIV/AIDS	1.51	1.27
Its all witchcraft	1.98	1.24
Culture	1.54	1.09

4.4.2 Summary of various factors

Promotion, price and information were the main influencers of adoption of new behaviors. These w ere followed closely b y product, place a nd motivation. Culture was the least influencer. Promotion was the leading influencer of behaviour change with a mean score of 3.5 and a standard deviation of 1.07. This means that it influences behaviour change to a great extent and that based on the standard deviations there was notable variation across groups. Price was the second

influencer of behaviour change with a mean score of 3.3 and a standard deviation of 1.48. This means that it influences behaviour change to some extent and that based on the standard deviations there was notable variation across groups. Information was the third influencer of behaviour change with a mean score of 3.03 and a standard deviation of 0.94. This means that it influences behaviour change to some extent and that based on the standard deviations there was little notable variation across groups. Product was the fourth influencer of behaviour change with a mean score of 2.95 and a standard deviation of 1.12. This means that it influences behaviour change to some extent and that based on the standard deviations there were notable variations across groups. Product was the fourth influencer of behaviour change with a mean score of 2.95 and a standard deviation of 1.12. This means that it influences behaviour change to some extent and that based on the standard deviations there were notable variations across groups.

Place was the fifth influencer of behaviour change with a mean score of 2.76 and a standard deviation of 1.23. This means that it influences behaviour change to some extent and that based on the standard deviations there were notable variations across groups. Motivating factors were the sixth influencer of behaviour change with a mean score of 2.72 and a standard deviation of 1.1.2. This means that it influences behaviour change to some extent and that based on the standard deviations there were notable variations across groups. Culture was the least influencer of behaviour change with a mean score of 1.54 and a standard deviation of 1.12. This means that it influences behaviour change almost to no extent at all and that based on the standard deviations there were notable variations across groups.

Most of the variables under study influence behaviour change to some extent tending to a great extent. Promotion price and information were the greatest influencers. Culture had the least influence, influencing behaviour change almost to no extent at all.

Table 12: Summary of all factors

Variables	Mean	SD
Promotion	3.50	1.07
Price	3.3	1.48
Information	3.03	0.983
Product	2.95	1.12
Place	2.76	1.23
Motivation	2.725	1.207
Culture	1.54	1.09

4.4.3 Whether factors vary according to the hierarchical level and geographical location of the employees.

One of the objectives of the study was to investigate whether the factors under study vary according to hierarchical and geographical location on employees. To fulfil this objective, the researcher used correlation analysis (Appendix 3) to determine the relationship between these demographic variables and the factors under study. Twenty one out of thirty two of the variables under study were positively correlated to the grade of staff. Six of these variable were positively correlated at 95% confidence level. This means that generally the factors vary by this demographic though not significantly.

The following were the findings of the analysis, The factors that were positively correlated to grade of the staff at a significant level with 95% confidence were:

Increased understanding of the dangers of current behaviour ; Realization of the need to adopt morally acceptable behavior ; Easy access to condoms within the workplace ; Accessibility to a peer educator who can accompany me to the VCT center ; Its against my culture to use a condom and There is nothing like HIV/AIDS. This means that the higher the grade the more likely someone was to be influenced by these factors.

Only one factor was negatively correlated to grade at a significant level namely; Fear that one may be too weak to work. This means that those of lower grades rated it significantly lower than those of higher grades.

Twenty two out of thirty two of the variables under study were positively correlated to the geographical location of staff. Six of these variables were positively correlated at 95% confidence level. Only two variables were significantly positively correlated to geographical location, these included; Fear that one maybe put on medication that has side effects and Fear of knowing ones status if one is HIV positive. Positive correlations means that those from Nairobi attached more influence on these variables than those from Lokichoggio. None of the variables was negatively correlated to geographical location at a significant level.

It can be concluded that while the factors vary with hierarchical level and geographical location of staff. The variation is not significant. Of the two hierarchy level is more of a discriminator than location.

