

**SOCIAL, CULTURAL AND ECONOMIC FACTORS IMPACTING
ON HIV/AIDS RISK PERCEPTION:**

A Case Study of College Students in Kenya

By

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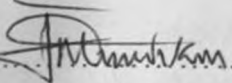
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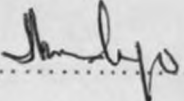
Declaration and Approval

I do hereby make a declaration that this research project is my original work and has not been submitted in part or any other form for a degree award in any other university.

Signed  Date .. 3/11/05

Approval

This project report has been submitted with my approval as University Supervisor.

Signature 

Dr. Joseph Mbindyo Date .. 3/11/05

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Dedication

I dedicate this research project to my late father, David Mwandikwa Maluki who passed on 5/7/2003 when I was halfway with my Master of Arts in Communication Studies degree programme.

A long serving teacher, he instilled in me an insatiable quest to broaden and enhance my knowledge.

ABSTRACT

The research project sets out to examine socio-economic factors that hinder risk perception of college students regarding HIV/AIDS pandemic among the Kenya college youth.

A lack of awareness of or unwillingness by our policy makers to address the social cultural and economic forces contributing to the transmission of the HIV/AIDS virus has hampered attempts to stem the scourge.

The study will contribute to an in-depth understanding of the gender differences and risk perception impelled by the above- mentioned factors that have received little focus with the bulk of efforts directed to behavioural change communication strategies.

A relationship between risk perception and factors that predisposes high risk sexual behavior have also been examined in an effort to come up with “ A Social Prevention Strategy” that ameliorates socioeconomic influences on HIV/AIDS virus transmission.

Policy makers and stakeholders in prevention campaigns should be aware of these forces because they profoundly influence the effectiveness of Behavioral Change Communication strategies, prevention, and treatment. The enquiry also provides a considerable amount of literature in the field of risk perception, which has continued to grip the attention of researchers in recent years spurring increased study of risk analysis.

College students in Kenya represent a population that, with a few exceptions, is sexually active and engages in risky behavior and an important one to warrant research.

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CHAPTER ONE

INTRODUCTION

1.1 Background

HIV/AIDS pandemic affects adolescents through out the world. One third of all currently infected individuals are youth, ages 15 to 24 and half of the new infections occur in the youth the same age. (UNAIDS (1999)

Smith and Colvin (2004) points out that young people represent 33 percent of the world's population. In Sub- Saharan Africa alone, 15-19 years olds have the highest growth rate of any population segment. This can also be translated to mean that it is this age category at the greatest siege posed by HIV/AIDS pandemic.

Of about 1.7 million new adolescent HIV infections, over half of the world's total, occur in Sub-Sahara Africa (in fact, nearly 70 percent of people living with HIV/AIDS live in Sub-Saharan Africa, and over 80 percent of AIDS death have occurred there. Mann *et al* (1999).

Although HIV/AIDS rates vary considerably throughout Sub-Saharan Africa—generally lower in Western Africa and higher in Southern Africa – the epidemic has had devastating effect on most African youth who often lack access to sexual health information and economic norms and pressures often put young African women at excess risk for HIV infection.

According to *Advocates For Youth (2004)*, health experts estimate that half a million African youth, ages 15 to 24, will die from AIDS by the year 2005. In African countries with long severe epidemics, half of all infected people acquire HIV before their 25th birthday. The epidemic means that African youth face a bleak future.

For example, In Nigeria the most populous African nation, (*Population Reports, 2002*) indicate that HIV/AIDS cases raised from 2 cases in 1986 to 4 million cases in 2002 with the youth hardest hit. Population surveys from both urban and rural areas indicated HIV prevalence among females aged between 15-34 years as 4.5-5-9 and 1.7-3.3 percent among males (UNAIDS 2001) reported that despite widespread under reporting and Misdiagnosis, evidence from hospitals (both rural and urban indicated average of 5-10 new cases.

A study carried out in Zambia by Munkenze (2001) found out that more than 23 percent of adolescents are sexually active by age 18. Almost one quarter of girls are mothers by age twenty, 20 percent of a sample of urban females aged 15-19 are HIV positive and young women in 15-19 age group are five times as likely to be infected with HIV as boys in that age.

Similarly, a study carried out by Zimbabwean Ministry of Higher Education (1994) shows that more than half of cases of HIV/AIDS infection in that country are aged between 20 and 39 years. In the 15-19 years group, females far outnumber the males. Six times more females are infected than men in age group 15-19 years. This is because biological and social vulnerability of adolescent females to catch HIV/AIDS is higher than for adolescent males.

In the neighbouring Tanzania, many adolescents have their sexual debut between 16 and 24 years old and learn and consolidate alcohol drinking, cigarette smoking and disco attendance at this stage. Adolescents in the country are thus at great risk of HIV infection. Lugoe (1996). He says that HIV/AIDS in the country is spread through heterosexual contact.

Sawaya *et al* (1995) in *Advocates For Youth* (2004) reveals that there is no official AIDS education programme in the school curriculum in Tanzania and previous studies in the East African Community have shown that condom use is not popular enough to effectively prevent HIV infection.

Kapiga *et al* 1991 continues to say that very little information, however, has been documented concerning the influence on HIV risky adolescent sexual behaviour of attitudes and opinions on condom use, as well as AIDS related knowledge, information source, risk perception and attitudes.

Mann *et al* (1992), says that the largest high-risk group is composed of young people who have recently become, or are about to become sexually active. This is a difficult audience to influence because of the peer pressure influence and influence of social norms as well as a sense of invulnerability that accompanies the youth. It is in this scenario that UNAIDS (1999) sees this sector in almost every country's population at enhanced risk in this pandemic.

Moreover, many young people are socially inexperienced and are dependent on others. Peer pressure easily influences them –often in ways that increase their risk. The youth continue to be exposed to multiple partners without any forum of protection even though they recognize the inherent risk of HIV/AIDS in individuals with multiple partners. (Lema,1993, Feldman 1993. Again, young people are at a risk of

contracting HIV/AIDS because they have multiple short-term sexual relationships and do not consistently use condoms.

As studies have shown, adolescents are not able to comprehend fully the extent of their exposure to risk. Societies often compound young people risk by making it difficult for them to learn about HIV/ AIDS and reproductive health. *Issues in world health (2001)*.

Young women are several times more likely to be infected with HIV/AIDS than young men. Physical, psychological and social attributes of adolescence make them particularly vulnerable to HIV and other sexually transmitted infectious (STIs).

The reason for the social vulnerability is that teenage girls generally have their first sexual intercourse at a younger age than teenage boys do. Frequently, it is with an older man who is more likely himself infected

Initial intercourse for boys is generally with younger girls who have not been infected with HIV/AIDS. It must be remembered that it is this age category, which represent the largest segment of the population.

Another angle based on gender was witnessed in sexual exposure of Kenyan high school students. Boys initiated coitus earlier than girls, and more had sexual partners compared to the girls. Kumah(1993)

In addition, experimentation with drug use, including injection, is often a feature of youth. This underscores the capital importance of implementing prevention programmes long before sexual or drug injecting activity might commence, because too many young people are unaware of the threat posed by HIV/AIDS.

The youth cite curiosity, peer pressure, expectation of gifts and money and forced sexual intercourse as the reasons of indulging in unsafe sex.

Young people are viewed as a “problem” – problem for prevention education and problem for potential HIV transmission. Negative perception of the youth as the problem has been lingering over centuries. Reluctance to participate in important debate is found in the 19th century Europe.

Belief stemming from this period regards young people as too immature, irrational and unqualified to participate in serious decision-making, Svenson *et al* (1998).

Svenson defends the youth adding that these opinions do not take the stock of the fact that the current situation for the young people and the future they are facing is very different from which faced their parents. HIV/AIDS is very much a part of this new situation.

According to Smith and Colvin (2004) the decisions youth make also affect their current and future life options. Becoming HIV during adolescence means death at an early stage is virtually inevitable in most developing countries.

Despite this flak directed at youth, there is something good that can come out of them. FHI vol. 3 (2004) says that young people are more likely to adopt and maintain safe sexual behaviours than older people with well-established sexual habits, making excellent candidates for prevention. IFRC (2000) adds that the youth are a force to reckon with on fighting HIV/AIDS epidemic.

UNAIDS (2002) report supports this sentiment by adding that it is young people who offer the greatest hope of changing the course of HIV/ AIDS

pandemic if they are given the tools and support to do so. The report further says that this particularly vulnerable group also has an extra burden of caring for family members living with HIV/ AIDS. Many are vulnerable to HIV because of substance abuse, because they lack access to HIV information and prevention services or for a host of socio-economic reasons.

Among the Kenyan youth, sex is mainly with peers/ age mates and is usually sporadic and opportunistic with peak occurrence in exit classes of primary and secondary schools Youri (1993).

A study of adolescents in Kenya by Lema (1994) shows that 37.3 percent had coitus with high-risk groups, which included strangers, bar girls and prostitutes. Males were significantly more likely to have high-risk exposure.

Seventy per cent did not change their behavior after hearing about HIV/AIDS and those who did 29.9 per cent opted to stick to one partner and 6.9 per cent of males reported condom use.

One would want to know the indicators of high-risk behaviour. Lema (1994) says that teenage pregnancy, STDs, and abortion can be used as indicators of high-risk behaviour. Several studies have documented that adolescents are at risk of STDS. In a hospital survey in Kenya, 36 percent of 13-15 years old were found to have an STDs.

The background information shows that the scale of the AIDS epidemic among youth in Kenya is enormous and continues its deadly course. Throughout Kenya, the HIV/AIDS epidemic is affecting large number of adolescents, leading to serious psychological, social, economic, and educational problems which demand urgent and relevant responses to

regain developments in health status particularly those which are being eroded as the government and other actors move to save the situation.

1.2 Statement of the problem

Awareness of AIDS in Kenya is widespread (99%) between both men and women as reported in KDHS (1998); however some people and especially college students continue risky sexual practice. For example, having multiple partners, engaging in substance abuse, not using condoms consistently and correctly though they know the behavior puts them at risk for HIV/AIDS.

The pandemic, needless to say, is to a large extent a crisis of sexual behavior and that unsafe sex is responsible for a large majority of HIV infection in Kenya.

In absence of credible vaccine and cure for AIDS and continuing increase in infection rates, avoidance of infection through practice of safe sex remains the most viable strategy for individuals living in Kenya today.

According to WHO (2002) behavioural change communication alone does not necessarily lead to perception and understanding risks. For example, it has been found out that there is a clear mismatch between behavioural change communication messages to stop the pandemic and AIDS risk perception among the youth hence a need to supplement it with other programmes in socioeconomic front.

Lack of awareness of or willingness to address the social, cultural and economic factors contributing to the transmission of human immunodeficiency virus has hampered the fight against the epidemic.

In Kenya, these factors are immensely correlated with AIDS risk perception. Where vulnerable groups are denied choices about their economic livelihood and sexuality and where they are confined to a narrow sphere, HIV transmission will be facilitated.

Thus, the purpose of this study is to examine whether social, cultural and economic factors that hinder risk perception among the youths, to investigate the gendered aspect of AIDS risk perception as influenced by socioeconomic forces and relation between risk perception and risky sexual behaviours.

A thorough understanding of these forces is very important to facilitate the reduction and the spread of the disease. It will bolster and strengthen efforts and programmes that ameliorate its transmission impact.

1.3 Objectives of the study

The research aims to examine the some of the social, cultural and economic factors that influence risk perception among the youths.

Specific objectives are:

1. to identify the major social, cultural and economic factors that hinder risk perception among the youths.
2. To explore the relationship between risk perception and risky behaviours which promote the spread HIV/AIDS.

3. To investigate the relationship of gender to HIV/AIDS risk perception and the extent to which it is influenced by socio-economic factors.

1.4 Justification of the study

While the importance of the Behavioral Change Communication or Information, Communication and Education (IEC) were embraced early in the fight against HIV, social, cultural and economic spheres were not given much attention to run side by side with these early initiatives.

The magnitude and the spread of AIDS is being felt 24 years into the epidemic with Kenya losing an estimated 500 of its people to the pandemic per day. HIV/AIDS is not just a serious threat to our socioeconomic development gains; it is a real threat to our existence and therefore a need for multi-pronged approach to ameliorate the negative impact.

There are no easy ways to change people's risk perceptions. Youths often perceive themselves to be invulnerable and most young people perceive AIDS with an optimistic bias or unrealistic optimism that is to say, 'a person considers that a particular incident is likely to occur to another person than to oneself.' Weinstein¹(1998_ a remote possibility affecting others but not them.

This perception is strengthened by the fact that the austere socioeconomic environments they find themselves in, impede their perception to risk. For example, in most African cultures women with many sexual partners are demonized; seen to be of easy virtue while men

¹ Weinstein, N.D. (1998). Unrealistic optimism about illness susceptibility: Conclusions from a community-wide sample. *Journal of Behavioral Medicine*, 10,481-500

with similar tendencies are 'glorified.' And hence do not take bigger responsibility for their health.

The study seeks to provide in-depth understanding of these forces which perpetuate transmission of HIV/AIDS epidemic and the realization that IEC alone is not a prerequisite for behavior change. Where marginalised and vulnerable groups such youths and women lack self-sufficiency, where they are denied choices about their livelihood and where they are confined to a narrow sphere, HIV rates will continue soaring.

The challenge is to develop 'A Social prevention strategy', targeting all areas of needs which in the end will support and facilitate positive behavioral change.

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To achieve this it is crucial in understanding of the youth, culture surrounding sexuality, their sources of information and factors that bog down their risk perception to HIV/AIDS.

In order to better understand how people integrate given information there is a need to analyse the connection between AIDS risk perception and various socio-economic variables which could affect them.

Factors that affect human and social behavior such as poverty, discrimination and disfranchisement have to be addressed globally if the pandemic is to be contained effectively. The findings of this study will go along way in contributing to policy making and implementation of sustainable programmes in HIV/AIDS prevention.

CHAPTER TWO

2.0 Literature review

2.2 Overview

In a study conducted by Sweat (1995) shows that economic factors have a strong influence on individual's social behaviour, mostly through poverty and underemployment. Cross – nationally, countries with the lowest standards of living are also the ones with the highest HIV incidence. Within both rich and poor countries poverty is associated with HIV and HIV intensifies poverty.

For example, HIV/AIDS developed in a time of severe economic crisis in Zambia and has enlarged that crisis. The average annual income in Zambia is US \$370, and the government can afford to spend only 14 per capita(about US \$ 52) for health.² The nation has only 200 medical doctors. Poverty and trying to survive are some of the reasons why people were not willing to talk and think about HIV/AIDS in the early years of the epidemic. This was concluded by a local NGO, *Copperbelt Health Education Project* who conducted researches in the early 1990s Also, HIV/AIDS was associated with illicit sex and immorality. Indeed, poverty increases illicit sex, because of poverty women has sex in exchange for money and goods.

In Zambia, everyone is currently confronted by HIV/AIDS, be it oneself suffering from AIDS, or having lost relatives, neighbours or friends due to this illness. According to UNAIDS (2002) In the country there are 1.2 million people living with HIV/AIDS, of which are approximately 1

²Singhal. A & Rogers. E (2003): *Combating AIDS: Communication Strategies in Action*.PP 213

millions adults (15-40) year and approximately 150,000 children (0-14 years). The total population is estimated at 10.6 million. The number of AIDS deaths in 2001 was 120,000. The number of children who have lost one or both parents is increasing and the number of orphans in Zambia is estimated at 570,000. Now a decade later, everyone in the Sub-Saharan state is confronted with HIV/AIDS and people are talking about it. Many young Africans grow watching their peers and parents fall ill and die.

Singhal & Rogers (2003) say that the situation is such desperate in Zambia such that 500 new infections occur everyday. About a hundred Zambians die daily from Aids, including an average of three schools teachers. (pp 209)

In 1996 president Chiluba of Zambia declared, "*our nation to at war with AIDS*". In the same year the National HIV/AIDS coordinating committee and in 2002 the National AIDS Council and secretariat were established. Since 1997 there is increasing awareness of HIV/AIDS issues among the general population and greater readiness to speak on the subject about sexual behaviour. However, there are also constraints and difficulties including understanding of the national AIDS office, limited enactment of a multi-sectoral approach which, means that HIV/AIDS is considered as only a health problem, and a general lack of national policy on HIV/AIDS (de Waal 2003) and implementing ways to stop the spread of HIV.

A 2001 study among South African students showed that young people living in households that recently experienced disruptive events (illness, job loss or divorce) were less likely to use condoms. Research also confirms that higher education levels are associated with higher rates of condom use.

Evidence of filtering effect of misleading beliefs comes from very different social environments, independent, from the degree of AIDS prevalence. Due to social norms people find it difficult to discuss frankly and non judgmentally sexuality and sexual activity. As a consequence people are often unaware of risk associated with specific social activities such as unprotected vaginal or anal intercourse and other high-risk behaviour such as injecting drug use.

Current estimates suggest that more than 99% of HIV infections prevalent in Africa in 2001 are attributable to unsafe sex. UNAIDS (2003). *Progress Report on the Global Response to HIV/AIDS Epidemic*.

In the rest of the world, the 2001 estimates for the proportion HIV/AIDS attributable to unsafe sex range from 13 percent in East Asia and the Pacific to 94 percent in Central America. Globally about 2.9 million deaths are attributable to unsafe sex, most of them occurring in Africa.

HIV/AIDS among adolescents is almost entirely by sexual intercourse. Findings show that 98 percent have been infected through sexual contact. In Kenya most girls are coerced or forced into first intercourse. Very large proportions of Kenyan youth are sexually active, about 90 percent by age 20 and most intercourse among them unprotected and with multiple partners with boys being 7 times more sexually active than girls (PCA 1999, NCPD, 1998, Erulkar *et al*, 1998).

Young girls are often preferred by older men who believe that unprotected sex is less likely to infection, and that sexual intercourse with a virgin will cure a sexually transmitted disease. Young girls living in poverty may find older men attractive because of their wealth, power and position and thus making them to be at a very high risk of high-risk infection (Greene, 1998, Fapahunda and Rutenberg 1999).

Recent research has showed a strong relationship between HIV infection and male circumcision. The thrust of evidence is that uncircumcised men are six times more likely to be HIV infected than males who have been circumcised. Among those men who were HIV positive 18 percent were not circumcised, while 2.6 percent were circumcised. Women who had their first intercourse with an uncircumcised man were 24 times more likely to be HIV positive (Population Council 1999).

Figures provided by Population Reference Bureau (PRB) show that teenagers in Kenya are more sexually active than their counterparts in USA. For example, about 50 percent of teenagers are sexually active compared to 22 percent in USA PRB 1998.

Another factor that is fuelling the epidemic is that sexual behaviour in Kenya has always involved the occurrence of multiple partners.

Idele – Akwara (2002) points out that at the onset of the epidemic, research and intervention only focused on bio- medical consequences of the disease and ignored the varying geographical, behavioural, social, cultural and economic contexts underlying the course of epidemic in Sub- Saharan Africa. Save the children (2000) says HIV prevention is more than just bio- medical intervention. It is as much a complex a social process, which includes factors difficult to assess.