4.5 Challenges faced in Promoting Behaviour Change among Employees

Table 12 below shows the key challenges faced in the promotion of behavior change. The respondents to this section were only the peer educators and those in the HIV/AIDS committee.

Table 13: Challenges faced in Promoting Behaviour Change

Challenge	Count
Failure to educate our staff / Staff are ignorant	2
Some peer educators seem dull / don't participate actively	2
Lack of support materials & tools for peer educators	2
Staff are reluctant to know their status	2
Stigmatization associated with HIV / AIDS	2
People don't want to talk about sex / such topics	2
People fear discrimination / neglect / being exposed	2
People would rather deal with other subjects	2
The peer educators are only noticed during functions	1
Consistency in talks eg lack of follow-up	1
Honesty & behavior of peer educators	1

Staff don't fully understand the role of peer educators	1
Some peer educators don't know what's expected of them	1
Don't trust (staff) peer educators	1
Expatriate staff disassociate themselves from peer educators	1
People are reluctant to go to VCT	1
People don't want to change	1
Collaboration with spouses staff is hard	1
People think there's more than meets the eye	1
People don't want to think of the past	1
Confidentiality is not assured	1
Openness within the peer & peer educators	1

The frequently cited challenges include staff reluctance to change, stigmatization, peer educators competence- dishonesty, educators lack role awareness, fear of discrimination, neglect and being abused, lack of resources and lack of support from expatriate staff. From the foregoing it is clear that the greatest challenge to the promotion of behaviour in the ICRC HIV/AIDS maisha+ campaign is associated with the peer educators, their role and lack of trust by the staff members.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Introduction

The objectives of this study were, to establish the adopter categories that ICRC employees belong to, the factors that influence adoption in an employer driven HIV/AIDS campaign among employees in ICRC and to establish whether these factors vary according to the hierarchical level and geographical location of the employees. In this chapter discussions of findings, conclusions and recommendations are presented.

5.2 Discussion

This findings of the study indicate that that several factors had a mean score of approximately 4 i.e. at least 3.5 which means that they were influencing behavior change to a large extent. These include (in rank order); Benefits of new behavior as highlighted in the literature and sessions, The HIV/AIDS workshops, Anticipated feelings of pride and joy from new behavior, Increased understanding of the dangers of current behaviour, Lunch time talk shows, Video-shows on HIV/AIDS, Fear of death and use of educational pamphlets.

The next level of influence that had a mean in the of 2.1 to 3.0 were viewed that they influence behavior change to some extent. They were composed of more than half of the factors under study. They include the following factors in rank order ; Realization of the need to adopt morally acceptable behavior, Fear of being too weak to work, Use of posters, Fear that family members will know my status if positive, Fear of knowing my status if I am HIV positive, Fear that I may be put on medication that has side effects, Information obtained from colleagues, Fear of loosing my job, Feelings of guilt and shame from current behavior, The atmosphere at the VCT center, Understanding of the products offered, Information that has been communicated to me directly, Easy access to the VCT center, Information obtained from published material, The encouragement I have received from peer educators, Fear of being discriminated by colleagues, Easy access to condoms within the workplace, and The need to fit in with and be accepted by my colleagues.

The next level of influence that had a mean of 1.5 to 2.0 were viewed that they influence behavior change to a small extent. They were composed of only 4 of the factors under study. They include the following factors in rank order; Accessibility to a peer educator who can accompany me to the VCT center, its all witchcraft, Free T-shirts and caps offered when I visit a VCT center and there is nothing like HIV/AIDS.

The last group of factors had a mean close to 1, meaning that they had a negligible or no influence at all on behavior change. There were only two variables in this group namely: My religion permits multiple partners and It is against my culture to use a condom

It was found that among the factors under study most influence behavior change to some extent and some to a large extent. A few influence this change to a small extent or to no extent at all. None of the factors under study was considered to influence individuals behavior to a very large extent.

One of the objectives of this study was to establish the adopter categories that ICRC employees belong to. The findings show that learn do feel adoption process is the most common among employees of ICRC. This is also in agreement with Robertson, Zielinski and Ward (1984), who advance that this learning model is the most widely used and researched model for influencing the behaviour of target adopters. It is however important to note that a number of employees were not sure which adopter category they belong to.