The sexual behaviour that people practice is determined by sexual orientation, knowledge and cultural expectations. According to Bernardi and Mencarini (2004), the second aspect, the knowledge about the ways in which HIV may transfer from one individual to another, could be a significant predictor of the probability to engage in risk behaviour. One cannot recognize and therefore prevent what one does not know. Having correct information on infection mechanisms, and possible ways to

prevent against it, in a precondition for performing an effective prevention. Yet, correct information is not sufficient indicator, since its effect on behaviour may be filtered by the co-presence incorrect beliefs. The individual may hold other misleading beliefs or “compensatory beliefs” that affect the casual relationship between behaviour risks of infection

Thus with the multiplicity of factors the epidemic has ravaged the continent such that leaders of some African nations, once unable to acknowledge the presence of HIV/AIDS, now publicly address HIV prevention and appoint task forces to mobilise and coordinate efforts against the epidemic. This includes president Thabo Mbeki noted for his initial opposition to providing anti-retroviral drugs to HIV positive individuals in South Africa (Singhal & Rogers 2003 pp 97)

At first he questioned whether HIV actually causes AIDS, a point on which there is overwhelming evidence. He supported the views of Dr. Peter Duesberg, a scientist at University of California at Berkeley who claims that sufficient evidence has not been presented. Duesberg opposes anti-retroviral therapies and urges HIV-positive people not to take AZT.

Mbeki had argued that anti-retrovirals were toxic. He especially opposed the provision of Nevirapine, which limits mother to child transmission of HIV.

His predecessor, the charismatic Nelson Mandela, told an international Aids conference in Durban, South Africa in July 2000 that “constant theme in all our messages has been that in this interdependent and globalised world, we have again become keepers of our brother and

sister. That cannot be more graphically the case in the common fight against HIV/Aids”³ Bartholomew (2002)

The then Kenyan president Daniel Arap Moi while declaring AIDS a national disaster on 25h November 1999 said that “the fight against Aids is a war we must win” (NACC, 2000)⁴

In addition to government, business coalitions and non governmental organisations (NGOs) often lead in utilising peer education, advocacy, youth-friendly service delivery and social marketing to battle HIV infection in sub-Sahara African nations, Some NGO’s encourage youth to get involved in combating AIDS.

2.2 The HIV situation in Kenya

Kenya, situated in East Africa, is one of the countries in Sub-Saharan Africa most affected by the AIDS epidemic. The Kenyan population is approximately 30 million. About 80 per cent of the population lives in the rural areas. The country is culturally diverse with over 40 ethnic groups. The diversity in culture makes it difficult to implement a single AIDS prevention campaign approach, as no single programme would be appropriate for all cultural contexts. Young population characterizes Kenya. Almost 50 percent of the population is aged less than 15 years Idele-Akwara (2002)⁵.

KDHS (1998) reports that more than 50 per cent are sexually experienced by age 20.

STIs including HIV/AIDS are increasingly becoming common among young people with 60 per cent of all new infections occurring among 15-

³ Reported in Singhal, A & Rogers, E M. :Combating AIDS Communication Strategies in Action

⁴ NACC, Kenya National HIV/AIDS Strategic Plan .2000-2005,2000

⁵ Idele-Akwara. P. The Social Context of Perception of Aids Risk and Sexual Behaviour in Kenya ppl

24 year olds; yet, vulnerability to these infections is systematically patterned so as to render some young people more likely than others. Gender, socio-economic and cultural status, sexuality and age are important factors structuring such vulnerability. Toroitich (2000).

Today, Kenya is at the beginning of a third wave of the epidemic which involves the spread, to and among the youth, adolescents and young adults. At present the percentage of new infections among under 20 years old is 30 percent female and 20 percent male. But in five years time, percentages of new infections among the under 20 will have increased dramatically to 40 per cent of all new male infection occurring to those under 20 and 60 per cent of all new female infection occurring to those under age 20. *The Effects of HIV/AIDS on Young People in Kenya PCA 1999, NASCOP, 1999*).

Almost one third of Kenya's population fall into teenage adolescent category 13-19 years. The average age at first sexual intercourse has not changed significantly in the past 50 years, and over the same period the average age at marriage for both males and females has increased by nearly 5 years (NCPD 1998)

2.3 Link between Gender, sexuality and HIV/AIDS.

Popular Version (2003) underscores the importance of understanding male and sexual behaviour, adding that it requires an awareness of the relationship between social cultural and economic forces that affect the distribution of power. The power underlying any sexual liaison determines how sexuality is expressed and experienced. There is often any unequal power balance in gender relations that favours men. (Baylies and Bujra 2003 pp50) say that the spread of HIV is bound up in

the inequalities of gender relations, making women particularly vulnerable.

In particular women are considered victims of HIV/AIDS. They carry the burden of increasingly looking after relatives who are ill, but may contract HIV/AIDS themselves. Slightly more women than men are HIV infected, from 12 years onwards, because they're more vulnerable to HIV/AIDS than men. This is mainly because of biological reasons, and because in many African societies women (are supposed) have no means to defend themselves against the sexual forces of (adulterous) husbands and other men (Engudu 1991, Schoepf et al 1991, Mac Fadden 1992, Careal 1993).

Rasing (1995) says that young girls are even more at risk, since they have no means to defend themselves against forceful sex. *Human Rights Watch* (2002) reports that the number of cases in which male relatives and men who are not related to the girl have forceful sex with a young girl is increasing. One of the reasons for the increase is the myth that one can cure himself from HIV by having sex with a young girl preferably a virgin. Young boys, too seem to be the victim of the myth but to a much lesser extent.

Poverty is a major factor that pushes some women into the sex industry. Research finding by (Idele-Akwara 2002 pp.31) say that women offer themselves for sex for exchange of monetary and material favours. The context of most commercial sex work is to make enough money by that they support themselves and their families. Young girls who are either full time sex workers are particularly vulnerable and often have no power to insist on safer sex practices.

The extent to which sexual partners are free to negotiate safer sex and to protect themselves and their partners is greatly influenced by the gendered aspect of sexual behaviour. The most effective methods of HIV prevention are partner dependent- abstinence, faithfulness and condom use as they require the active participation of both partners, they can best be effected when both parties are free to negotiate without fear of negative consequences. Therefore, gender and sexuality are at the heart of any understanding of the dynamics of HIV transmission.

2.4 Gender aspect and HIV/AIDS in Kenya

According to *Popular Version (2003)* HIV/AIDS impact men and women differently. Although the pandemic affects both genders, recent trends are indicating that more women than men are becoming infected at very young ages. At the beginning of the pandemic, women and girls were at periphery, today there are at the core. Globally, the incidence of the disease among women has risen at an alarming rate, in 1997 41 per cent of all AIDS cases were women, by 2002 this figure had risen to 46 percent (*Ibid pp9*)

This trend is evident in Kenya. Statistics prove that both the spread and impact of HIV and AIDS is not random. It disproportionately affect women and adolescent girls who are socially, culturally biologically and economically more vulnerable than men or adolescent boys.

Examples of how gender and sexuality renders females vulnerable to HIV transmissions include the fact that women are often not in a position to say 'no' to sex, to enforce their partners or to insist on condom use. This is what Rollof and Miller (1980) refer to as disadvantaged bargaining

position. Bargaining being the process by which two or more people attempt to reach an agreement about terms of exchange between them.

An agreement stipulates how each party will behave in future. Bargaining involve positive, giving, or rewarding behaviour as well as negative, deprivation, or punishing behaviour.

For example, children agreement to eat all their vegetables may be exchanged for the promise of their parents not to spank them. This example shows that bargaining may be important dimension in most human relationship. Women, and especially young girls are expected to be ignorant about sexuality and sexual matters which constraint them from seeking information concerning sex (Mouli 1991) Silence surrounding sexuality within societies also stigmatises women who seek treatment for STIs.

Notwithstanding a degree of economic independence, social and cultural expectations may make it extremely difficult for them to set terms for sexual encounters. Examples of double standards for males and females abound. Producing children gives status to a family, but childlessness in women is regarded as reason for rejection and divorce (Kamenga et al 1991.p64)

Women are expected be faithful, multiple sexual relationship are acceptable and even encouraged for men.

Young women tend to have older, more experienced sexual partners who have more control in the relationship are more likely to have sexually transmitted infections (STI's) due to their previous sexual experiences.

Not all young women have sex because they want to (*Human Rights Watch 2002*) Dale 2003. There is growing evidence that a large number of

share of new cases of HIV infection is due to gender based violence in homes, schools, the work place and other social spheres.

Sexual relationships involving exchange of money or gifts may place adolescents at greater risk of unintended pregnancies and STIs. For young women receiving payment, the power imbalance in the relationship may make it difficult to refuse sex, or negotiate condom or contraceptive use.

In Kenya, 21 per cent of women reported that they had recently received money for sex while 17 percent of men reported they had given money for sex (*PRB 2001*)

It is evident from the report that young unmarried women are slightly more likely than young unmarried men to report having had a recent sexual relationship, more than one fifth of young unmarried women in Kenya shows have changed in a sexual relationship involving some form of exchange.

In a Kenya-wide study of sexual abuse of women and girls under 24 years of age, 25 Percent said they lost their virginity due to forceful sex (*Popular Version (2003)*) A recent University of Nairobi study indicated that 4 Percent of HIV infections especially for girls, since force is used, abrasions and cuts are more likely and the virus can move easily find its way into the blood stream, what's more condom use is unlikely in such situations (*Ibid pp9*)

As graphically confined above, social and economic dynamics are skewed against women and especially girls, including those in the colleges selected for the study.

Gender roles also render women vulnerable to sexual prowess, multiple partners and control over sexual interactions, define masculinity. Often men are required to prove their masculinity by being dominant or having many sexual partners. They may fear the ridicule of their male peers if they are faithful to only one woman. It is not uncommon in Kenya to hear that a man has been “sat-on” by the wife especially the hard-nosed and nonsensical type, who dominate the relationship with the husband. Men are expected to be knowledgeable about sex and sexuality and are unable to seek information or medical treatment. Largade et al (1996). Such beliefs challenge messages such as partner faithfulness or reduction of a number of partners.

Gender and risk perception

Subgroups of a community can react according to their cultural and social characteristics, and also according to gender. Slovic (1999)⁶ Generally speaking, women feel more insecure with regard to an industrial threat because:

1. they perceive technological events as more potentially hazardous;
2. they have less knowledge of the organization of industry and consequently cannot perceive the effectiveness of industrial safety precautions; as a result they have less faith in such measures.
3. they have less real knowledge of the hazards and their origins; and
4. they are more prone to anxiety (as a personality trait).

It has also been observed that women more frequently report situations of alarm with reference to industrial activities. Since women have higher values than men in terms of personal health, well-being and care for

⁶ Slovic. p.(1999).Trust. Emotion. Sex. Politics and Science :”Surveying the risk assessment Battlefield” Vol. 19, No 4 pp 689-701

families, they are subject to greater stress than men and feel more threatened by industrial hazards.

2.5 HIV/AIDS Risk Perception

Risk can be defined as the chance of an adverse outcome to human health, the quality of life, or the quality of environment. *The World Health Report 2002* defines risk as a probability of an adverse outcome, or a factor that raises this probability. Oxford Dictionary of Psychology, 2003. Pp 641 “a situation in which an action will result in an outcome that is not known with certainty, but the set of possible outcomes and their associated probabilities are known or can be estimated”

The important factor here is that this definition refers to situations in which one will prevail. If for example a gambler participates in a game of toss, the probabilities are known as 1/6 for each number on dice but it is not certain which in advance on which number one should bet to win. The gambler takes the risk to either lose or win. If he bets on the wrong number and loses some money it is not life threatening although it is a loss nonetheless. What comes maybe more spontaneous to our minds when we think about risk, the fact that risk taking often involves a danger or novelty which usually stimulates anxious feeling in people.(Levenson, 1990)

People tend to be particularly resistant to the idea that they are at risk from any particular hazard. Most people believe that they are in less danger than the average individual, with a lower than average likelihood of dying from a heart attack, a lower probability of being burned, or of becoming addicted to drugs; they tend to feel infallible. For example, virtually all individuals believe that they drive their vehicles better than

average; or that they have less likelihood of getting cancer than the average person. This unreal optimism is based on the information available and on a reasoning process that induces us to think that the hazard in question is not a real threat, even though it may affect persons known to us. All of this influences people's response to risk. The message "*this includes you*" is more difficult to get across than "*many will die.*"

A report by UNAIDS (2002) reveals that even where knowledge on HIV/AIDS has been substantially increased "knowing" is not necessarily "doing". Many young people do not connect knowledge and risk perception with behaviours.

Risk -reduction strategies are likely to succeed only if they intervene in the social networks of these risk takers to change norms and behavior. Mann et al (1992).

It remains unclear how knowledge of HIV/AIDS is translated into safe sexual behaviour at the community and individual levels. It is not clear how perceptions of risk influence or is influenced by sexual behavior as the association between two variables can work both ways.

For example, in another Zambian study by Mchangwi (1993), it was found that the practices of having multiple sexual partners were very common among married and unmarried couples. Many Zambians perceived condom use and reducing the number of their sexual partners, the two main sex behaviour changes recommended by health/medical experts as being of dubious value. Some 57 percent of the survey respondents said that using a condom during sex with HIV infected could not fully protect a man. Further 1 only 27 percent of the respondents said that reducing their number of sexual partners would prevent HIV infection. Only 5 percent of the respondents said that they

had used a condom during their last sexual intercourse (this use rate was 33 percent average life expectations has dropped from 59 to 40 years de Waal (2003).

Despite a lot of information provided through radio and television programmes, and discussions and lectures for teachers, religious leaders, journalists, health workers, and political leader organised by (local) NGOs very little was noted in change of practicing safe sexual behaviour. In the 1990's it turned out that although there was much knowledge about greater awareness of HIV/AIDS, there was little change in attitude. Schoef *et al* (1991).

In KDHS (1998) noted that, about a third of both Kenyan men and women felt they were not at risk of HIV/AIDS. 50 percent and 14 percent of sexually active unmarried men and women respectively reported having had two or more sexual partners in the last year of the survey.

Condom use is low in Kenya and is confined to only certain types of sexual liaisons, although use is common with non-regular than with regular partners. Idele- Akwara (2002) adds that low use of condoms in extra-marital relations heightens the risk of HIV.

The strong influence of socio-cultural environment may explain the observed inconsistency between what Kenyan people claim to know and beliefs and risk taking behavior associated with increased risk of HIV/AIDS infection. Certain cultural beliefs in (wife inheritance) Kenya have encouraged the epidemic for instance, when a married man dies, this widow must cleanse herself of his spirit by having sexual intercourse with one of her late husbands brothers or other male relatives. This traditional belief about purification, while slowly dying out, is particularly dangerous in spreading HIV infection if the husband died of

AIDS and his widow is HIV positive, she may infect his brother or other male relative who may in turn infect his wife and future children.

Another aspect, which promotes AIDS risk perception, is that in most societies in Africa dominant ideologies promote sexual ignorance (disguised as innocence) among young women. At the same time, many young girls and young women actually have little control over how, when and where sex takes place. UNAIDS (2002)

2.6 Socioeconomic factors and their link to AIDS risk perception

According to (WHO, 1995) urbanisation and migration increases opportunities for sexual encounters and provides new models for sexual behaviour. The results suggest that urbanisation and modernisation favour transgression of the more restrictive traditions that exist in the rural areas.

Findings showed that sexual activity among young people in Kenya frequently as a result of an obligation, a gift, a favour or monetary payment. This is particularly prevalent practice among poor, unmarried, uneducated, unemployment urban girls by older men (Greene 1998, Eureka *et al.* 1998).

In a community-based survey some 10 percent of Kenyan adolescent boys (13-19) report previous contact with a commercial sex worker. HIV rates of infection among Kenyan commercial sex workers (and particularly those working in high prevalence places) can often exceed 80 percent (Cleland and Ferry, 1995, Gibnex, Di Clemente and Vermund, 1999).

From a selected list of risks, the WHO report identifies top ten risk factors globally and regionally in terms of the burden of disease they cause. The ten leading risk factors globally are underweight, unsafe sex, (linked to HIV/AIDS and unwanted pregnancies) high blood pressure, tobacco consumption, alcohol consumption, unsafe water, sanitation and hygiene, iron deficiency, indoor smoke from solid fuels, high cholesterol and obesity.

The number of such factors is countless and the report does not attempt to be comprehensive. For example, some important risks factors associated with infections disease, such as viruses, bacteria and anti-microbial resistance, are not included. Instead the report concentrates on a selection of risk factors—real risks to health, and often the actual causes of major diseases—for which the means to reduce them are known and produces some startling findings about their time impact.

The WHO findings give an intriguing and alarming insight into not just the current causes of disease and death and the factors underlying them, but also into human behaviour and how it may be changing around the world. Most of all they emphasize the global gap between the poor and the rich by showing just how much of the world's burden is the result of under nutrition among the poor and over nutrition among those who are better off, wherever they live.

The contrast is shocking in relation to HIV/AIDS my major concern in this study. In terms of global risk factors, underweight is closely followed by unsafe sex, the main factor in the spread of HIV/AIDS. The rate of development of new cases is highest in Eastern Europe and central Asia. Life expectancy at birth in Sub-Sahara Africa is currently estimated at 47 years, without AIDS it is estimated that it would be around 62 years.

For example, at least 30 percent of all disease burden occurring in many developing countries, such as Sub-Saharan Africa and South East Asia, result from fewer than five of the ten risks mentioned above.

Together these account for more than one-third of all deaths worldwide. The WHO report shows that a relatively small number of risks cause a huge number of premature deaths and account for a very large share of the global burden of disease.

According to the report, the impact of many of the risk factors can be reversed quickly and most benefits will accrue within a decade. Even modest changes in risk factor levels could bring about large benefits.

Apart from the obvious health benefits, the report says that overall, reducing major risks to health will promote sustainable development and reduce inequities in society.

2.7 Perceiving Risks

Hudspith (2003) explains that both risks and benefits have to be considered when seeking to understand what drives some behaviours and why some interventions are more acceptable and successful than others. Social, cultural and economic factors are central to how individuals perceive risks similarly, Societal and structural factors can influence which risk control policies are adopted and the impact that interventions can achieve.

A study of HIV risk behaviour among 2000 16 - 24 year olds in France, United States, and United Kingdom observed that despite knowledge

about perception of HIV/AIDS, as risky, high percentage of young people continued to experiment with high risk behaviours. According to the investigators, these findings suggest that intervention programmes that merely educate young people about risk behaviors are inadequate in producing behavioral change.

The concept of risk is highly complex. Our understanding of the complexity of the concept has increased as specialists in different disciplines have investigated what we mean when we refer to risk.

To do this one must first find ways of segregating individual differences and needs, and then include the real concerns of the public in the risk information provided.

It is important to transmit information about the magnitude of the risk so that people may become aware of risks that they had never heard of before; while information about personal vulnerability is important for the transition from awareness to the decision to act. The decision to act is not, however, the same thing as acting.

Since most people are concerned about the same things that concern their friends, they are alert and responsive when presented with evidence that a particular hazard may (or may not) represent a local concern.

Individuals who feel safe and those whose attitudes reflect some degree of knowledge about the risk in question experience fewer obstacles to modify their environment than those who respond defensively. This aspect will have repercussions when planning activities for a risk communication program.

WHO Report(2002) says that preventing risk factors has to be planned within the context of local society, bearing in mind that success of preventive interventions is only partly a matter of individual circumstances and education.

Factors related to the characteristics of a person making the judgment can be summarised below:--

A. 1) Ways of thinking and decision making ability

- a) The closeness of the events
- b) Experts versus non-experts
- c) Dread

2) Education

3) Personal values

4) Gender and ethnicity

5) Addiction (such as tobacco consumption)

B. Factors related to characteristics of risk

- 1. Personal versus social
- 2. Voluntary versus non-voluntary
- 3. Familiar versus exotic

Natural versus Technological

C Other factors

1. Media

Heavy media coverage of risks can have a measurable effect by introducing what is commonly referred to as “availability bias” to risk perception Fiscoff (1995). This type of bias results when events can be easily recalled by the public. These events are then perceived to be more frequent and this in turn leads to an overestimation of the frequency of the event. For example, survey data show that the public perception in

the US from 1996–1997 of the perceived threat to food safety from spoilage, E. coli and quality control increased by 20 percent. It is suggested that this is due largely to increased media coverage of the risk of food-borne illness⁷.

Slovic (2000) says that studies by anthropologists and sociologists have shown that risk perception and the acceptance of a risk have their roots in cultural and social factors. It has been argued that friends, family, colleagues among the social influences transmit the response to a hazard, and respected public officials. In many cases, however, the perception of risk can be formed through a process of reasoning on the part of the individual himself/herself.[Sandman (1987), Fischhoff (1995)]

Defining traits of perception

Researchers on risk perception have studied the characteristics of risk that influence perception. The conditions defined below have the greatest influence on the way risks are perceived.

1) Dread

Which idea frightens you more, being eaten by a shark or dying of heart disease? Both can kill, but heart problems are much more likely to do so. In spite of this, the most feared deaths are the ones that worry us the most. Cancer, for example, causes more dread because it is perceived as a terrible way to die. This explains why hazards that can cause cancer, such as radiation and chemical agents, arouse intense fears. Fear is a clear example of what we think about a risk in terms of our intuitive feelings, a process which is called the heuristic effect.

2) Control

⁷CFIA(2001) Ibid PP 2

Most people feel safe when they drive. Having the steering wheel in their hands produces a feeling of power, a sense of being in control. If we change places and ride in the passenger seat, we feel nervous because we are no longer in control. When people feel that they have some control over the process that determines the risk facing them, that risk will probably not appear so great as in the case when they have no control over it.

3) *Is it a natural risk or a man-made one?*

Nuclear energy sources, as well as mobile telephones or electric and magnetic fields, are often a greater cause of concern than the radiation produced by the sun. However, it is a well-known fact that the sun is responsible for a large number of skin cancers each year. The natural origin of a risk makes people perceive it as a lesser risk than a man-made one. This factor helps to explain the widespread public concern about many technologies and products.

4) *Choice*

A risk that we choose to take seems less hazardous than one imposed upon us by another person. If you use a mobile telephone while driving, you may perceive it as hazardous that another driver uses one and you will be angry because of the risk the other driver imposes on you, even though you are taking the same risk yourself. You are less concerned about the risk you yourself are taking: your control over your car influences your risk perception.

5) *Effects on children*

The survival of the species depends on the survival of its offspring. This explains why the risks such as Mother-to-child infection of HIV virus

appear to be more serious than the same risks in adults (exposure to HIV/AIDS through unprotected sex).

6) *New risks*

New risks, including the, bird flu, Ebola and HIV/AIDS and new technologies and products, tend to be more alarming than those risks that we have lived with for some time and which our experience has helped us to put into perspective.

7) *Awareness*

Yankovich in CFIA (2001) calls this, “the journey from raw opinion to public judgement.”⁸ The more aware we are of a risk, the better we perceive it and the more concerned we are. For example, Severe Acute Respiratory Syndrome (SARS) was given wider coverage, received more attention, and caused greater concern than influenza, which is responsible for a large number of deaths each year. Awareness of certain risks can be high or low, depending on the attention given to them.

8) *Possibility of personal impact*

Any risk can seem greater to us if we ourselves or someone close to us are the victims. If for instance college male students perceive their female counterparts to be at higher risk of HIV/AIDS why they (themselves) are not, then some factor could be impeding their risk perception as under normal circumstances they should. This explains why the statistical probability is often irrelevant and ineffective for communicating risks. The closer we are to the risk, and the clearer our knowledge of its consequences, the greater will be our perception of it.

⁸ Canadian Food Inspection Agency (2001)
http://www.inspection.gc.ca/english/corpafr/publications/riscomm/riscomm_ch2e.shtml

9) Cost-benefit ratio

Some risk perception analysts and researchers believe that the cost-benefit ratio is the principal factor that determines how much we fear a given threat. If there is a perceived benefit in a specific behaviour or choice, the risk associated with that behaviour or choice would seem smaller than when no such benefit is perceived.

10) Trust

The more confidence we have in the professionals responsible for our protection or in government officials or institutions responsible for our exposure to risk (for example, Public Health officials or disaster preparedness managers) or in the people who transmit risk information to us, the less fear we will feel. The less we trust them, the greater will be our level of concern.

11) Memory of risks

A memorable accident makes a risk easier to evoke and imagine, and therefore it can seem greater (for example, many Kenyans are aware of terrorist threats following the bombing of United States embassy in Nairobi in August 1998 that affected thousands of persons). They are now more conscious of the terrorist threat. The experiences that people have had are an important element in their risk perception. A person's experience will determine whether he or she attaches greater importance to one particular risk than to other statistically significant ones.

12) Spread over space and time

Unusual events such as nuclear accidents are perceived as riskier than commonplace risks (collisions on the highway).

13) *Effects on personal safety and personal properties*

An event is perceived as risky when it affects basic interests and values; for example, health, housing, the value of property, and the future as explained by Abraham Maslow who developed the Theory of Humanism and “The Hierarch of Needs.” Maslow (1968)

14) *Fairness*

People who have to face greater risks than others and who do not have access to benefits normally become indignant. The community believes that there should be a fair distribution of benefits and of risks.

15) *Process*

The agency or government must demonstrate trustworthiness, honesty and concern about impacts on the community. In addition, it needs to communicate with the population before making decisions, and establish a relationship of mutual respect. It should also listen to the people, and respond to any doubts or questioning on their part. When these conditions are not met, the perception of the risk in question is negatively affected.

Risk perception includes different elements that need to be considered as a whole for a good understanding of how individuals and social groups perceive risks. To know how a specific health problem such as HIV/AIDS, is perceived in a community is essential if we are to prepare an effective plan for risk communication.

The social, cultural and economic issues identified in the literature review and the theoretical models which are used in explaining sexual human behaviour that relate to the spread of the epidemic include poverty, alcohol and drug use, commercial sex, western media influence.

These factors are connected to prevailing sexual relations among college students and therefore vulnerability to HIV/AIDS and impaired risk perception associated with the factors.

The literature review has revealed that HIV/AIDS awareness and perception of risk of HIV/AIDS are totally different and both need to be integrated for an effective campaign strategy to epidemic to start bearing fruit.

2.8 Theoretical framework

There are a number of behavioural theories that can be used in study of risk perception and what drives some behaviours such as reluctance to use condoms for protection against HIV/Aids, cessation of smoking, alcoholism and a host of other behaviors that pose risk to human health.

Either implicitly or explicitly, all prevention interventions are based on theory. Most rely on assumptions that giving correct information about transmission and intervention will lead to behavioural change of the target population. Yet according to UNAIDS (1999) *Sexual behavioural change for HIV: Where have theories taken us?* Research has proven numerous times that education alone is not enough to induce behavioural change among most individuals.

According to Sweat (1995) social researchers more recently have come to realise that because complex health behaviour such as sex takes place in context, socio- cultural factors surrounding the individual and his or her immediate social relationships lie the larger issues of structural and environmental determinants that also play a significant role in sexual behaviour.

With HIV/AIDS, behavioural intervention models and theories specifically dealing with AIDS have been developed such as AIDS Risk Reduction Model (ARRM) and Health Belief Model.

It must be remembered however, that there is dearth of information on tests of the relevance of behavioural change models in differing contexts, especially in Sub-Saharan Africa countries where many people have been brought first to their knees and to their graves by the AIDS pandemic.

In Sub-Sahara Africa, having a holistic view of these models is important in that no one model adequately addresses the wide range of variables, which inhibit or influence risk perception process.

The relevant models examined by this study are;

- AIDS Risk reduction model
- Diffusion of Innovations
- Health Belief Model
- Theory of diffusion of Innovation
- Social Learning Theory

AIDS Risk Reduction Model

The AIDS risk reduction model is a psychosocial model specifically developed for AIDS. Psychosocial models of risk behaviour can be categorized in three major groups: *those predicting risk behaviour, those predicting behavioural change and those predicting maintenance of safe behaviour*. Models of individual behavioural change generally focus on *stages* that individual pass through while trying to change behaviour. These theories and models generally do not consider the interaction of social, cultural and environmental issues as independent of individual factors (Auberback in UNAIDS 1999)

Although each theory is built on different assumptions, they all state that behavioural changes occur by altering potential risk producing situations and social relationship, risk perception, attitude, self efficacy beliefs, intentions and outcome expectations. Central to HIV prevention interventions based on psychological behaviour intervention is the practice of targeted risk reduction skills. These skills are generally passed to individuals in a process consisting of instruction, modeling, practice and feedback. The psychological theories that have been most

successful is the design and development of HIV prevention are described in details below.

AIDS Risk Reduction Model developed in 1990 by Catania uses constructs from *Health Belief Model* and the *Social Cognitive Theory* and diffusion of innovations theory to describe the process individuals (or groups) pass through while changing behaviour regarding HIV risk, especially condom use.

AARM conceptualizes an individual's relationship to HIV as a process as much as *Stages* and emphasizes changes of perceptions as much as volition, the will to make changes.

The model identifies three stages involved reducing risk for HIV transmission

- Behaviour labelling
- Commitment to change
- Taking action

In the first stage, knowledge about HIV transmission, perceived HIV susceptibility as well as aversive emotions influence how people perceive AIDS.

The commitment stage is shaped by four factors: Perception of enjoyment, self efficacy, social norms and aversive emotions, sexual communication, help seeking behaviour and social factors affect people's decision making process.

Programmes that use the AARM focus on:

- Clients risk assessment
- Influencing the decision to reduce risk through perceptions of enjoyment or self- efficacy
- Clients support to enact the change (access to condoms, social support)

The theory is crucial to the study of youth who are a high- risk group, and how they react to this pandemic threatening their very existence.

Health Belief Model

This model is another psychosocial model or basically a theory focusing on individuals developed in the 1950's and one of the most widely used conceptual framework for understanding health behaviour.

It holds that behaviour is a function of individuals' socio-demographic characteristics, knowledge and attitudes. According to this model, a person must hold the following beliefs in order to be able to change behaviour.

- 1) Perceived susceptibility to a particular health problem, e.g. condom use, seatbelt use, medical compliance (*am I at risk for HIV?*)
- 2) Perceived seriousness of the condition (*How serious is AIDS, how hard would be my life if I got it?*)
- 3) Belief in effectiveness of the new behaviour change (*Condoms are more effective against HIV transmission*)
- 4) Changes to action (*For example witnessing the death or illness of a close friend or relative due to AIDS*)
- 5) Perceived benefits of preventive action (*if I start using condoms, I can avoid HIV infection*)
- 6) Barriers to taking action (*I don't like using condoms*)

In this model, promoting action to change behaviour include changing individual personal beliefs. Individuals weigh the benefits against the perceived costs and barriers to change. For change to occur, benefits must outweigh loss (UNAIDS 1999) With respect to HIV intervention often target perception of risk, belief in severity of AIDS (*there is no cure yet*) belief in effectiveness of condom use and benefits of condom use delaying onset of sexual relations.

Social Cognitive Theory (SCT)

A psychosocial theory otherwise referred to as **Social Learning Theory** is associated with Bandura.

The premise of social cognitive or social learning theory states that new behaviours are learned either by modeling the behaviour of others or by direct experience and can result in behavioural change in lifestyle.

Observational learning is also known as imitation or modeling. In this process, learning occurs when individuals observe and imitate other's behaviour. Bandura (1977) says there are four components process influenced by the observed behaviour following exposure to models. These components include: attention, retention, motor reproduction and motivation.

Social Learning Theory focuses on the important roles played by various symbolic and self regulatory processes in psychological functioning and looks at human behaviour as a continuous interaction between cognitive, behavioural and environmental determinants.

Central tenets of the social cognitive theory are

- Self-efficacy- the belief in the ability to implement the necessary behaviour (I know I can insist on condom use with my partner)
- Outcome expectations- beliefs about outcomes such as the belief that using condoms correctly will prevent HIV infection.

Programmes built on SCT integrate information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy. Specifically, activities focus on the experience people have in talking to their partners about sex and condom use, the positive and negative beliefs about adopting condom use, and the types of environmental barriers to risk reduction.

Diffusion of Innovations Theory

The theory is associated with Everett Rogers (1995). His scholarly and scientific theory has become the standard text for diffusion studies. He offers insightful explanations of the conditions that dictate an adoption of an innovation.

Rogers suggests that for good or bad, an idea change can be promoted easily in a social system through a domino effect. This can be described otherwise as the tipping 'point the point at which a trend catches fire-spreading exponentially through the population.

The most striking feature for diffusions theory is that, for members of a social system, the innovation-decision depends heavily on the innovation-decisions of the other members of the system. For example, using the members of target population, such as men who have sex with men (MSM) or female commercial sex workers.

Empirically, the successful spread of an innovation follows an S-shaped curve (pp23). There is after about 10-25 percent of system members adopt an innovation,(innovator and opinion leaders) then relatively rapid adoption by remaining members and finally a period in which laggards or holdouts adopt. (Orr 2003)

The innovation decision is made through a cost benefit analysis where the major obstacle is uncertainty. People will adopt an innovation if they believe that it will, all things considered, enhance their utility. So they must believe that the innovation will yield some relative advantage to the idea it supercedes. How can they know for sure whether there are benefits?

Also, in conservation of costs, people determine to what degree the innovation would disrupt other functioning facets of their daily life. Is it compatible with existing habits and values? Is it hard to use?

The newness and unfamiliarity of an innovation infuse the cost benefit analysis with large dose of uncertainty. It sounds good, but does it work? Will it break? (e.g. using condoms). If I adopt it, will people think I am weird?

Since people are on average risk averse, the uncertainty will often result in postponement of the decision until further evidence can be gathered. But the key is that this is not always the case for everyone. Each individual's decision is largely drummed by personal characteristics and this diversity is what makes diffusion possible.

For a successful innovation, the adopter distribution follow a bell shaped curve, the derivative of s-shaped diffusion curve, over time and approach normality. (Rogers, 1995, pp257)

Diffusion scholars divide this bell- shaped curve to characterize five categories of system member innovativeness, where innovativeness is defined as the degree to which an individual is relatively earlier in adopting new ideas than other members of the system. These groups are;

1) Innovators, 2) Early adopters, 3) Early Majority 4) Late Majority 5) Laggards (pp 262)

The personal characteristics and interaction of these groups illuminates the aforementioned domino effect.

The mass media's most powerful effect on innovation is that it spreads knowledge of innovation to a large audience rapidly. It can even lead to

changes in weakly held attitudes. But strong interpersonal ties are usually more effective in formation and change of strongly held attitudes.

Singhal and Rogers (2003) say that soon after the HIV/Aids epidemic got underway, gay men or men who have sex with men (MSM) organization in the United States began to launch prevention programmes. The most noted, and effective, of these, was STOP AIDS.

This intervention programme was founded by gay San Franciscans and was based on social psychologist Kurt Lewin's Small Group Communication Theory and Diffusion of Innovations theory. (Rogers, 1995)

Focus group interviews were initially conducted by STOP AIDS in order to assess how much MSM already knew about the epidemic and what they wanted to know.

STOP AIDS relied heavily on diffusion theory, which suggested that only those early *adopters* who make up relatively small segment of the population, need to initiate a new behaviour for it to spread the population.

Mechanism of Diffusion

Diffusion is the process by which innovations is communicated through certain channels over time among members of a social system (e.g. college students). Given that decisions are not authoritative or collective, each member of the social system faces his/her own innovation- decision that according to (Rogers 1995, 162) says that it follows a 5-step process.

- 1) **Knowledge-** A person becomes aware of an innovation and has idea how it functions

- 2) **Persuasion**- Person forms a favourable or unfavourable attitude towards the innovation
- 3) **Decision**- Person engages in activities that lead to a choice to adopt or reject innovation
- 4) **Implementation**- Person puts an innovation into use
- 5) **Confirmation**- Person evaluates the results of an innovation –decision already made (McQuail et al, 1981) adds that he may reverse his previous decision if exposed to conflicting messages about the innovation. (pp52)

According to Rogers, getting a new idea adopted even when it has obvious advantages is often difficult. An innovation is any idea, object, practice, technology et cetera that is perceived by an individual or other unit of adoption.

The perceived newness of idea for unit of adoption e.g. condom (use) determines its reaction to it. Newness need not just involve new knowledge. A development of favourable or unfavourable attitude or perception towards it (to adapt or reject it) may be expressed as newness in terms of decision or attitude (*Ibid.* 1995)

The adoption of safe sexual behaviour by a students and their perception to be at risk is a consequence of multiple factors, with research evidence being only one. Diffusion theory offers a plausible explanation for why some safe sexual behaviours and risk perceptions are developed and adopted rapidly and others only with difficulty, despite strong evidence of their potential benefits. Some behaviours may be adopted relatively easily because of the nature of the behaviour itself, while others may involve a complex interplay between social systems, communication style and the decision-making process. There is a need to prospectively test the assumptions of the model in the

way students adopt condom use for HIV/AIDS prevention and how they adopt “being at risk”. The adoption of safe sexual behaviour is important for the survival of populations at risk of HIV/AIDS epidemic.

Singhal and Rogers (2003) reveal that using diffusion theory, media campaign STOP AIDS was aimed at MSM population of San Francisco to raise awareness- knowledge about HIV/AIDS.

The number of new infections dropped from 8,000 annually in the earliest years of the epidemic, to only 650 by the mid 1980's. (pp 167) Then attendance at small group fell off, and it became difficult for STOP AIDS to recruit fresh volunteers

The critical mass of early adopters of safer sex MSM community had been reached and the idea of safer sex would continue thereafter.

STOP AIDS declared victory in 1987, and closed down its local operations. In 1990 however, STOP AIDS swung back into action in San Francisco in order to carry safer sex into the city message to new cohorts of younger gay men who were migrating.

The theories discussed though developed in developed countries, particularly United States and therefore may not capture the elements necessary for behaviour change in every culture and population. They do provide, however examples of how behaviour change is believed to occur and also provide basis for communication strategies and other risk reduction strategies in high-risk group.

Limitations in the Theories discussed and their application to this study

In the case of Aids Risk Reduction Model, it focuses on the individual. For example, many students in the study felt at risk of HIV/AIDS, not because of their own behaviour but of their sexual partners, an issue they reported was outside their control. As a result consideration of social cultural and economic issues that influence an individual's behaviour choices and ability to take action are not included in the model.

Diffusion of Innovation Theory which in summary focuses on five elements (1) the characteristics of an innovation which may influence its adoption; (2) the decision-making process that occurs when individuals consider adopting a new idea, product or practice; (3) the characteristics of individuals that make them likely to adopt an innovation; (4) the consequences for individuals and society of adopting an innovation; and (5) communication channels used in the adoption process, does not provide free will in the this case, it is fated as to what is information is received to the masses, they have no choice to what they are exposed to.

However the diffusion of innovation process can be tracked on a micro level, as is the case of an individual who is a targeted member of an audience, or traced at the macro level when considering economic development or technological advances. To this end diffusion of innovation theory comes up as a versatile and relevant model in this research. It is useful to apply to situations when trying to explain how ideas are spread through our society from the media, which is also being focused on this study.

Health Belief Model (HBM) attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. It explores a variety of long-term health behaviours and the transmission of HIV/AIDS. It is relevant in this study as it is used to explore a variety of health behaviours in diverse populations. Most students in colleges are

from diverse social cultural and economic background from all over Kenya and hence its applicability in this research. Its limitation however is that it is a psychosocial model and does not take into consideration other factors, that may influence health behaviours such as environmental or socioeconomic factors that may influence health behaviours. The model does not incorporate the influence of social norms and peer influences on people's decisions regarding their health behaviours (a point to consider when working with adolescents on HIV/AIDS issues).

On the other hand the Social Cognitive Theory (SCT) has been useful in Public Health studies. It has been used a wide range of health problem, from medical therapy compliance to alcohol abuse, to immunisation. One particular useful area of investigation is to which the SCT can be employed is the study of moral and value internalization among children.