The second objective of this study was to determine the relative factors of the factors that influence adoption in an employer driven HIV/AIDS campaign among employees in ICRC. Adoption of new behaviour is triggered by various components with the four P's in social marketing – product, promotion, place and price being the greatest influence whether the target adopters will adopt the new behaviour or not. The findings indicate that of the four Ps, promotion was found to have the greatest influence on adopting new behaviour. The findings are in agreement with Kotler et al (2002) that promotion is perhaps the marketing mix tool that is relied on most to move target adopters to the next stage of behaviour change. This was followed by

price, with fear being the biggest influencer in the price variable. This is in agreement with Davar (2000) who advances that though fear is a negative motive it is a powerful one. Her states that the most basic instinct of a human being is self preservation and a person would do anything to preserve himself and guarantee his safety. He asserts that possible fears include the fear of death, fear of loss and fear of the future. Product and place are the third and fourth most influencing factors respectively. They both influence behaviour change to some extent. Information was found to influence behaviour to Culture was rated to have the least influence on adoption of new behaviours which may be explained by the fact that AIDS is a modern disease whose severity is beyond culture. This is some how in contradiction with the literature and can be viewed as constituting a new learning. According Davar (1991) the exposure in upbringing and cultural roots results in certain type of behaviour. These factors influence the way consumers behave hence influencing the adoption of new behaviour.

The third objective was to establish whether these factors vary according to the hierarchical level and geographical location of the employees. The findings indicate that while the factors vary with hierarchical level and geographical location of staff. The variation is not significant for most factors studied. Of the two hierarchy level is more of a discriminator than location.

5.3 Conclusions

From the foregoing it is evident that, promotion, price and information were the main influencers of adoption of new behaviors. These were followed closely by product, place and motivation. Culture was the least influencer. The staff of indicated varying extents to which various measures influence the adoption of new behaviors. Most of the variables had high standard deviations indicating notable variations across groups. The findings indicate that that several factors influence behavior change to a large extent. The top factors included : Benefits of new behavior as highlighted in the literature and sessions ; The HIV/AIDS workshops ; Anticipated feelings of pride and joy from new behavior ; Increased understanding of the dangers of current behaviour ; Lunch time talk shows ; Video-shows on HIV/AIDS ; Fear of death and Use of educational pamphlets.

Promotion was the leading influencer of behaviour change. It influences behaviour change to a great extent and that based on the standard deviations there was notable variation across groups. Price was the second most important influencer of behaviour change. It influences behaviour change to some extent with notable variation across groups. Information was the third most important influencer of behaviour change. It influences behaviour change to some extent with no notable variation across groups. Product was the fourth most important influencer of behaviour change. It influences behaviour change to some extent with notable variations across groups. Product was the fourth most important influencer of behaviour change. It influences behaviour change to some extent with notable variations across groups. Place was the fifth most important influencer of behaviour change. It influences behaviour change to some extent with notable variations across groups. Motivating factors were the sixth most important influencer of behaviour change. They influence behaviour change to some extent with notable variations across groups. Culture was the least influencer of behaviour change. It influences behaviour change almost to no extent at all with notable variations across groups.

Most of the variables under study influence behaviour change to some extent tending to a great extent. Promotion price and information were the greatest influencers. Culture had the least influence, influencing behaviour change almost to no extent at all.

It can also be concluded that while the factors vary with hierarchical level and geographical location of staff. The variation in most cases was not significant. Of the two hierarchical level was found to be more of a discriminator than location.

The factors that were positively correlated to grade of the staff at a significant level were: Increased understanding of the dangers of current behaviour; Realization of the need to adopt morally acceptable behavior; Easy access to condoms within the workplace; Accessibility to a peer educator who can accompany me to the VCT center; Its against my culture to use a condom and There is nothing like HIV/AIDS. This means that the higher the grade the more likely someone was to be influenced by these factors.

Only one factor was negatively correlated to grade at a significant level namely; Fear that one may be too weak to work. This means that those of lower grades rated it significantly lower than those of higher grades.

Twenty two out of thirty two of the variables under study were positively correlated to the geographical location of staff. Only two variables were significantly positively correlated to geographical location, these included; fear that one maybe put on medication that has side effects and fear of knowing ones status if one is HIV positive. Positive correlations means that those from Nairobi attached more influence on these variables than those from Loki. None of the variables was negatively correlated to geographical location at a significant level.

Most of the challenges were related to staff reluctance to change, peer educators competence- dishonesty, educators lack role awareness, lack of resources and lack of support from expatriate staff.

5.4 Recommendations

Several recommendations were made based on the foregoing. One is that ICRC and other organisations undertaking behaviour change programs need to increase the level of promotion element to create awareness on the need to change. The promotion element was viewed to have the greatest influence on behaviour change. Promotional programs should focus on; benefits of new behavior, anticipated feelings of pride and joy from new behavior, dangers of current behaviour and consequenceis of lack of change.

The executors of these programs need to carry out staff segmentation in the social marketing. This is mainly because demographics e.g. hierarchical level and location of staff were found to have some relevance to behaviour change tendencies. Peer educators need to be educated on the need to be educated to "look the part'. For example they need to instil confidence and show empathy to staff.

Limitations of The study

The study had several limitations. One was that there were chaos in Northern part of Kenya during the period of study which resulted to low responses from staff on the hot spots. This also proved to be a logistical nightmare due to accesibility. The method of administration was self completion and hence some respondents even filled sections which were not meant for them creating a lot of editing work for the researcher. Most people consider the issue of HIV/AIDS and behaviour very personal hence collecting data was difficult as many employees who were part of the sample were reluctant to participate as they were not fully confident that it will not be possible to tell whose response it is. However, the research was completed successfully and it can be viewed to be a true representation of the situation on the ground.

Suggestions for Further Research

The researchers suggests future research on employer based behaviour change programs to focus promotion used – measure effectiveness and impact, track actual behaviour and experimental research to find out the best approaches. A research covering expatriate employees is also recommended as they were viewed to be a stumbling block by some peer educators. Qualitative research may also be carried out to find out the real motivation for behaviour change.

REFERENCES

Ansoff, I. A. and McDonnel, E .J. (1990), **Implanting Strategic Management**. 2nd Edition, Prentice Hall Europe.

Bartlett ,J. A. (1993), **Care and Management of Patients with HIV Infection**, Glaxo Inc.

Center for Disease Control and Prevention (1999), **Making a difference – The business community takes on Diabetes**.

Cooper, D. R and Schindlor P.S, (2003), **Business Research Methods**, 8th Edition Tata McGraw Hill Edition.

Davar, S (1991), **Modern Marketing Management**, Universal Book stall, India.

Fishbein .M and Ajzen .I (1975), **Belief, Attitude, Intention and Behavior: An Introduction to theory and Research,** Addison Wesley.

Glanz .K, Lewis .F and Rimer .K, (1997), **Health Behavior and Health Education**, Jossey-Bass Inc.

Government of Kenya, (1994), **National Development plan 1994-1997,** Government Printer.

Greavens,.D., Hills.G and Woodruff .R, (1996), **Marketing Management**, AITBS publishers and distributors.

Gumunden .H.G (1985), **Perceived Risk and Information Search: A systematic Meta-analysis of the Empirical Evidence**, International Journal of Research in Marketing, Vol 2 pp79-100.

ICRC (1996), **Fundamentals and Principles of the Red Cross**.

ILO, (2001), **An ILO code of practice on HIV/AIDS and the work place.**

Kansas Health Foudation (2003), **Take it Outside.**

Kippra (Kenya Institute for Public Policy Research and Analysis) (2002), **A situational analysis of poverty in Kenya**.

Kotler, P and Andreasen A (1991), **Strategic Marketing for Non profit organizations**, Englewood cliffs, Prentice Hall.