In fact, it has been argued that the greatest contribution of SCT is its aid to understanding how children are socialised to accept standards and values in their society. Johnston *et al* (1997).

An applicable example in this study to help illustrate Diffusion of Innovations involving adoption of Western TV programmes and VCD/DVD by college students. These programmes on harmful influence either the opinion of and/or the decision of whether to watch/adopt them are important in understanding media influence on students.

Thus theoretically based approaches to HIV/AIDS prevention have the potential to specify critical factors to target for change, to suggest methods for effecting change, and to guide in evaluating HIV/AIDS prevention intervention process and outcome. The theories are of fundamental importance to HIV/AIDS prevention because they specify probable determinants of HIV/AIDS risk perception and preventive

behaviour. As such, the theories can designate factors that should be targeted for change in intervention attempts, and by extension, factors that should be assessed to determine intervention efficacy and used as a basis for discussing the construction of targeted prevention.

There is evidence that not considering separately, the effect of social learning and social influence processes within a group of peers may lead to a distorted measure of the effect of individual characteristics on risk perception (Bernardi (2002). For instance, our residence variable appears to be a relevant characteristic only as far as behavioural performances are concerned. The fact that residence is not related to risk perception tells us only that behaviour and risk perception are differently affected by the context. It seems plausible that the degree of risk perceived may better be caught by social context (social networks) than by the residence proxies, since information regarded as true requires some degree of trust in the source.

The theory tells us what to target for change and provides useful clues concerning how to effect change and guides us in evaluating change.

It has been observed that prevention programmes are more effective if organized by the members of the target audience.

Usually, some sort of coordinating network or consortium is needed to integrate these diverse psychosocial theories, social theories in formulating diverse HIV/AIDS prevention programmes.

Finally, a key theoretical issue identified in the risk perception literature is that of trust, and trust in partners was reported as a reason for believing a partner could not be HIV positive, regardless of knowledge of their HIV status.

Background

Project Objectives

The primary objective of this project is to evaluate the effectiveness of the proposed intervention in reducing the incidence of the target behavior. The secondary objectives are to assess the acceptability and feasibility of the intervention in the target population and to identify any barriers to implementation.

Methodology

The study will be conducted using a randomized controlled trial design. The intervention group will receive the proposed intervention, while the control group will receive a placebo. The primary outcome measure is the incidence of the target behavior, which will be measured at baseline and at follow-up. Secondary outcome measures include acceptability and feasibility.

Results & Conclusions

The results of the study indicate that the proposed intervention significantly reduced the incidence of the target behavior compared to the control group. The intervention was also found to be acceptable and feasible in the target population.

These findings suggest that the proposed intervention is an effective and acceptable strategy for reducing the incidence of the target behavior. Further research is needed to evaluate the long-term effectiveness and sustainability of the intervention.

CHAPTER THREE

3.0 Methodology

3.1 Research Method

This chapter presents the research approaches and methods of data collection that were used in order to meet the objectives of the study as set in Chapter One. Included in the study is the unit of analysis, research setting, population, sample and sampling design, data collection instrument and data analysis techniques.

3.2 Unit of Analysis

These are entities (objects or events) under study whose social characteristics are the focus of this study. Nachimias & Nachimias (2000) pp 67

For this study therefore youths in 3-year government sponsored diploma colleges are the cases.

3.3 The Research Setting

The study was carried out in Nairobi's colleges, namely Kenya Institute of Mass Communication situated at South B about three Kilometres from the city centre and the Kenya Polytechnic within the fringes of the Central Business District, specifically Haile Sellasie Avenue.

The colleges were selected owing to the variety of courses offered and consequently attracting students nationwide intake of students from diverse backgrounds across the country hence the selected colleges seems to offer social, economic and cultural diversity necessary for

identifying the salient factors such as poverty, peer pressure influence etc, and issues that play an important role in the formation and influences of risk perceptions. Again limitation of scope due to limitation of time and costs was made considered during the selection.

Thus they are meant to be illustrative of social, cultural and economic variables impacting on HIV risk perception among college students in Kenya and not to be statistically representative, consequently, no attempts are made to generalize the results of this study to the wider Kenyan population.

It enabled the identification of variables/factors

Quota system adopted during the Moi administration in 1980s ensured that all areas of country had their slots; a system that is still in use by the current Narc government.

The colleges offered another advantage and were also selected owing to their proximity to the researcher in an effort to facilitate him with easier access owing to limited time, money and resources. The number is large enough to provide a sizable population for the study of socioeconomic variables that bog down HIV/AIDS risk perception.

The city of Nairobi has many colleges offering diplomas and certificates and therefore not all can be reached owing to the explanations given above. The choice of the two is hoped will provide the necessary universe and subsequent sample for the study.

3.4 The Population

The population of the two colleges is 4500 students. KIMC has 1500 while The Kenya Polytechnic is the leading college in Kenya in terms of enrolment with 4000 students.

The population will consist of all students undertaking all types of courses diplomas courses excluding teachers and other auxiliary staff.

This criterion of selecting the students has the advantage that it is easy getting access to them through the permission of the authorities and ensures cutting costs of conducting interviews. Categorization based on gender for each of the colleges will be utilized.

3.5 The Sample

A sample of 351 students was selected. Thus 187 males and 164 females from the college were interviewed.

A close collaboration and understanding between the researcher, the heads of departments and the college deans on one-on one basis ensured that respondents responded as they were introduced and briefed in a classroom setting.

Simple random sampling was used as a criterion to select the respondents. A number was given to every student. The numbers were placed in a container and then picked at random. The students corresponding to the numbers picked were interviewed through a self-administered questionnaire.

3.6 Variables of the study

Social, cultural and economic factors such as poverty/economic hardships, media culture, need to affirm ones sexuality, alcohol / drug abuse consists the independent variable.

Risk perception on the other hand represents the independent variable. Condom use, monogamous relationships, optimistic bias i.e. unrealistic optimism (it can only occur to others), visit to VCTs is an indication of perceiving oneself at a risk of HIV/AIDS.

3.7 Data Collection

The study used primary data collected using questionnaires issued to the 400 students sampled for the study.

The questionnaires were administered on a drop and pick up later basis. This method was used to ensure a high proportion of usable responses and a high return rate. The questions closed -ended (structured) and open-ended (unstructured) were both used in questionnaire.

The questionnaire had a range of questions to explore the socio-economic link factors to HIV risk perception, risk perception and HIV/AIDS risky sexual behaviours and to investigate the extent to which each gender's risk perception was influenced by social, cultural and economic factors.

A letter of introduction (see appendix) was given to each respondent prior to the research.

3.8 Data Analysis

Once the questionnaires were collected from the respondents, the mass of raw data collected was systematically organized in a manner that

facilitates analysis. This approach adds scope and breadth to and ensures that biases inherent in one approach are countered.

Data was analysed through the use of the Statistical Package for Social Science (SPSS) Version 10 according to the objectives of the study.

The data was cleaned, coded, and key punched into a computer and analysed. Mugenda *et al*, (1999, pp 115)⁹.

Since qualitative research generates large number of textual data requiring a systematic method of segmenting the data into meaningful units or themes, the responses in the questionnaire were arranged in categories and themes and subsequently given codes.

These levels of codes were developed to enrich the analysis process. Both approaches supplemented each other to provide in-depth explanations (qualitative) while data needed to meet required objectives and to test hypothesis require quantitative method.

Analysis of quantitative data was carried out by assigning numerical values to responses. Response was either Yes or No. Number 1 was assigned to Yes while number 2 was assigned to No.

Inferential statistics was used to infer sample results to the entire universe.

⁹ Mugenda M. et al 1999. Research Methods. Qualitative and Quantitative Applications

CHAPTER FOUR

4.0 Data Analysis and Interpretation

4.1 Introduction

This chapter presents the results of this study in relation Educational (Institution, Year, Programme and gender category) in line with the objectives set out. Respondents' age ranged from 19 –27 years of age. (Mean= 23 years). Results were further narrowed into three categories namely:

1. (a) Media Culture Influence
(b) Social and Economic factors.
2. Gendered aspect of HIV/AIDS and its link to AIDS risk perception
3. Relationship between risk perception and risk taking in sexual relations

4.2 Media Exposure/Preferences for Entertainment

The preferred media source of entertainment [Western or Local?]

The pie chart illustrations in Fig.1 shows that the western programmes are the preferred source of entertainment to most college students. Responses shows that more than three quarters of students preferred western media programmes to the local ones with female students at slightly greater influence. This implies that they are likely to be influenced more by what they watched, read or listened to in their lifestyles.

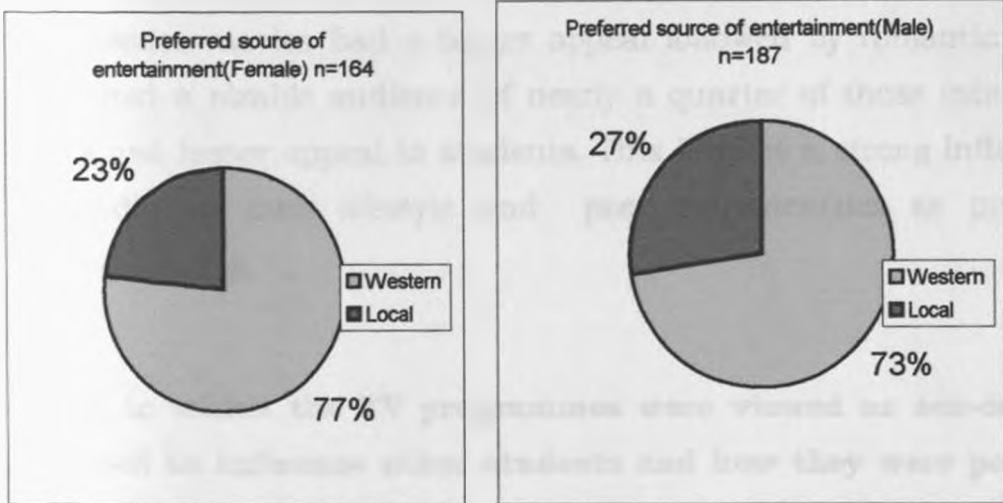


Fig.1 Preferred source of entertainment programmes
For college students.

Favourite TV programmes influencing lifestyle.

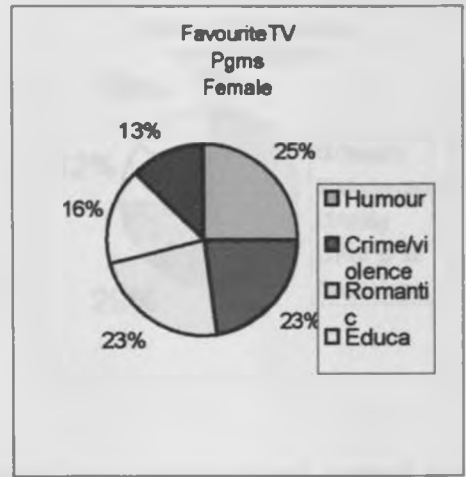
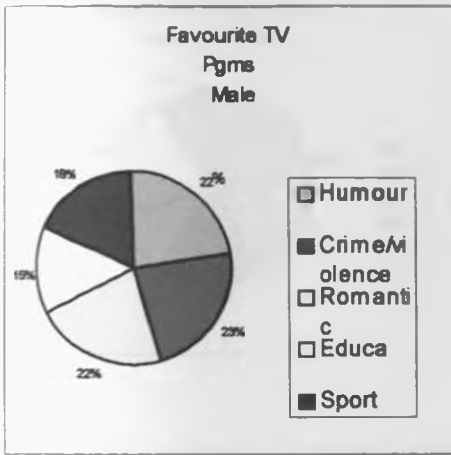


Fig. 2 Favourite Television programmes influencing students lifestyles.

College students reported that they watched humour programmes/movies more than any other category of what was in the menu. This constituted about a $\frac{1}{4}$ of students interviewed.(Fig2). Crime and violence movies had a bigger appeal followed by romantic themes which had a sizable audience of nearly a quarter of those interviewed. Sports had lesser appeal to students. This implies a strong influence of the media on their lifestyle and peer influence/ties as previously presented in Fig. 1.

Extent to which the TV programmes were viewed as sex-oriented, perceived to influence other students and how they were perceived to influence sexual behaviour among the peers. Figs 3,4 and 5.

A high percentage of students expressed that the television programmes they watched were considered by other students as sex oriented as illustrated in Fig 3 and Fig 4. Nearly $\frac{4}{5}$ of female students and over half of male students.

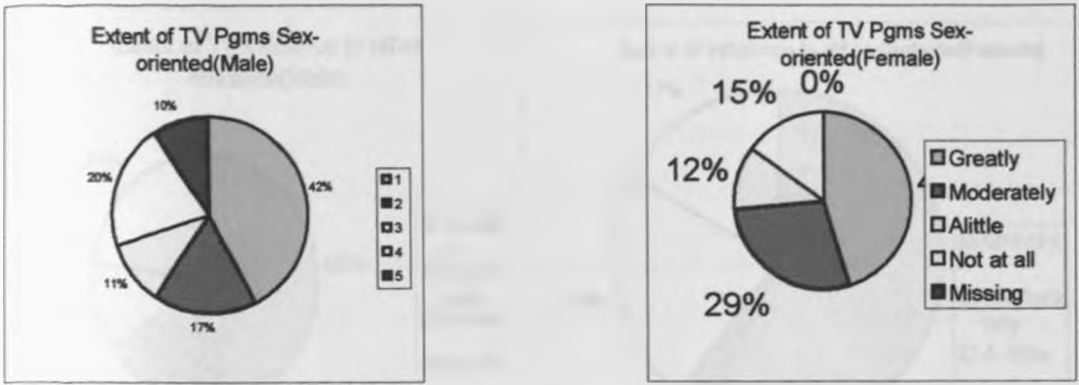


Fig. 3 Illustration on extent of how the Television programmes were viewed as sex-oriented by the students.

Extent to which TV programmes were perceived to influence to other students.[Measure peer group pressure]

The pie charts illustrations shows that about half of the students in colleges knew what their colleagues liked watching in the television. The results are an indication that peer group influence was great on what other did for their leisure. About two thirds of male students and over three quarters of female students. The results from Fig 3 and 4 are similar and show that peer group influence was of great influence among the student community. Peer group pressure among female students on TV they watched was much more among than to males. About a quarter of female students felt said that the extent of influence was little. This points out that they are more in denial than male students with less than a quarter sharing the same views with their female counterparts.

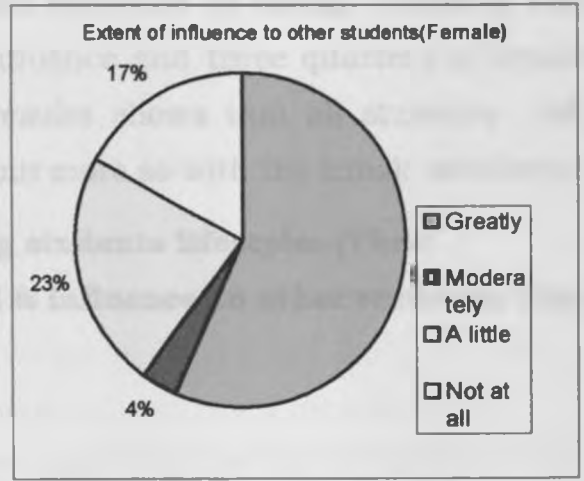
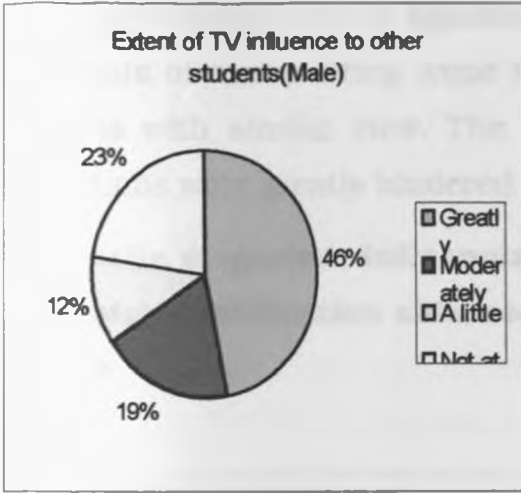


Fig. 4 Extent of TV influence to other students

TV programmes/movies influence on sexual behaviour[To measure risk perception]

Illustrations shown in the bar chart Fig. 5 gives the students' opinions on whether they thought the programmes they watched had any influence on their sexual behaviour, particularly choice of partners and whether these programmes/movies had any hindrance of HIV/AIDS risk perception.

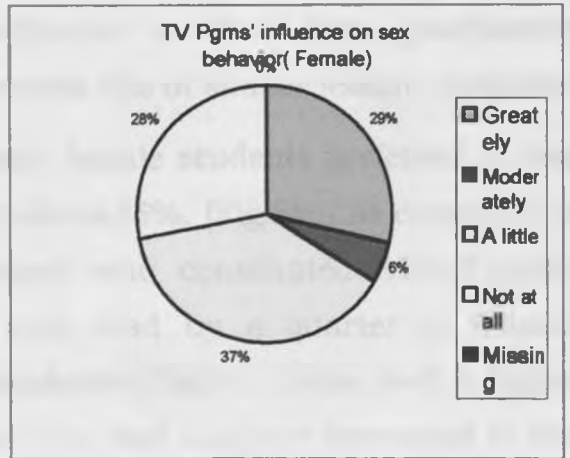
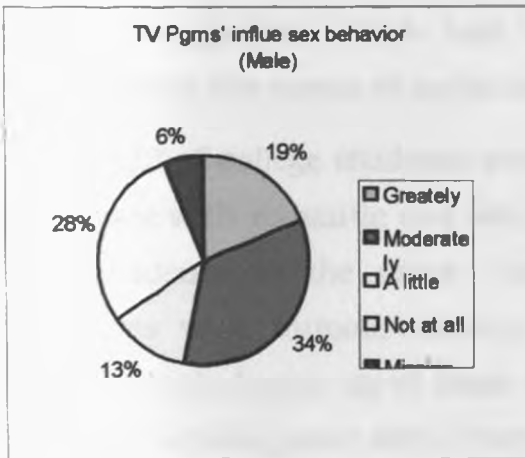


Fig. 5 Student's programmes influence on sexual behaviour

The programmes were of significant influence to college students with two thirds of males citing some influence and three quarters of female students with similar view. The results shows that all students risk perceptions were greatly hindered but more so with the female students.

Favourite magazines influencing students lifestyles.[Their Contents], Gratification obtained & influence to other students. Figs 6,7 & 8

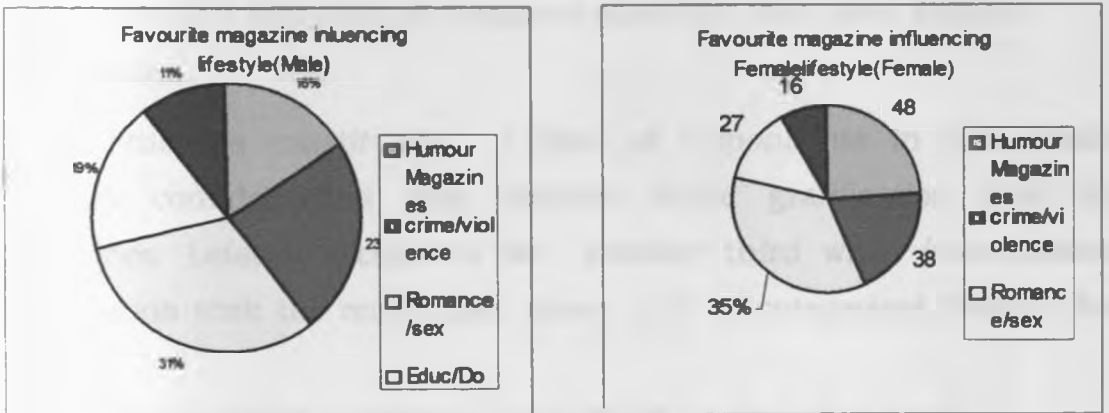


Fig 6. Favourite magazines thought to be influencing students lifestyles and type themes covered.

Figures 6, 7, 8 & 9 below presents students responses on the different types of magazines which had influence on their lives, gratification obtained and the extent of social network ties of similar leisure pursuits.

Nearly 1/3 of college students mostly female students preferred to read magazines with romantic and sex themes 35%. [Fig.6(a)] as compared to male students in the same category who constituted 31%.[Fig.6(b)]. Magazines with humour stories were read by a quarter of females students with lesser no of male students (Fig6b). Crime had a higher preference among male with nearly ¼ in that category interested in this theme.

Students were less interested in educational and documentaries category of magazines and while sport category trailed with the least readership.

This implies lifestyles which triggered HIV/AIDS risk taking behaviour were given more prominence by students.

Students said they read the magazine because they offered four types of gratifications as categorized. (a) informative/Educational(b)Derive erotic feeling(c) Leisure. On the second category, more male respondents revealed greater influence of magazine contents than their female colleagues.

Male students constituting a third of respondents in that gender category confided that they received erotic gratification from the magazines. Leisure accounted for another third while informational gratification took the remaining about a ¼ of categorized themes. See Fig.7 a .

Female respondents comprising nearly half on the other hand gratification they received to erotic feeling they derived.

Over ¼ went to leisure with the other quarter going to leisure or unwinding of stress.(Fig.7b)

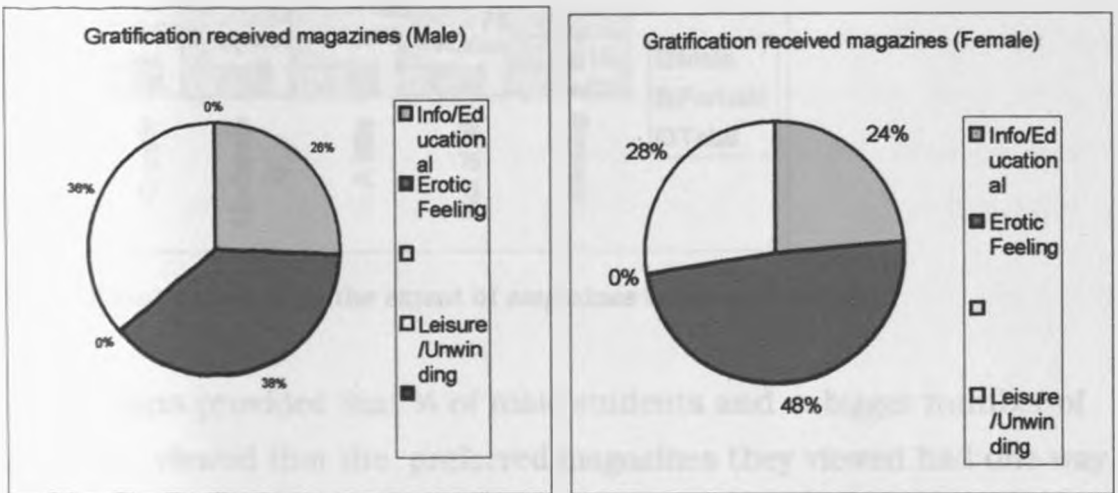


Fig. 7 Illustrations shows the reported students types of gratification from the magazines they read.

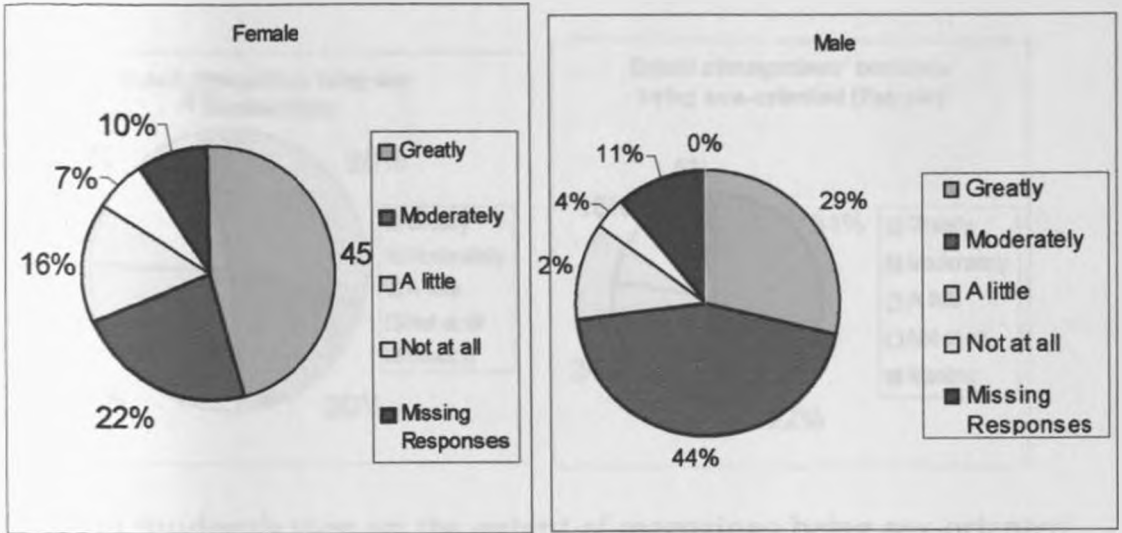


Fig. 8 Extent of magazines influence to other students

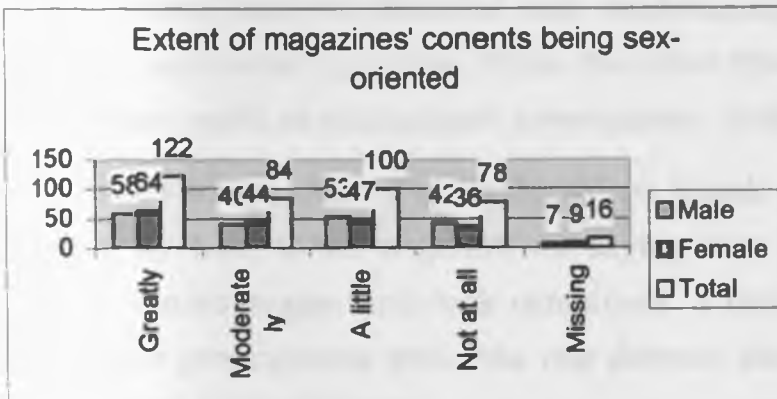


Fig.9 (a) Student's view on the extent of magazines being sex-oriented

Illustrations provided that ¼ of male students and a bigger number of students viewed that the preferred magazines they viewed had one way or another were sex-oriented in content.

The implication here is that what they read had greater influence to outlook towards sex and in a way influenced sexual behaviour which is linked to HIV/AIDS risk factors.

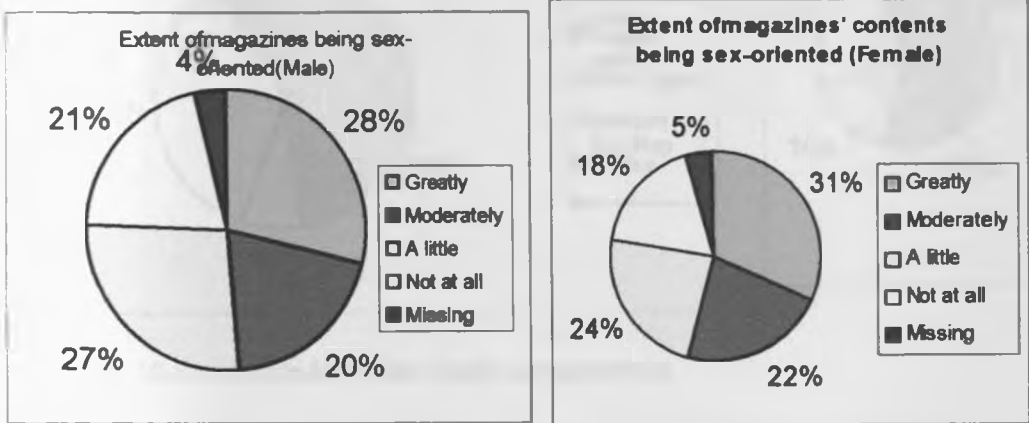


Fig. 9(b) Student's view on the extent of magazines being sex-oriented

Favourite FM Radio programmes and sex-orientedness Figs 10 and 11.

Results shows that two thirds of male students spent most of their time on reggae and rock/rap music. While the other third dedicated their time other issues such as educational programmes politics and salutations.

The results in pie chart Fig 10 (b) shows female student's listenership with nearly half of the respondents saying they devoted their time to Western music (reggae and rock combined). A third dedicated their time to religious programmes while the rest devoted their time to educational programmes and salutations.

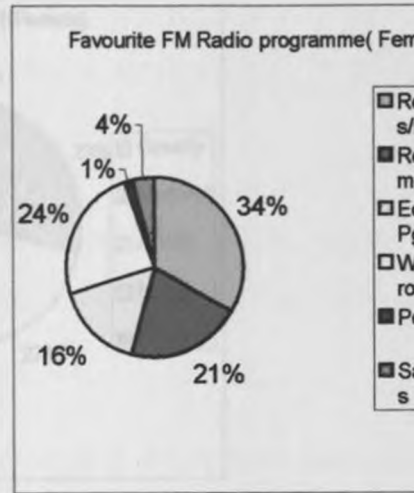
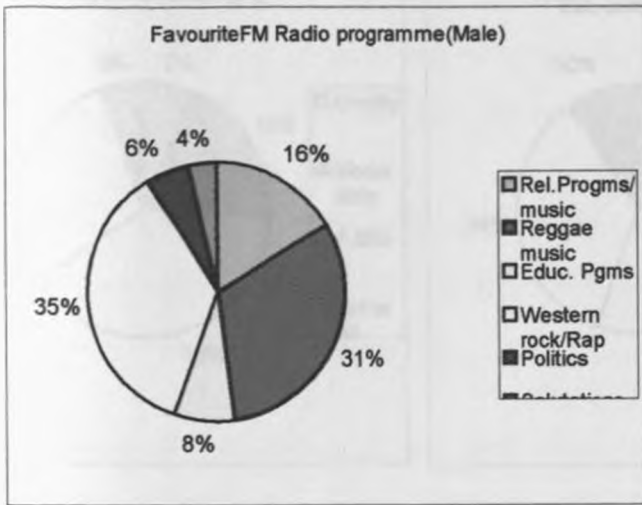


Fig 10. Student's favourite Radio programmes

The results in Fig 11 shows that over half of the students viewed the programmes they listened to as sex-oriented. 56% of male and 87% female respondents. N/B ("Greatly", "moderately" and "a little" classification of responses are added together)

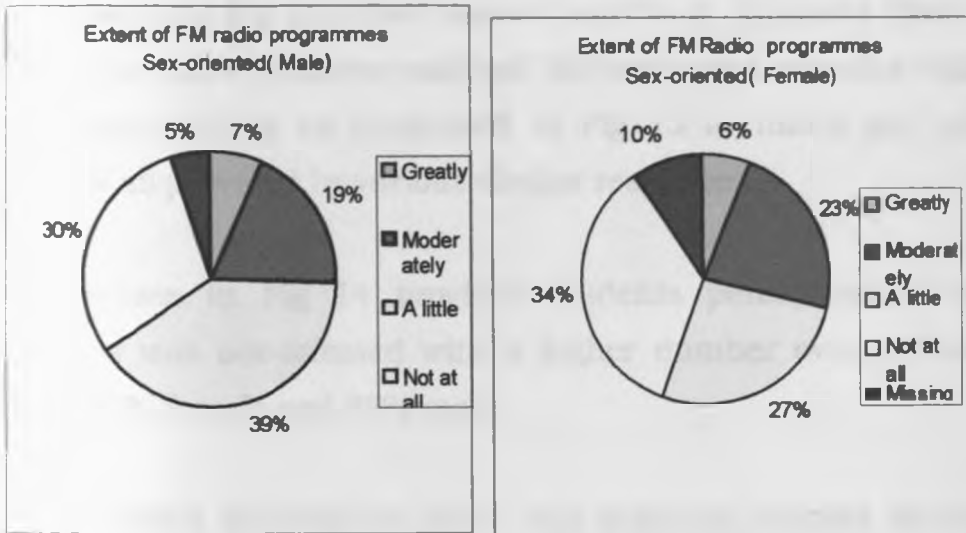


Fig 11. Extent of FM radio programmes being sex-oriented

Favourite Video /Vcds/Dvds, Extent of their popularity by other students and extent to which they were perceived to be sexually explicit. Figs 12,13&14

About ¼ of male students sampled for the study, admitted that they watched pornographic material with a lesser number of female students citing this as their hobby or interest.

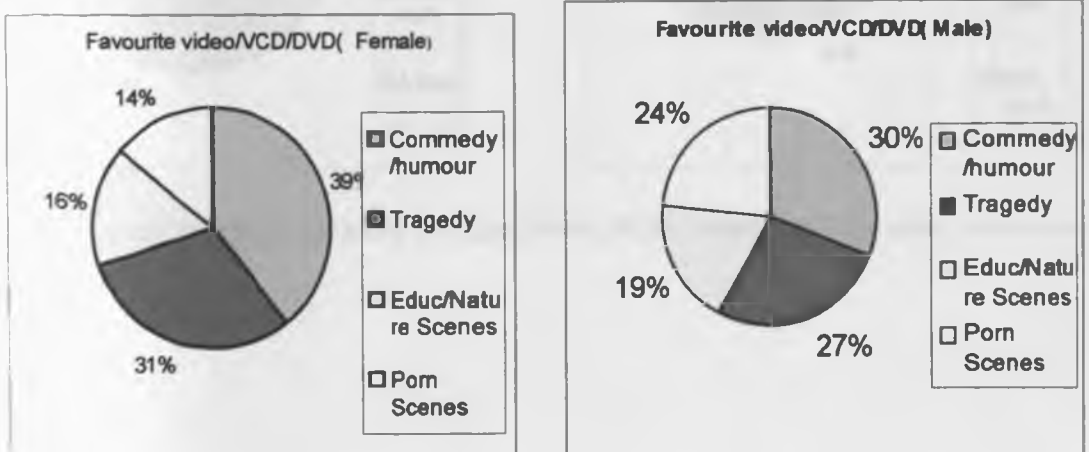


Fig. 12 Students response on type of favourite VCD/DVDS they watch for their leisure

The results in Fig 13 below shows over ¾ of students liked to identify with what other students watched. Influence was recorded higher among male respondents as illustrated in Fig 13 a, males and about ¾ of females as provided by various similar responses.

Illustrations in Fig 14 provides students perceptions, if what they watched was sex-oriented with a higher number over 4/5 saying they were. 90% female and 88% male.

The provided illustrations show that students adopted lifestyles which were likely to influence negatively to societal norms which promoted morality.

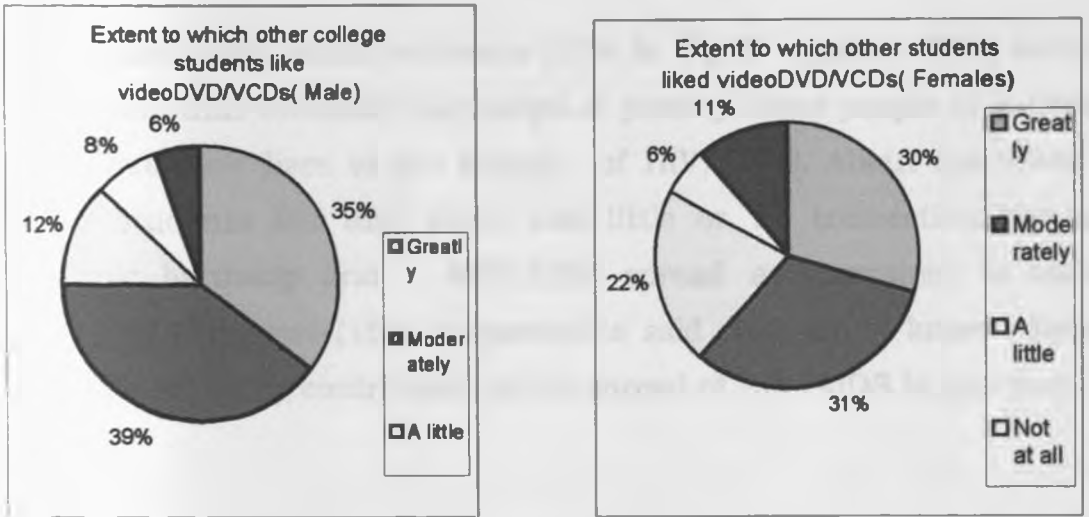


Fig. 13 Extent to which students thought DVDs/VCDs were liked by other students.

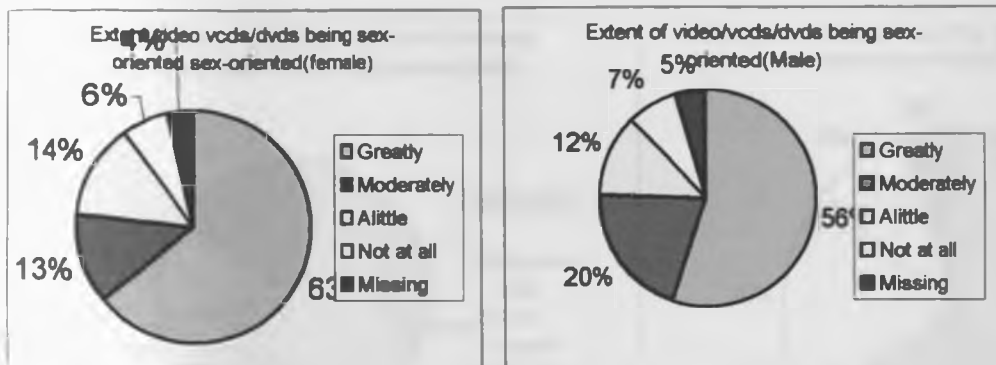


Fig. 14. Extent to which students perceived the DVDs/VCDs they watched as sex-oriented.

[b] Social and economic factors and HIV/AIDS risk perception

Extent to which Economic hardships/poverty contribute to the spread of HIV/AIDS.[Respondents' opinions& Experiences]

More male than female students (57% in Fig15 against 39%) were of the opinion that economic hardships or poverty drove people to activities which put their lives to the danger of HIV/AIDS. About one third of female students felt that there was little or no connection between economic hardship and HIV/AIDS spread as compared to males' 18%(12+6).More male(15%) respondents said they didn't know whether economic hardship contributed to the spread of HIV/AIDS in any way.