Kotler, P and Armstrong, G (1996), **Principles of Marketing,** 7th Edition, Prentice Hall.

Kotler, P and Zaltman .G, (1971), **Social Marketing: An approach to planned social change**, Journal of Marketing, 35 July 1971, pp 3-12

Kotler, P and Roberto .E, (1989), **Social Marketing: Strategies for changing public behaviour**, The Free Press.

Kotler ,P, Lee .N and Roberto .E (2002), **Social Marketing; Improving the quality of life,** 2nd Edition, Sage Publications.

Matthews, E.A. (1964), **Marketing an Introductory Analysis**, McGraw Hill

Meyer, A. J.(1980), **Skills Training in a Cardiovascular Health Education Campaign**, Journal of Consulting and Clinical Psychology, Vol 48 pp 129-142

Muraah, W.M., Kiarie.W.N, (2001), **HIV and AIDS: Facts that could change your life,** English Press, Nairobi.

Muraah, W. M, (2003), **Strategic responses by Kenyan Pharmaceutical firms to the challenge of the HIV/AIDS pandemic,** Unpublished MBA project, University of Nairobi.

Murambi, (2001), **Human Resource Policy responses to the HIV/AIDS pandemic. A study of Insurance companies in Kenya**, Unpublished MBA project, University of Nairobi

Mwaura ,A.K. (2001), **Perceived Service Quality**, The case of the Matatu Industry, Unpublished MBA project.

Nganga, H.W (2004), **Internal Marketing practices in the service Industry:** A case study of Kenya Power and Lighting Company Limited, Unpublished MBA project.

Obel A. K. et. Al (1984), **Acquired Immunodeficiency Syndrome in an African,** East Africica Medical Journal; 724-726

Organisation for Economic Co-operation and Development (OECD) (2000), **Waging the global war on poverty: Strategies and case studies,** Paris OECD.

Porter M. E. (1998), **Competitive advantage, Creating and Sustaining Superior Performance**, Free Press, New York.

Rau, B (2002), **An Action Guide for Managers**, Family Health International

Ray M. L. (1982), **Advertising and Communication Management**, Prentice Hall.

Rice R.E, Paisley W. J (1981), **Public Communication Campaigns** Sage Publication

Roberto, E. I and Valbuena E. S (1976), **Deciding on the advertising appeal with the use of a consumer Attitude Behaviour Model,** Philippine review of Business economics, Vol 2 pp1-28.

Robertson T.S, Ward.S and Zielinski.J (1984), **Consumer Behaviour,** Scott Foresman & Co

Robertson L.S, O'Neill B and Wixom C. W (1972), **Factors associated with Observed Safety Belt use**, Journal of Health and Social Behaviour, Vol 13 pp 18-24

Rokeach .M, (1966), **Beliefs, Attitudes and Values**, San Francisco: Josey Bass

Roselius T (1971), **Consumer Rankings of Risk Reduction Methods**, Journal of Marketing, Vol 35 pp56-61.

Savitz L. A and Umble .K (2002), **Social Marketing: A vehicle for employer driven health promotion and disease prevention**, Executive Brief, National Health Care Purchasing Institute.

Shilts .R (1988), **And the Band Played on: Politics, People and the AIDS pandemic,** Penguin Books.

Siegel M and Doner L (1998), **Marketing Public Health: Strategies to Promote Social Change**, Gaithersburg.

Smith R.E and Swinyard W.R (1982), **Information response models; An integrated approach,** Journal of Marketing, Volume 46, pp80-86.

Sternthal B and Craig C .S (1982), **Consumer Behaviour: An information processing perspective**, Prentice-Hall.

Stevens P.A, Greene J. G and Primavera L. H (1982), **Predicting Succesful Smoking Cessation**, Journal of Psychology, Vol 118 pp 235

UNAIDS (2002), **Employers Handbook on HIV/AIDS**.