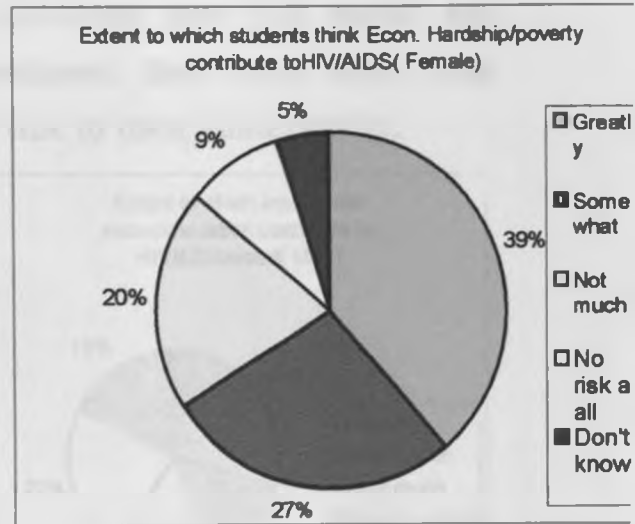
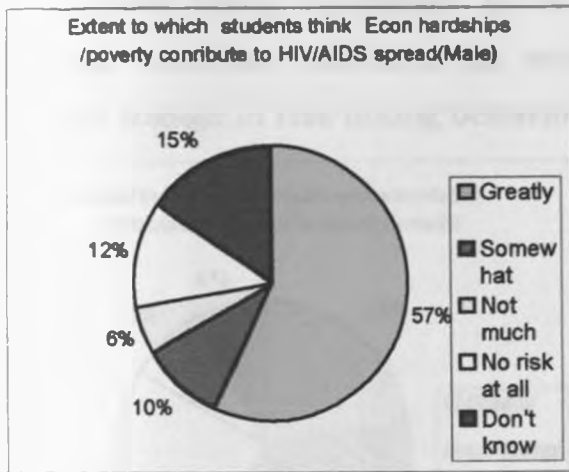


Fig 15. Extent to which students thought economic hardships/poverty contribute to HIV/ AIDS spread.

Extent to which inadequate accommodation at college contribute to the spread of HIV/AIDS. [Respondents' opinion& Experiences]

Results shown in Fig16 illustrates students views on whether they thought inadequate housing or accommodation in the colleges hostels in any way contributed to students engaging in risky behaviour which could lead to the spread of HIV/AIDS.

Over ¼ of the students interviewed said lack of adequate housing/accommodation which occasioned overcrowding at students hostels, placed them at the mercy of other students and more so male students and this lack of personal space somehow drove them to sexual activities which put them at risk of HIV/AIDS.

The number being significant is an indication how this social and economic condition nurtured an environment that could lead some students engage in risk taking behaviour due to their vulnerability.

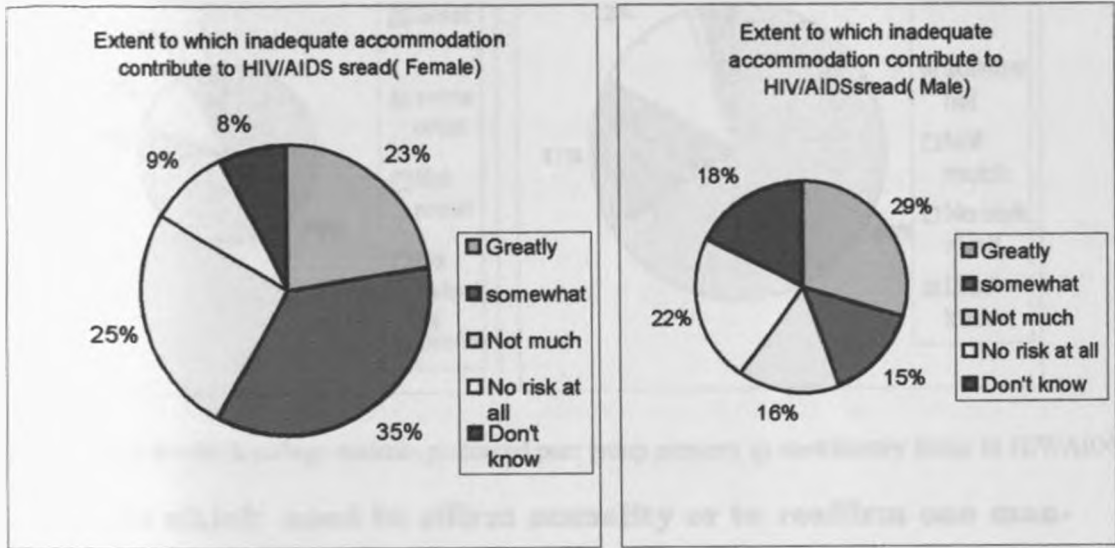


Fig.16. Extent to which students thought inadequate accommodation contribute to HIV/AIDS spread.

Extent of peer group pressure to the spread of HIV/AIDS.]

[Respondents' opinions & experiences]

There was a general concurrence among both male and female students that peer group influence led to college students in engaging in risk taking activities which fuelled HIV/AIDS spread. Over ¾ female(Fig.17) and 2/3 of male students. However, small number of students in both categories felt there was no link of the factor to HIV/AIDS. Overwhelming response that social network ties or peer pressure influence could lead one do something that he/she wouldn't under ordinary circumstances is an indication of how social cultural and economic influences could contribute to bogged down risk perceptions that they were not under threat of HIV/AIDS.

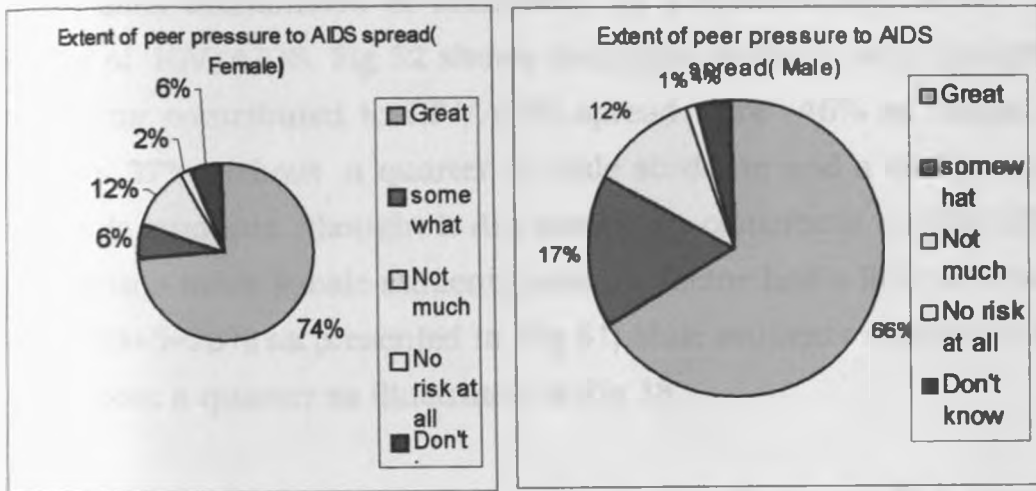


Fig. 17. Extent to which college students perceived peer group pressure as contributory factor to HIV/AIDS.

Extent to which need to affirm sexuality or to reaffirm one man-wood or woman-wood contribute to HIV/AIDS.[Respondents' opinion & Experiences]

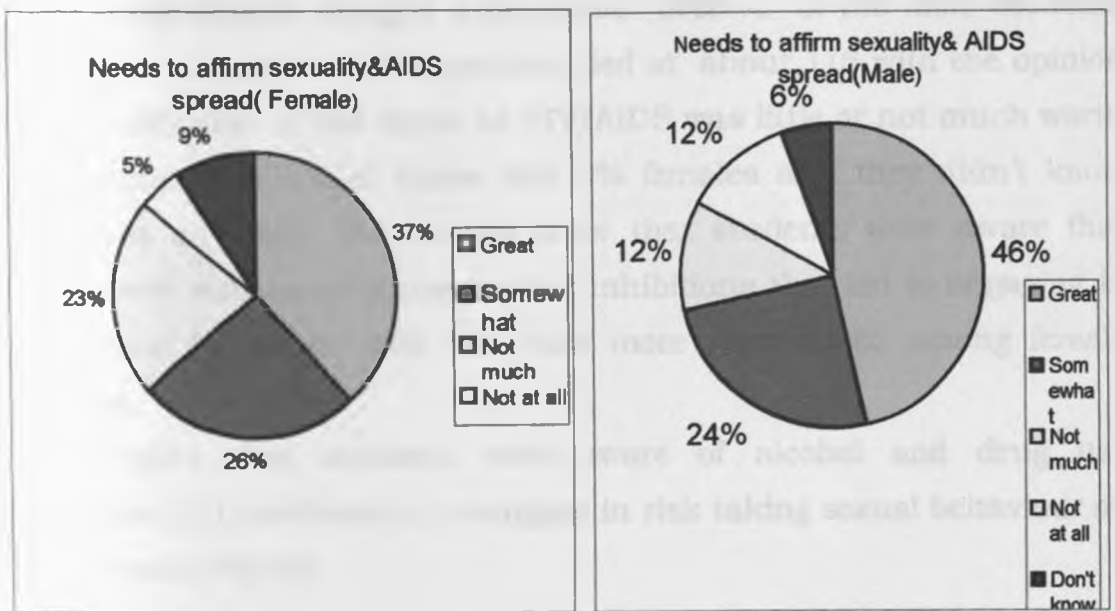


Fig 18. Extent to which need to affirm sexuality contributed to the spread of HIV/AIDS.

Fig 18 presents results of what respondents views were on the need to affirm ones womanhood or manhood as a contributory factor to the spread of HIV/AIDS. Fig 52 shows that male students who thought that this factor contributed to HIV/AIDS spread were 46% as compared to females' 37%. About a quarter of male students and a similar number of female students thought it did somewhat contribute to HIV/AIDS. In comparison more female students said the factor had a little link or none at all (23+5=28% as presented in Fig 51). Male students sharing this view were about a quarter as illustrated in Fig 18.

Extent to which alcohol/drug abuse contribute to the spread of HIV/AIDS.[Respondents' opinion& experiences]

Fig19 records how the sampled students responded to this question which sought to get views whether students perceived alcohol and drug abuse as a contributory factor to the spread of HIV/AIDS. About ¾ of female respondents thought it did while over ½ of the male students shared the same view. both genders tied at about 1/5 with the opinion that contribution of this factor to HIV/AIDS was little or not much worth mentioning. Only 7% of males and 3% females said they didn't know there was any link. The results show that students were aware that alcohol and substance abuse caused inhibitions that led to engaging in risk sexual behaviour with this view more pronounced among female students.

This implies that students were aware of alcohol and drug use inhibitions but continued in to engage in risk taking sexual behaviour as those cited in Fig 26.

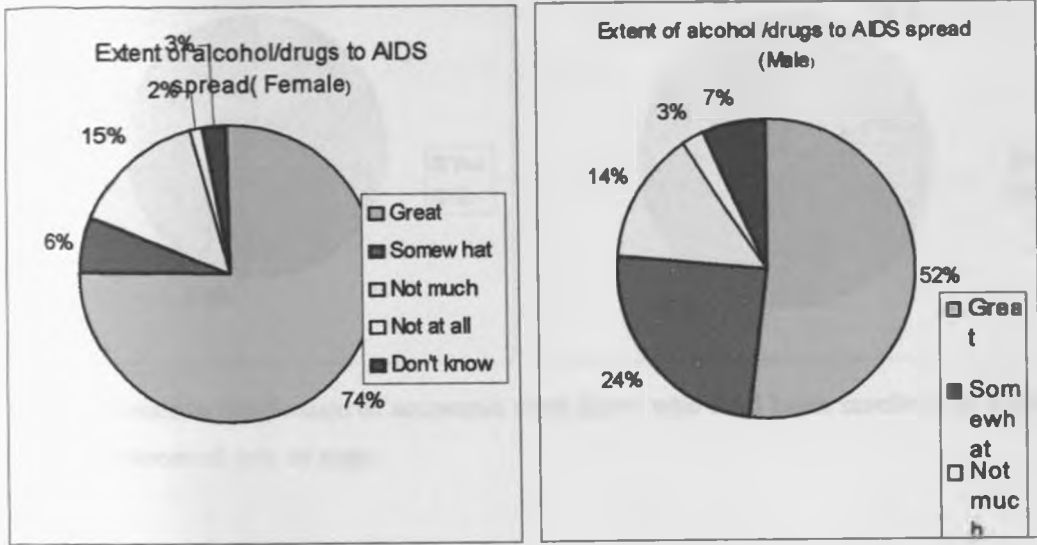


Fig.19. Extent to which students perceived alcohol/drug abuse led to the spread HIV/AIDS.

Knowledge of someone involved in a situation of non-consensual sex or rape.

The pie chart illustration in Fig. 20 students' response on whether they knew of someone or had heard of somebody in their college who had been raped. Nearly all students did. As amplified in Fig 21 it is most likely the person known to have been involved in non-consensual sex or rape was a female student.

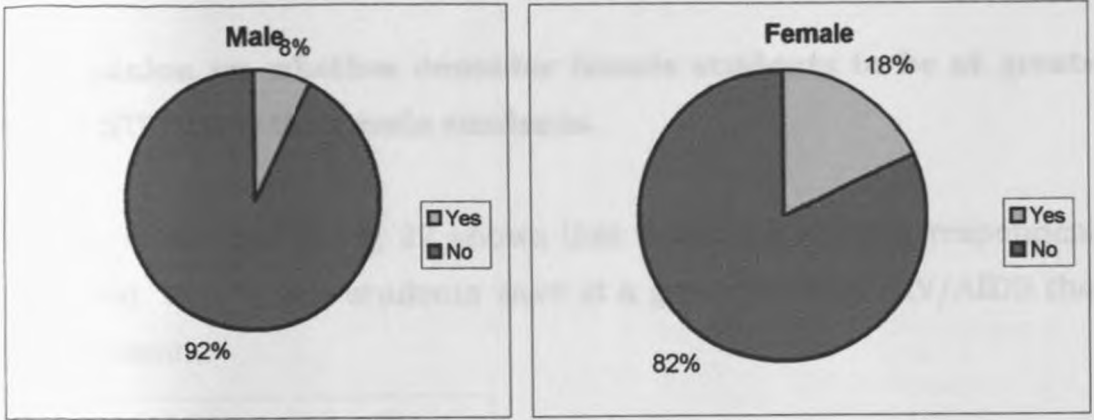
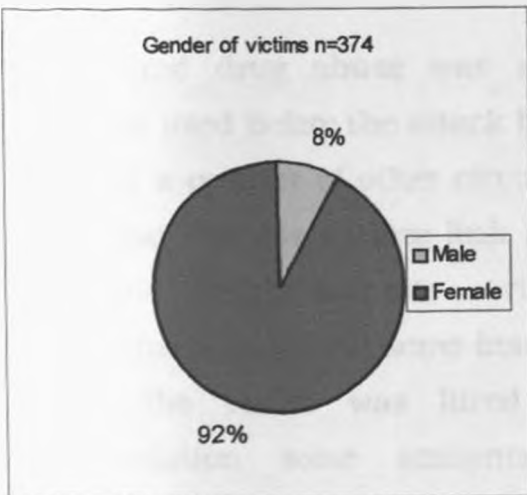


Fig. 20 Students disclosure of someone they knew who had been involved in a situation of non-consensual sex or rape.

The gender of the victim

Results shown in Fig 21 depict that nearly all the victims of sexual assault were female as reported by all genders. This shows that female students are at higher risk of contracting HIV/AIDS as a result of rape or sexual molestation than their male colleagues. Similar results are presented in Fig 20 and Fig 23.



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Fig. 21. The stated gender of the victim

Your opinion on whether consider female students to be at greater risk of HIV/AIDS than male students.

Results illustrated in Fig 22 shows that nearly all student respondents concurred that female students were at a greater risk of HIV/AIDS than male students.

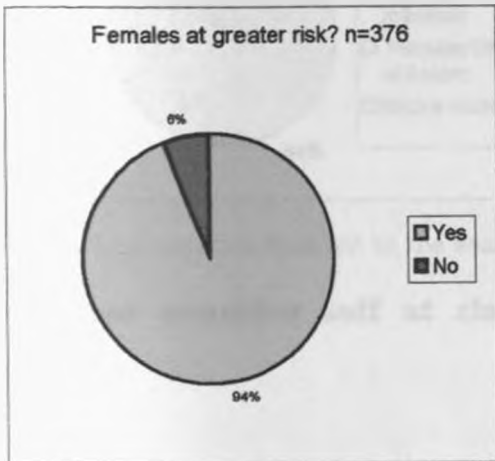


Fig 22 Responses on those considered to be at higher risks of contracting HIV/AIDS.

Circumstances cited in the sexual attack.

Alcohol and drug abuse was mentioned as pre-cursor or "escort" substance used before the attack by nearly all student respondents. Only less than a quarter of other circumstances or reasons were cited. This shows that there is a close link between alcohol and substance abuse inhibitions which promote risk perception to HIV/AIDS. Many respondents said that at some instance both parties were drunk. In most cases the victim was lured with alcohol. Due to inadequate accommodation some students were entrapped with an offer accommodation and then raped. Another marginal circumstances mentioned reason was peer group influence.

There were instances when the victim was lured with an offer of accommodation then raped by the “good Samaritan” or his/her friends/accomplices. At other times the motive behind the attack could not be established.

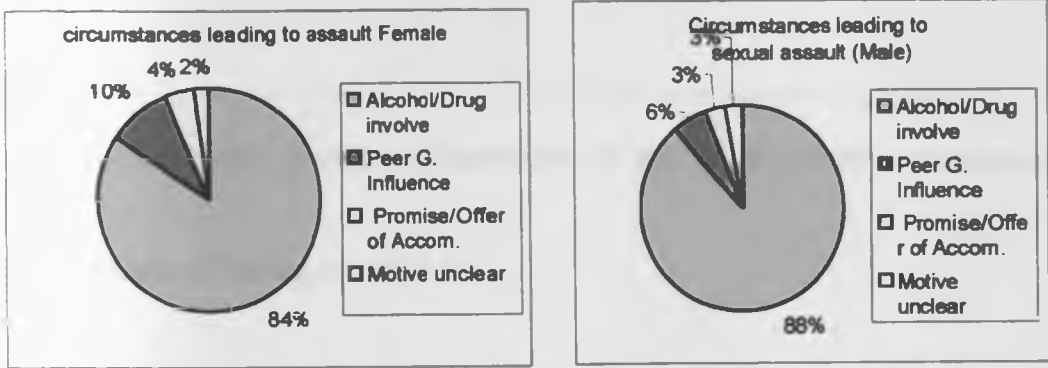


Fig.23 Circumstance that led to the sexual attack

Whether consider self at risk of HIV/AIDS on account of your gender.

Result illustrated in pie charts Fig 24 shows the number of students who responded to the question on whether they considered themselves to be at risk.

Many respondents were in denial of being at risk. Over three quarters of the two category of the respondents said they did not consider themselves to be at risk of HIV/AIDS despite having previously said that they found themselves in circumstances that put other others at risk. This can be concluded to mean that most students were in denial of the risks associated with HIV/AIDS. About a quarter of the respondents said they considered themselves at risk hence their risk perception was not limited as such by the socio-cultural and economic factors they found themselves in.

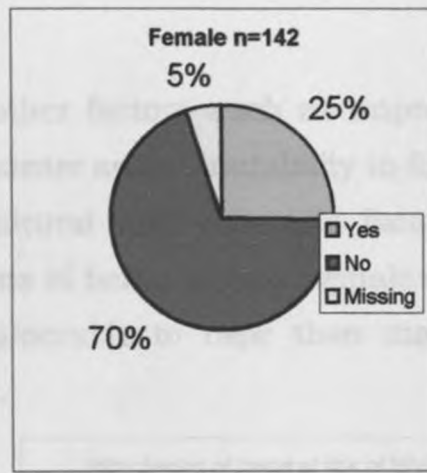
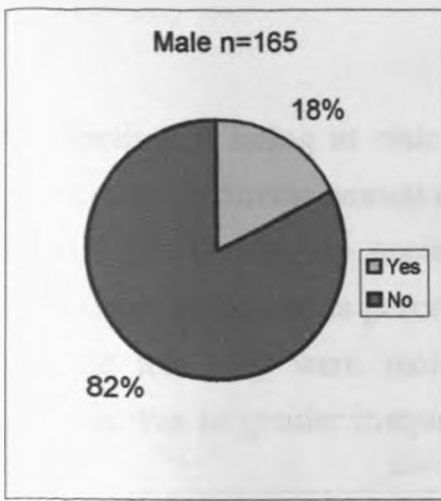


Fig. 24 Students who considered themselves at risk of HIV/AIDS on account their gender.

Why feeling of being at risk ?

Elicited responses were categorized into four: (a) Vulnerability to rape(b)Unfaithful partner(c)No control of condom use(d)Unprotected sex.

Female respondents felt more vulnerable to HIV/AIDS due to their higher possibility of being raped. Fig 25 shows that a third of female students felt they were prone to sexual assault. A similar number due to unfaithful partner.

About a quarter had no power over their partner to compel him use a condom during every sexual contact. The rest of female students accounting to 1/6 of female respondents said they felt at risk because they a times engaged in unprotected sex and a negligible number said they were vulnerable to forced sex.

Results in Fig 25 for male students responses show that over three quarters considered themselves to be at risk of HIV/AIDS due the possibility of a partner being unfaithful. Less than a quarter attributed

their feeling of being at risk to other factors such as unprotected sex, lack of control during sexual encounter and vulnerability to forced sex. The results show that social cultural and economic factors greatly contributed to students perceptions of being at risk. Female students for instance felt they were more vulnerable to rape than male students probably due to gender inequality.

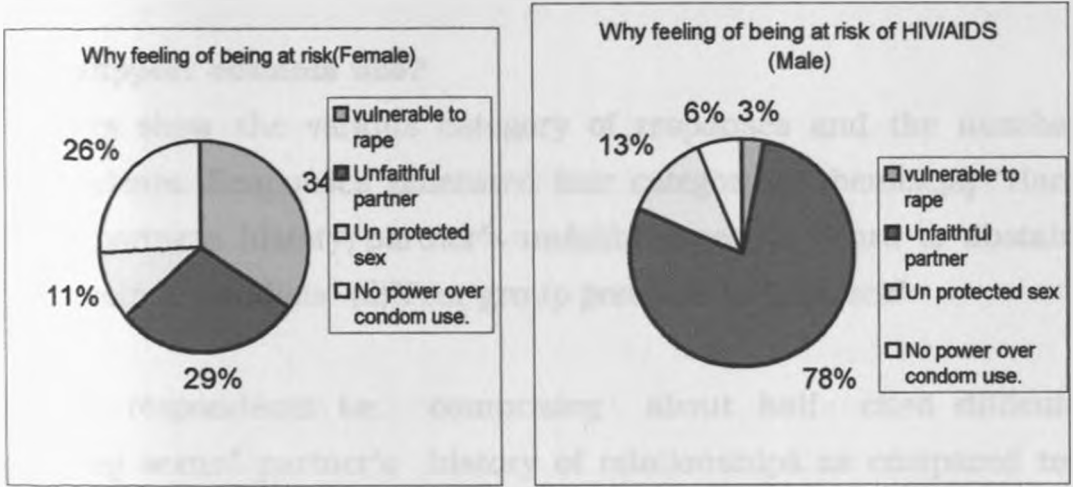


Fig 25 Students' reason for feeling to be at risk of HIV/AIDS.

Support of the use of condom by college students.

The pie chart below shows the number of respondents who support condom use by the students as a measure of controlling HIV//AIDS spread.

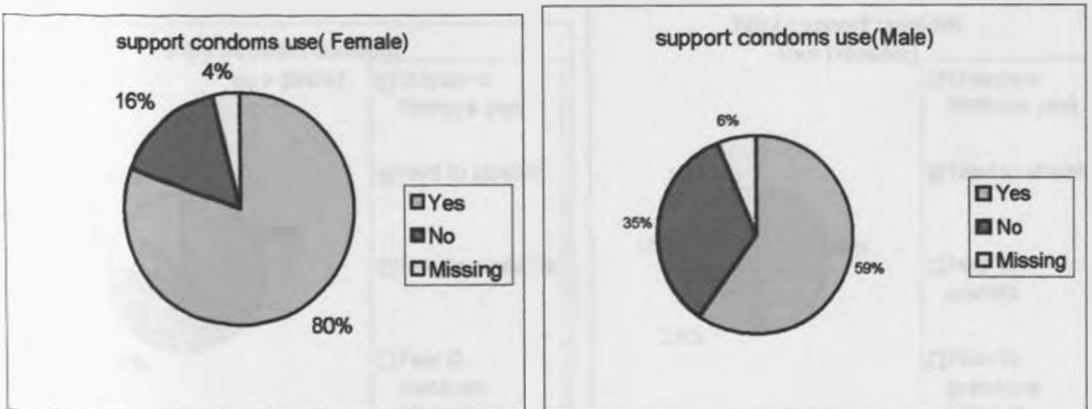


Fig 26 Students who supported condom use as HIV/AIDS prevention measure.

Results show that over three quarters of female students and nearly two-thirds of male students considered themselves to be at greater risk of contracting HIV/AIDS as compared to male students. Only a third of male respondents and less than a quarter of female respondents said they did not support condom use as means of preventing HIV/AIDS transmission.

Why support condom use?

Results show the various category of responses and the number of respondents. Responses generated four category of themes.(a) "Hard to know partners history/partner's unfaithfulness"(b) "Hard to abstain"(c) "CDs help sex addicts" (d)"Peer group pressure to have sex"

Female respondents i.e. comprising about half cited difficult in knowing sexual partner's history of relationships as compared to of males who registered a high response but lower to female students

About a third of males said it was difficult to protect oneself because it was hard to abstain as compared to about a quarter of female students with the same view. Almost the same number of both male and female students(nearly 1/6) said they supported the use of condom because peer group pressure to have sex was very great.

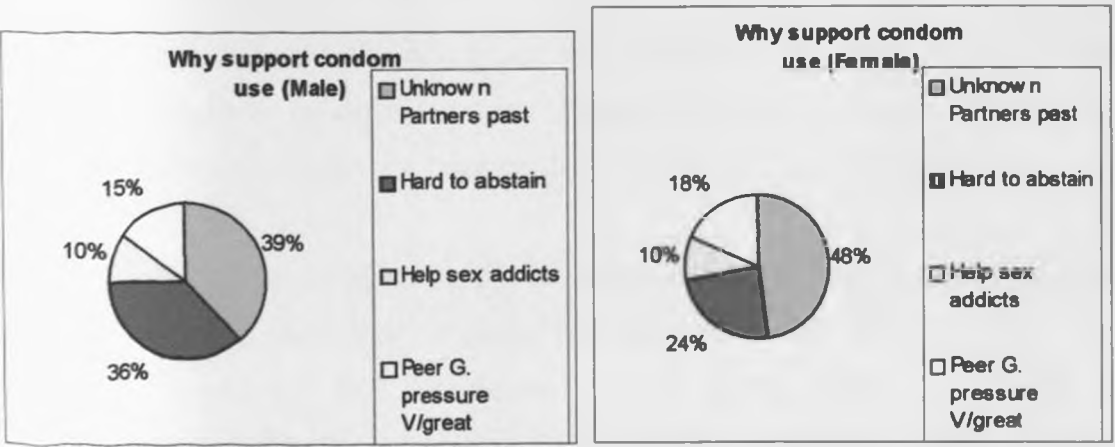


Fig 27 The rationale of supporting Condom use by students

Why no support for condom use among college students?

The pie chart below Fig 28 presents the coded /classified results and the number of those who responded to that question in each of the gender category.

Various responses were coded into four themes(a) Encourage promiscuity/encourage pre-marital sex(b) Should be self-controlled(c) Ineffective/Not 100% Effective(d) No pleasure.

Results shows that more female than male students did not support the use of condoms because in their opinion it encouraged promiscuity. A quarter of them said it reduced sexual pleasure hence no need to be used, while a bigger number of male students held this view. A small number of them said condom use was not 100 percent effective while a similar number did not respond to the question.

The fact that a number of students provided reasons such as it was not 100% effective, no pleasure, and it encouraged promiscuity is a pointer that most students were in denial of the dangers posed by HIV/AIDS.

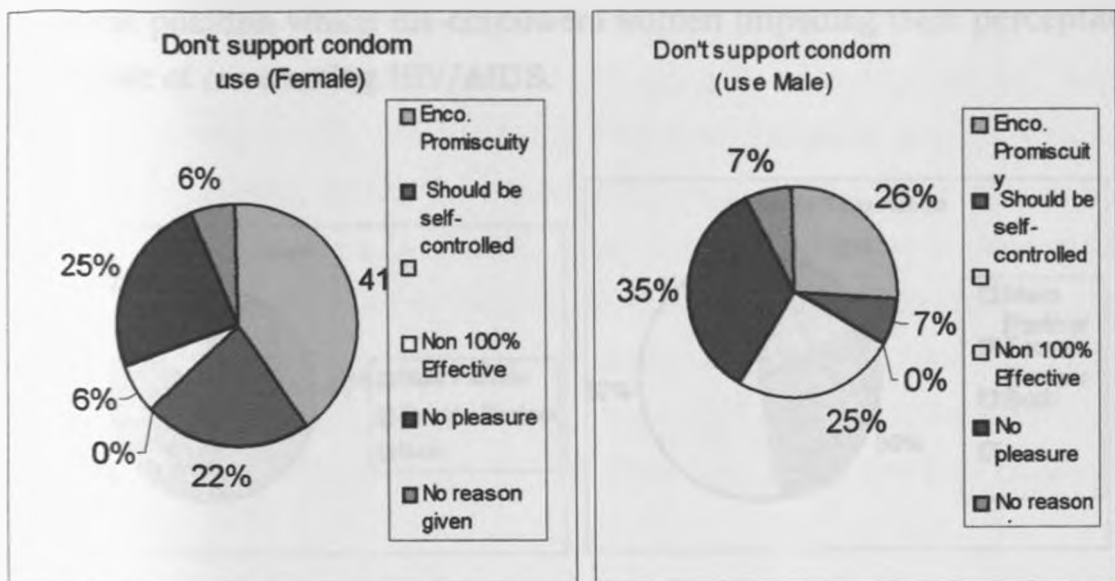


Fig. 28 The reason for not supporting condom use by college students

Who should decide when to use a condom during sexual encounter?

Results presented in Fig.29 below shows that that female respondents comprising over half felt that both partners should have a say on who should decide condom use while only 1/5 of the male students had a similar view. About 1/3 of the female students would rather a female partner decide while over another 1/3 of male students felt same. That a high number of female student interviewed almost half, said they would wish men dominated the encounter is a pointer to strong cultural norms which allows men to dominate everything, including placing women at circumstances of being at a higher risk of contracting HIV/AIDS.

Fig 29 a, shows that half of male students either believed female partner should have the final say or both partners were active in condom use decision making as compared to nearly 4/5 of female students(52+30=82%). That a sizable number believed a male partner should play a dominant role is an indication of social cultural and

economic position which dis-empowers women impeding their perception to the risk of contracting HIV/AIDS.

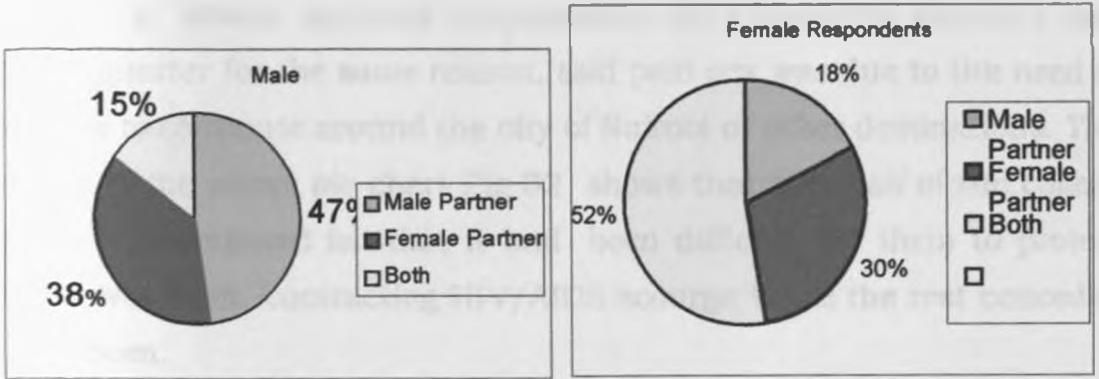


Fig 29 Students response on who should decide condom use during sexual encounter

Whether students engaged in paid sex(transactional),Why they did it and [To establish socioeconomic forces driving college students to risky behaviour and whether they found themselves vulnerable to HIV/AIDS.] Fig 30,31 & 32

Fig 31 shows that over three quarters of all students sampled for the study conceded that some of their colleagues engaged in paid sex. Only a small fraction of less than a quarter of the respondents did not know whether some of their peers engaged in paid sex. A negligible number did not know or declined to respond to the question.

The results in Fig 31 shows that about a third of male respondents felt that students engaged in transactional sex due to economic hardships they faced right from their homes while about a quarter of female students concurred with this position.

Peer pressure as a reason as to why students engaged in paid sex was more pronounced among male respondents at

Over a third of male students as compared to females who rated slightly in citing this as the driving force of indulging in transactional sex. Lack of bus fare was attributed to the driving force to paid sex by about a quarter of female students respondents. Men students recorded less than a quarter for the same reason. said paid sex was due to the need of bus fare to commute around the city of Nairobi or other destinations. The results in the above pie chart Fig 32 shows that over half of the college students interviewed felt that it had been difficult for them to protect themselves from contracting HIV/AIDS scourge While the rest conceded it had been.

The fact that such a high number admitted that it had been difficult to protect themselves is an indication of that socioeconomic factors greatly influenced their denial not to perceive themselves to be at risk.

Another driving force to engage in paid sex was the desire to dress in western fashions. About a quarter of the female students and lesser number of male students gave this as a reason as to why college students engaged in paid sex.

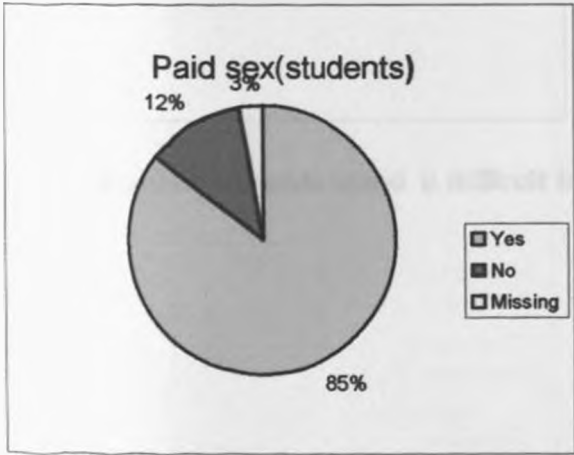


Fig. 30 Illustration on whether college students engaged in paid sex

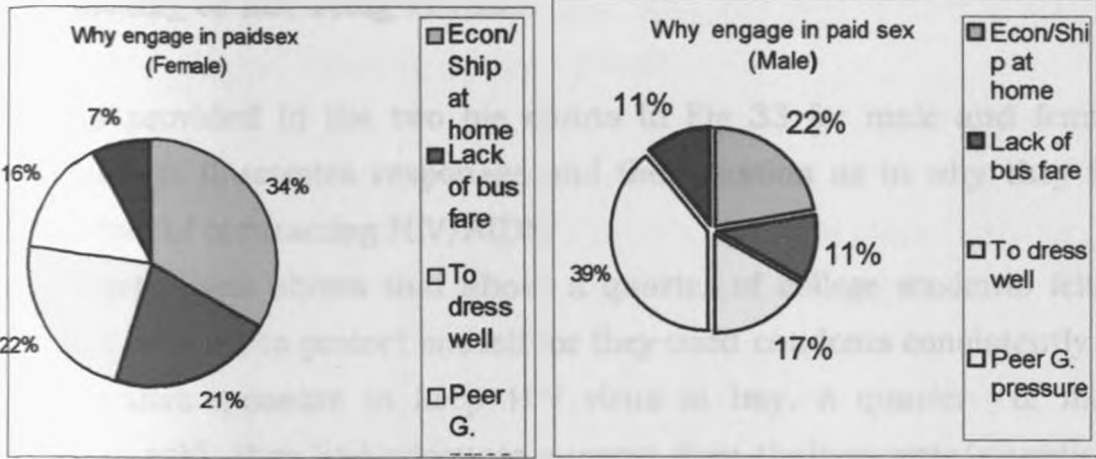


Fig 31. Why college students engaged in paid sex.

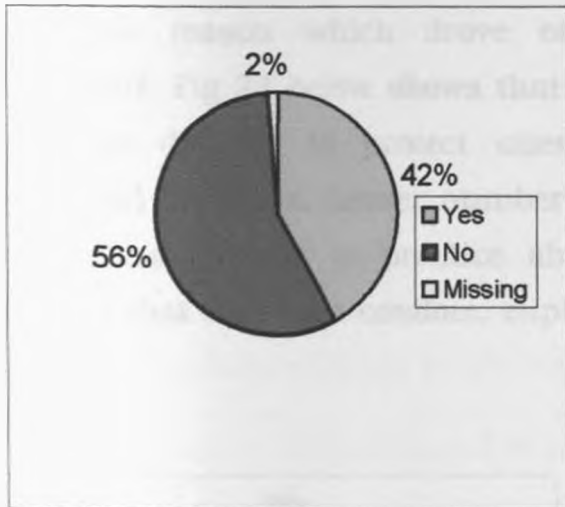


Fig 32 Whether students found it difficult to protect themselves from HIV/AIDS.

Why feeling of not being at risk?

Results provided in the two pie charts in Fig 33 for male and female respondents illustrates responses and the question as to why they felt not at risk of contracting HIV/AIDS.

The illustrations shows that about a quarter of college students felt it was not difficult to protect oneself for they used condoms consistently as a preventive measure to keep HIV virus at bay. A quarter of male students said they had adequate support from their parents/guardians and as such never engaged in risky sexual behaviour to supplement their incomes. Less than quarter of female respondents gave a similar reason and thus said they did find it difficult to prevent HIV/AIDS on account of economic reason which drove others to indulge in risky sexual behaviour. Fig 33 below shows that about half of female students felt it was not difficult to protect oneself from HIV/AIDS because they abstained from sex. Lesser number of male respondents had a similar view. They claimed to practice abstinence. Over a quarter of males claimed that they use a condom, euphemistically referred to as CD by the youth.

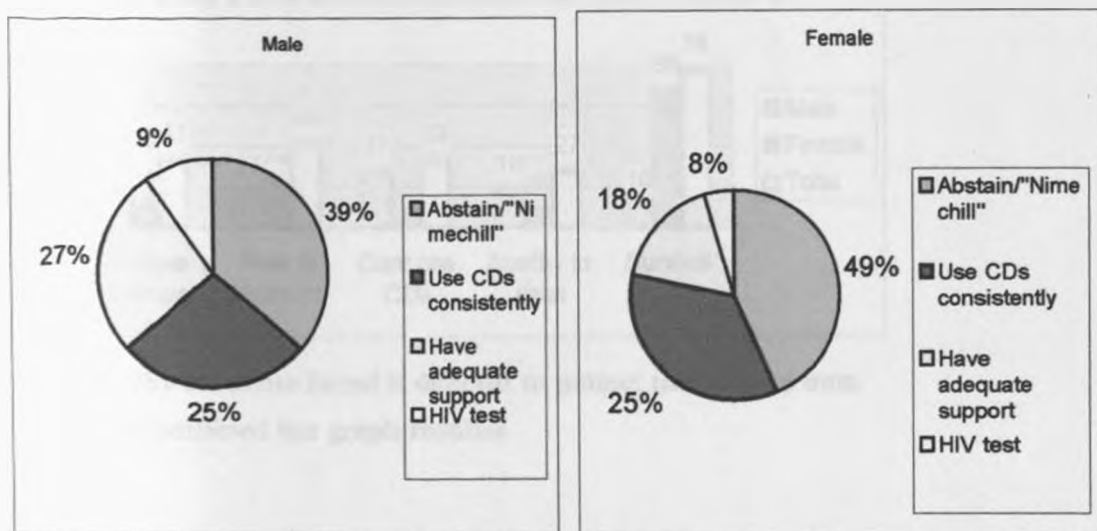


Fig. 33 Why students felt it was not difficult to protect themselves from HIV/AIDS.