UNAIDS (2003), **Business and HIV/AIDS: Who me? A global review of the business response to HIV/AIDS**

Viacom and Kaiser Family Foundation (2003), **Know HIV/AIDS**

Wadler M (1987), **ABC of AIDS**, 3rd Edition, BMJ Publishing Group

Walsh .D, Rudd .R, Moeykens .A & Moloney .T (1993), **Social Marketing for Public Health**, Health Affairs.

Williams and Wilkins (1996), **Guide to Clinical Preventive Services**, 2nd Edition, United States preventive services task force.

Williams T.G (1982), **Consumer behaviour**, West Publishers.

APPENDIX I – LETTER OF INTRODUCTION

Catherine Mwangi
C/O University of Nairobi
Lower Kabete Campus
P O Box 30197
Nairobi

26 June 2005

Dear Sir/Madam

RE: REQUEST FOR RESEARCH DATA

I ma a post graduate student in the Faculty of Commerce, University of Nairobi. I am conducting a Management Research on "The factors influencing the adoption process in an employer driven social marketing HIV/AIDS campaign, A Case Study of ICRC".

In order to undertake this research, you have been selected to form part of the study. I therefore request you to assist by completing the attached questionnaire as truthfully as you can. The information you give will be treated in strict confidence and is needed purely for academic purposes. In no way will your name appear in the final report.

A copy of the final report will be made available to you upon request.

Your assistance and co-operation will be highly appreciated.

Yours Sincerely,

.....
Catherine Mwangi
(Student)

.....
Margaret A Ombok
Lecturer, Department of Business
Administrtation (Supervisor).

APPENDIX 2

QUESTIONNAIRE

PART A

General Information

1. Your Name ..... (Optional)

2. Job Title .....

Please tick as appropriate

3. Indicate your Grade

8-9	( )
6-7	( )
4-5	( )
1-3	( )

4. Geographical Location

Nairobi	( )
Lokichoggio	( )

5. Nature of Work

Office work	( )
Field work	( )
50% in the field, 50% in the office	( )

6. Level of Education

Primary	( )
Secondary	( )
College	( )
University	( )
Post graduate	( )

7. Length of Service

Less than 5 years	( )
5 – 10 years	( )
More than 10 years	( )

PART B

Please indicate the extent to which in your view the following factors influence your adoption of new behavior in the ICRC HIV/AIDS (Maisha+) campaign

		To a very large extent (5)	To a large extent (4)	To some extent (3)	To a small extent (2)	To no extent at all (1)
1	Use of posters					
2.	Lunch time talk shows					
3.	Video-shows on HIV/AIDS					
4.	Use of educational pamphlets					
5.	Benefits of new behavior as highlighted in the literature and sessions					
6.	The HIV/AIDS workshops					
7.	Increased understanding of the dangers of current behaviour					
8.	Realization of the need to adopt morally acceptable behavior					
9	Feelings of guilt and shame from current behavior					
10	Anticipated feelings of pride and joy from new behavior					
11	Fear of knowing my status if I am HIV positive					
12	Fear that family members will know my status if positive					

13	Fear of death					
14	Fear that I may be put on medication that has side effects					
15	Fear of loosing my job					
16	Fear that I may be too weak to work					
17	Fear of being discriminated by colleagues					
18	Understanding of the products offered					
19	Easy access to condoms within the workplace					
20	Easy access to the VCT center					
21	Accessibility to a peer educator who can accompany me to the VCT center					
22	The atmosphere at the VCT center					
23	Information that has been communicated to me directly					
24	Information obtained from colleagues					
25	Information obtained from published material					
26	The need to fit in with and be accepted by my colleagues					
27	The encouragement I have received from peer educators					
28	Free T-shirts and caps offered when I visit a VCT center					
29	Its against my culture to use a condom					
30	My religion permits multiple partners					

31	There is nothing like HIV/AIDS					
32	Its all witchcraft					

PART C

Please tick the process that best describes your behavior when faced with a new product (tick only one).

Tick here	Description of adoption process
	Take an interest in the product and learn about it – develop a liking for the product - try the product.
	Try the product on a limited basis – develop a liking for it – learn more about the product.
	Learn about the product – try the product – develop a liking for it
	Try to find the association between the desired benefit and the product before deciding to adopt the product

PART D - (to be answered only by those in the HIV Committee & Peer Educators)

On the space provided below, please indicate the challenges in promoting behavior change among the employees of ICRC

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....
7. .....
8. .....
9. .....
10. .....

Thank you very much for your co-operation

APPENDIX 3

CORRELATION MATRIX

		GRADE	LOCATION	NATURE OF WORK	EDUCATION	LENGTH OF SERVICE
Use of posters	Pearson Correlation	0.0074	0.13	0.091	-.373(**)	.15
	Sig. (2 tailed)	.622	.38	.544	.01	.314
	N	47	47	47	47	47
Lunch time talk shows	Pearson Correlation	-0.136	0.07	-0.048	-.386(**)	-0.032
	Sig. (2 tailed)	0.363	0.62	0.747	0.01	0.83
	N	47	47	47	47	47
Video shows on HIV/AIDS	Pearson Correlation	0.06	0.09	-0.056	0.05	0.033
	Sig. (2 tailed)	0.687	0.54	0.711	0.74	0.828
	N	47	47	47	47	47
Use of educational pamphlets	Pearson Correlation	-0.076	0.12	0.224	-.376(**)	0.157
	Sig. (2 tailed)	0.61	0.44	0.131	0.01	0.291
	N	47	47	47	47	47
Benefits of new behaviour as highlighted in the literature and sessions	Pearson Correlation	-0.111	0.16	.408(**)	-.340(*)	.352(*)
	Sig. (2 tailed)	0.459	0.29	0.004	0.02	0.015
	N	47	47	47	47	47
The HIV/AIDS workshops	Pearson Correlation	-0.146	0.1	0.129	-0.28	0.17
	Sig. (2 tailed)	0.328	0.52	0.388	0.05	0.254
	N	47	47	47	47	47
Increased understanding of the dangers of current behavior	Pearson Correlation	.338(*)	0.05	0.124	-.305(*)	0.054
	Sig. (2 tailed)	0.02	0.75	0.407	0.04	0.721
	N	47	47	47	47	47
Realization of the need to adopt morally acceptable behavior	Pearson Correlation	.532(**)	0.13	-0.174	0.12	-0.128
	Sig. (2 tailed)	0	0.4	0.242	0.41	0.393
	N	47	47	47	47	47
Feelings of guilt and shame from current behaviour	Pearson Correlation	0.202	0.19	0.16	-0.23	0.139
	Sig. (2 tailed)	0.174	0.21	0.282	0.12	0.35
	N	47	47	47	47	47

Anticipated feelings of pride and joy from new behaviour	Pearson Correlation	0.235	0.1	0.069	-0.12	0.14
	Sig. (2 tailed)	0.112	0.49	0.647	0.42	0.35
	N	47	47	47	47	47
Fear of knowing my status if I am HIV positive	Pearson Correlation	-0.147	.307(*)	0.183	-0.19	0.108
	Sig. (2 tailed)	0.325	0.04	0.219	0.21	0.471
	N	47	47	47	47	47
Fear that family members will know my status if positive	Pearson Correlation	-0.173	0.28	.407(**)	-.312(*)	0.24
	Sig. (2 tailed)	0.246	0.06	0.005	0.03	0.105
	N	47	47	47	47	47
Fear of death	Pearson Correlation	-0.186	0.25	0.186	0.05	0.257
	Sig. (2 tailed)	0.211	0.09	0.21	0.74	0.081
	N	47	47	47	47	47
Fear that I may be put on medication that has side effects	Pearson Correlation	-0.059	.289(*)	0.177	-0.22	0.218
	Sig. (2 tailed)	0.692	0.05	0.235	0.15	0.142
	N	47	47	47	47	47
Fear of loosing my job	Pearson Correlation	-0.16	0.28	0.249	-0.21	.335(*)
	Sig. (2 tailed)	0.283	0.06	0.091	0.16	0.021
	N	47	47	47	47	47
Fear that I may be too weak to work	Pearson Correlation	- 337(*)	0.28	0.27	-0.11	.417(**)
	Sig. (2 tailed)	0.02	0.06	0.067	0.45	0.004
	N	47	47	47	47	47
Fear of being discriminated by colleagues	Pearson Correlation	0.001	0.05	0.162	-0.04	0.095
	Sig. (2 tailed)	0.994	0.75	0.277	0.78	0.524
	N	47	47	47	47	47
Understanding of the products offered	Pearson Correlation	0.225	-0.03	-0.013	-0.26	-0.19
	Sig. (2 tailed)	0.128	0.86	0.93	0.08	0.201
	N	47	47	47	47	47
Easy access to condoms within the workplace	Pearson Correlation	0.347(*)	-0.03	-0.113	-0.2	-0.035
	Sig. (2 tailed)	0.017	0.86	0.45	0.17	0.817
	N	47	47	47	47	47
Easy access to the		.421(**)	-0.13	0.011	-0.23	0.008

VCT center	Pearson Correlation					
	Sig. (2 tailed)	0.003	0.4	0.94	0.12	0.956
	N	47	47	47	47	47
Accessibility to a peer educator who can accompany me to the VCT center	Pearson Correlation	.505(**)	-0.21	0.06	-0.04	-0.284
	Sig. (2 tailed)	0	0.16	0.686	0.79	0.053
	N	47	47	47	47	47
The atmosphere at the VCT center	Pearson Correlation	0.222	-0.03	0.203	-0.22	0.154
	Sig. (2 tailed)	0.133	0.87	0.172	0.14	0.302
	N	47	47	47	47	47
Information that has been communicated to me directly	Pearson Correlation	0.185	-0.07	-0.046	0.2	-0.192
	Sig. (2 tailed)	0.214	0.64	0.758	0.19	0.195
	N	47	47	47	47	47
Information obtained from colleagues	Pearson Correlation	-0.007	0.12	0.331(*)	-0.22	0.209
	Sig. (2 tailed)	0.965	0.43	0.023	0.13	0.158
	N	47	47	47	47	47
Information obtained from published material	Pearson Correlation	0.159	0.23	0.114	0.06	-0.021
	Sig. (2 tailed)	0.286	0.13	0.446	0.7	0.891
	N	47	47	47	47	47
The need to fit in with and be accepted by my colleagues	Pearson Correlation	0.204	0.23	0.151	-0.11	0.187
	Sig. (2 tailed)	0.168	0.12	0.31	0.47	0.208
	N	47	47	47	47	47
The encouragement I have received from peer educators	Pearson Correlation	0.283	-0.03	-0.108	0.14	-0.085
	Sig. (2 tailed)	0.054	0.84	0.468	0.34	0.57
	N	47	47	47	47	47
Free T-shirts and caps offered when I visit a VCT center	Pearson Correlation	0.261	0.02	-0.274	.349(**)	-0.099
	Sig. (2 tailed)	0.076	0.87	0.062	0.02	0.507
	N	47	47	47	47	47
It is against my culture to use a condom	Pearson Correlation	0.364(*)	-.009	-0.093	0.15	-0.164
	Sig. (2 tailed)	0.012	0.55	0.533	0.3	0.272
	N	47	47	47	47	47
My religion permits multiple partners	Pearson					
		0.169	-0.1	0.036	0.11	-0.199

	Correlation					
	Sig. (2 tailed)	0.257	0.5	0.81	0.45	0.179
	N	47	47	47	47	47
There is nothing like HIV/AIDS	Pearson Correlation	.427(**)	-0.11	-0.184	0.07	-.306(*)
	Sig. (2 tailed)	0.003	0.48	0.215	0.66	0.037
	N	47	47	47	47	47
Its all witchcraft	Pearson Correlation	0.073	0.01	.300(*)	-.407(**)	0.2
	Sig. (2 tailed)	0.625	0.98	0.041	0.01	0.177
	N	47	47	47	47	47
* Correlation is significant at the 0.005 level (2- tailed)						
** Correlation is significant at the 0.01 level (2-tailed)						