Why felt it was difficult to protect oneself from HIV/AIDS [TO help examine socioeconomic factors hindering risk perception]?

Fig 34 (a) and Fig 34(b) shows that the number of students who responded to this question and the different categories made from the open-ended responses received from the sampled respondents. The results are illustrated in a bar chart and pie charts to amplify the results. The responses which were qualitative in nature were coded and given five categories. (a) "Have many partners /not sure partner faithful" (b) "Survival skills" (c) "Apathy to risks"(d) "peer pressure/acceptability" (e) "Inconsistency CD use/can't use condoms".

Less than a quarter of male respondents cited peer group influence as the reason as to why they found themselves to be at risk of HIV/AIDS while over half of female students respondents gave peer group influence as a factor that put them to engage in risky sexual behaviour in order to identify with group values. About a quarter of female respondents said survival techniques put them at threat of HIV/AIDS while a lesser number of male respondents had a similar opinion. They said they engaged in commercial sex to survive.

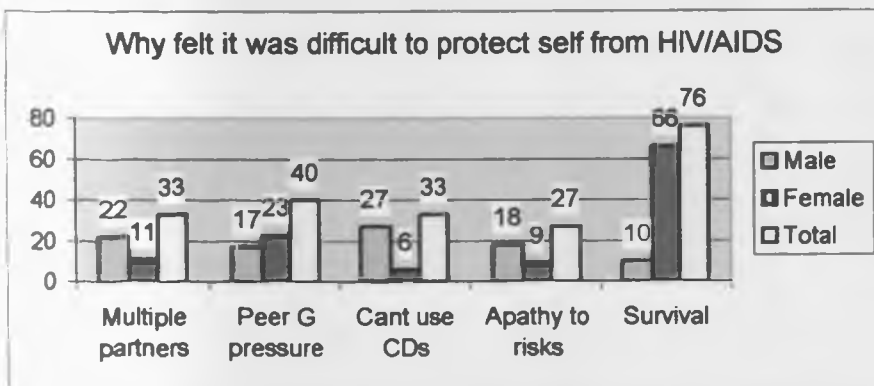


Fig 34(a) Why students found it difficult to protect themselves from HIV/AIDS(Combined bar graph results)

Reason why found it difficult to protect yourself against HIV/AIDS.

Interviewed students who said they found it difficult to protect themselves from HIV/AIDS gave various reasons as in Fig 32 (b) below.

The reasons such as they have multiple partners, that they had to identify with their group social networks, that they didn't think there was any risk involved is an indication that they continued to put their health at risk despite knowledge of the danger posed by HIV/AIDS.

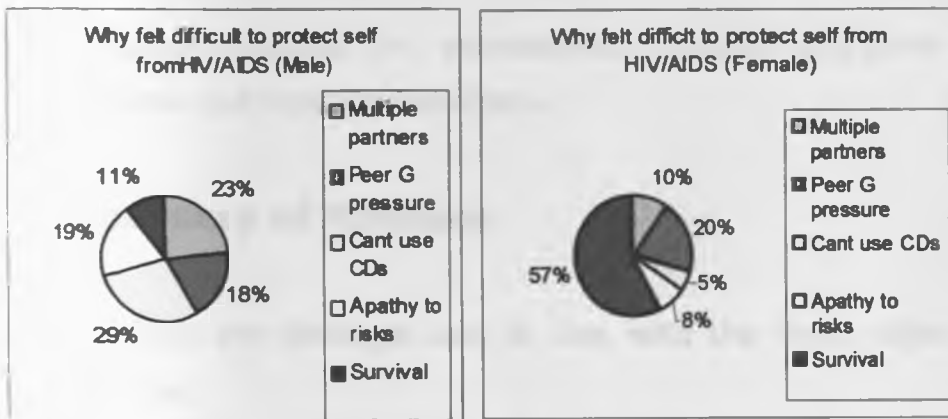


Fig 34(b). Why students found it difficult to protect themselves from HIV/AIDS (pie chart illustrations)

CHAPTER FIVE

5.0 Conclusions and Recommendations

5.1 Introduction

This chapter presents the summarised findings and gives appropriate conclusions and recommendations.

5.2 Summary of Findings.

Arising from the findings and in line with the three objectives of the research i.e.

- To identify the major social, cultural and economic factors that hinder risk perception among the youths.
- To investigate the gender link between the said social, cultural and economic factors and HIV/AIDS risk perception
- To explore the relationship between perception of being at risk and risky behaviours, which promote the spread of HIV/AIDS, the following issues were noted.

The study found that social, cultural and economic factors greatly hindered HIV/AIDS risk perception even though earlier researches showed a higher a high level of AIDS awareness of both men and women respondents in Kenya. KDHS (1998).

Economic hardships or poverty was cited by respondents as an hindering factor up to with about half of the respondents talking of the factor. Respondents repeatedly admitted that poverty motivates students to have sex in exchange for favours or money making them vulnerable to HIV/AIDS.

It is on this basis that 4/5 of respondents revealed that some students engaged in prostitution or transactional sex due to insufficient pocket money from their parents, guardians or sponsors. Their mentioned providers could not sustain them fully due to economic hardships at home. This drove some students to risk taking behaviour to supplement their unmet needs. For example, results illustrated in Fig 29 students gave various responses as to why they engaged in paid sex. Economic hardships, social network influences(i.e. peer pressure) to dress in vogue as presented in the Western media programmes pressured them.

The study found out that conformity to normative behaviour plays a significant role in young people's sexual behaviour. This is shown by responses from various media listenership; namely, television, video/DVDs/VCDs, youth magazines, and FM radio stations. Their preference was found out to be similar to their peers with some disparity in gender responses. Students wanted to do what others did as to feel a sense of belonging to the inner circle of their friends. Most students said what they watched, read and listen to what interested their peers meaning they had similar pursuits in most social engagements.

For instance, most students revealed that they preferred watching, reading and listening to what was sex-oriented. Television media was viewed by nearly half of both female and male college students. Its influence was greater among female respondents at 56% and 46%(male).

als that drug use increases in poverty-stricken areas or populations. study on what students thought of alcohol and drug abuse as a tributary factor to risk of HIV/AIDS revealed that respondents held its consumption greatly hindered risk perception to HIV/AIDS.

1/4 of those who knew of someone involved in non-consensual sex at the colleges, majority of the students cited alcohol and drug in the circumstances preceding the attack (Fig19). On the receiving in these sexual assaults, almost all the victims were female students in most instances were lured with alcohol. This was a form of seduction by male partners who in most cases are generally economically better off places female at vulnerable position. Male victims constituted a paltry of the victims while the remaining did not know of anybody who had been assaulted.

The findings of this study showed that the majority of college students preferred the western media programmes to the local one while the remaining conceded to identifying themselves with the local media. Social networks influence i.e. (peer pressure) again was greatly mentioned as compelling especially on what has come to be referred to as American media cultural imperialism.

Television programmes and movies categorized into six namely; humor, crime/violent, romantic/sex, education/documentary, music movies/ sport. Students disclosed that they were of significant influence on their lifestyles. Nearly half of the students confided that they received erotic gratification from this form of literature. This implies that their perception to risk in regards of HIV/AIDS was highly compromised as research elsewhere regard this literature as an impelling and an inhibiting factor to morality and its importance in keeping HIV/AIDS at bay. Similar results were obtained from analyzing the video movies they

Many students revealed that what they watched influenced their sexual behavior and that of their colleagues as illustrated in Fig 5. three quarters of male students said TV programmes greatly influenced their sexual behavior while a similar number of their female counterparts comprising two thirds had a similar view.

Magazines attracted over three quarters of the students' readership who were interested in various themes as illustrated in Fig 6. Video movies, some of which comprised "nasties" had widespread popularity (over three quarters of male respondents owned up to watching them.

Consequently, most respondents attributed pressure from social networks of peers as contributing to the spread of HIV/AIDS in colleges. Findings of the study shows that negative influence of peers was very great as illustrated in Fig 17.

A closely related factor, the social paradigm of proving sexual prowess among the young people otherwise referred to here as need to affirm to reaffirm sexuality or need to reaffirm ones manhood or womanhood was given by about 2/3 of female students as an impeding factor to risk perception. Nearly ¾ of male students were of the same opinion.

Respondents consisting of over ¼ of the students said they thought inadequate accommodation bogged down risk perception among college students as illustrated in Fig 16.

Slightly over 2/3 said did not think strongly on its impact while 9% had no idea at all.

A study on socioeconomic influences on the transmission of human Immunodeficiency virus infection by Carmichael & Fournier (1998)

reveals that drug use increases in poverty-stricken areas or populations. My study on what students thought of alcohol and drug abuse as a contributory factor to risk of HIV/AIDS revealed that respondents held that its consumption greatly hindered risk perception to HIV/AIDS.

Of 1/4 of those who knew of someone involved in non-consensual sex or rape at the colleges, majority of the students cited alcohol and drug use in the circumstances preceding the attack (Fig19). On the receiving end in these sexual assaults, almost all the victims were female students who in most instances were lured with alcohol. This was a form of entrapment by male partners who in most cases are generally economically better off places female at vulnerable position. Male victims constituted a paltry of the victims while the remaining did not know of anybody who had been assaulted.

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preferred about a quarter of the students revealed that they watched pornographic movies but the number was lesser when it came to female counterparts. Further revelations showed that over three quarters of students tended to identify with what other students indulged in including video movie watching as illustrated in Fig.13.

The findings further disclosed that the risk concerning the own person was perceived considerably smaller compared to the risk for students in general. Male students took this perception more than female students., objective of exploring the relationship between risk perception and risk taking behaviour was addressed by this data.

Most interviewees felt that female students were at greater risk of contracting HIV/AIDS with 94% (Fig. 23) of responses with this perception. For many students, female students' possibility of sexual assault was a reality females, were observed to be particularly vulnerable to sexual coercion and violence. Sometimes this coercion clearly involved the use of force, at other times it is subtler and involves economic or psychological manipulation especially. A sizable number of female students comprising about a third of interviewees saw themselves to be at a greater risk due to their vulnerability to rape. The findings indicate that most male students did not feel personally at risk from HIV, believing that HIV affected other people and not themselves or their peers, and this was reflected in their stated behaviour. This shows that despite all students being vulnerable to other socioeconomic factors many were living in denial as is shown by responses in Fig 32.

The data suggests that students believe that risk for people with which they engage in sex increases although this perception does not include them, a form of denial suggesting risk perception which has been interfered with by other factors. Male respondents perceived themselves

to be at greater risk from unfaithful partners. They did not think of their own unfaithfulness. This follows earlier admissions that socioeconomic factors they found themselves in hindered students risk perception on HIV/AIDS. The contradictory answers implies that some people may not be motivated to change risk-taking behaviour and thus conclusions can be made that these factors have bogged down their risk perception despite the fact that they are also a vulnerable group. There was also some degree of stigmatisation of "others". Male students for example believed female were more likely to become infected with HIV/AIDS. This notion can be attributed to culture, which tended to blame social ills to women.

Findings of the study show that whereas a sizable number of students felt that both partners had a role in deciding condom use some students still believed it was a male partner who was supposed to decide the use of the condom during sexual encounter. The findings highlights the difficulties that young females have in refusing sex or insisting on condom use with their partners, and their general tendency to acquiesce to the authority of their partners.

Further, this shows the inhibitions that young females face in exerting their negotiation on condom use, when faced by peer and social pressures that strongly encourage sexual activity, and the difficulties young females face in countering threats of sexual coercion and force. This implies that our social cultural environment still places at a disadvantaged position women despite some respondents holding the opinion that both partners should have equal power to decide the use of condom and this may contribute to bogging down their risk perception of HIV/AIDS in order to conform to social demands.

Thus the objective of investigating gender differences and risk perception showed significant gender differences in approaching the issues of sexuality. Females perceived themselves to be at greater risk due to aforementioned factors being harsher to them. It was thus observed that female students tended to rate risk significantly higher than and are more consequences than male students did. This is largely due to more being more susceptible to prostitution and disadvantaged by economic hardships.

The objective of finding out whether there was a relationship between risk perception and risk taking behaviour was measured by the support the students gave to condom use. Over half of male interviewees said they thought condoms were useful in HIV/AIDS prevention while about a third thought they were not useful.(Fig. 27) A negligible number did not respond. Students gave various reasons as to why they support condoms as illustrated in Fig 26.They ranged from unknown partners sexual history/ difficult to abstain, peer pressure to have sex was great among college students and its usefulness in helping sex addicts who could be more vulnerable to HIV/AIDS. Others differed on the use of condoms saying that it encouraged promiscuity adding that people should be self-controlled. This implies influence by cultural and especially religious aspect which from on premarital sex with the issue of condom use not arising in the first place.

The position taken by others especially male students that it was not 100 percent effective in preventing HIV/AIDS as mishaps could occur implies that some students risk perceptions were impaired because condom use is adopted after self risk assessment and the wider benefit it can provide in protecting ones health. This also indicated fatalistic attitudes adopted by some student to rationalize death and a number of students said they would die anyway and there is nothing they can do in the face of socioeconomic problems they faced. Female students who perceived

themselves higher to be at the risk of HIV/AIDS overwhelmingly supported condom use.

Perception of “invulnerability” by some students stems from the fact that “survival” in day- to -day live is overriding in the wake of, for instance, economic hardships. Findings suggest that BCC messages that people hear may not be addressing their needs as behavioral change communication has been promoted at the expense of social contexts.

5.3 Recommendations

Many respondents pointed out that socioeconomic variables impelled perception of risk. Economic hardships, alcohol and drug abuse, peer pressure, western media influence just to mention a few.

This report offers a unique opportunity to the Government of Kenya. It can use it to take bold and determined actions in the fight against HIV/AIDS by supplementing Behavioral Change Communication strategies spearheaded by specialized bodies such as NACC and NADSCOP with increased funding directed to both micro and macro development plans targeting the vulnerable groups

A kind of a “Marshall Plan” is urgently required to address unemployment among the youth and poverty among the marginalized groups such as the slum dwellers, the girl-child, and those from Arid and Semi-arid Lands (ASALs) The levels of resources devoted to the effort is a measure of commitment to the belief in the knowledge that in nearby future large gains in healthy expectancy for its citizens.

This is undoubtedly a radical approach. It requires the government to see the value of shifting the main focus from behavioral change communication in fight against HIV/AIDS to include improving the welfare of the masses through ambitious policies to overhaul retrogressive social, cultural and economic contexts that create apathy to life-threatening situations.

They need to ensure that policies and programmes to combat and prevent the impacts of HIV/AIDS form a central pillar of development expenditure and acknowledge the interface with poverty reduction, health, education and sustainable development.

At the same time governments will need to strengthen the empirical evidence for its policies. It will have to improve dialogue and communications; develop greater levels of trust for risk prevention among all interested parties; and consider carefully a range of ethical issues by scrutinising the programmes imports used by the local electronic media and other issues to start disabusing the minds of Kenyans of wrong notions bought about by this unsuitable foreign influence.

Recommended actions to the government and its partners in development should include:

- More specifically, research is needed to examine ways in which social constraints make young women particularly vulnerable and unlikely to exert choices relating to their sexual and reproductive lives for example use of condoms choices. Research is also needed to identify circumstances under which adolescent and young women may be able to exercise greater autonomy in these matters.

- The government should be able to promote intersectoral and international collaboration to reduce HIV/AIDS risk perception among the vulnerable groups.
- Give top priority to developing effective, committed policies for the prevention of large risk to health particularly HIV/AIDS. The right balance should be struck between population-wide risk reductions and aiming to reduce in a smaller number of high-risk individuals. The former has great, often unrealised potential. Risk communication/strategies initiatives must be designed to ensure that the messages target individual groups within the population such as the youth who are at unique risk of contracting HIV/AIDS.

Collaborative action is needed to ensure that the intergenerational nature and widespread socio-economic impacts of HIV/AIDS are recognised, addressed and prevented. This collaboration should take place at all levels:

between youth and the government, HIV/AIDS service organisations and other NGOs, national governments and international donors and policy makers.

Policy makers, key government officials, church ministers and researchers need to rectify the type of low risk perception that young people have on HIV/AIDS through AIDS education and socioeconomic empowerment which in long run increase their perception of risks, This calls for stakeholders to create a supportive environment by creating social support institutions that ease up problems that contribute to this feeling of invulnerability.

- Unemployment problems should be given more attention by those seeking to address the situation. Most people have greater survival problems that supersede the looming danger of HIV infection which needs to be catered for first. Thus, behavior change initiatives need to have a component of income generation and life support skills to address, poverty which could be a cause and effect of bogged down risk perception in Kenya.

The government needs to come up with a National Information and Communication Policy to regulate media content particularly moral- corrupting Western media. Existing anti-pornographic laws should also be enforced to prevent young people from being hooked to the 'nasties' which are alien to our African culture. The same should be extended to preventing access to pornographic websites, principally by the youths.

Recommendations for research include:

The study can be replicated using other colleges specifically those in the rural areas that were not included in this study but are equally important to warrant enquiry. The number of colleges can be increased.

- Other methods of data collection can be used instead of self-administered questionnaire used in this study. e.g. focused group discussion.
- Future research is needed to explore other social, cultural, environmental and economic variables that influence young people's perception and behaviors, which in turn influence their lives. More socioeconomic variables can also be correlated with students' HIV/AIDS risk perception.

5.4 Conclusions.

The analyses of the results allow us to draw important conclusions about the determinants of risk perception and of risk behaviour college among students in Kenya.

First college students do generally feel at higher risk to catch HIV/AIDS and more likely if they are faced with socioeconomic difficulties. Female students are more conscious to this fact. At the same time students are more likely not to incur in unsafe behaviour if they perceive themselves to be at risk, in addition to the said factors and if escort or precursor substances such as alcohol and drug abuse were not involved.

Peer pressure, western media influence, failure to use a condom during sexual intercourse increases the probability of engaging in risky

behaviour, despite fair knowledge of the real transmission mechanisms of infection that may be present. In order to promote preventive behaviour, it seems important to fight the spread of incorrect perception about the effectiveness of condom.

Awareness of the risk perception has to be accompanied by the perception of having some degree of control on how to prevent the infection especially among some female students who felt culturally constrained by gender power imbalance as the determinants of the degree of risk perception and of engaging in unsafe sexual behaviour were found to be diversified by gender. Above all, this study suggests that gender inequalities are already present among the college students. Vulnerability of young females, already a matter for concern, is exacerbated by these unequal values. Partially, this is evident in how students responded as to who was in actual control during sexual intercourse.

Similarly, gender roles and scripts concerning sentimental and sexual relationships or on specific age norms about sexual behaviour may differ between male and female students. In order to better understand these differences, our results need to be interpreted in the broader framework provided by the study.

Despite these interesting results, we face some limitations in their interpretation, mostly imputable to the lack of relevant information on the specific social context in which students live in. This information is fundamental because both sexual scripts and risk assessment are learnt and defined in social interaction (Douglas and Wildawsky, 1983; Lauman *et al.*, 1994).

Considering the educational status of the respondents, it was expected that the level of risk perception would be higher; the picture that emerges suggests that risky sexual behaviour is typical of substantial proportions of young people in every setting studied.

The findings showed that majority of the students appeared to be apathetic to risk due to pressure occasioned by the austere socioeconomic environment they find themselves in. The frequency to which poverty was linked to apathy in risk perception needs particular attention to eradicate it and subsequently shore up AIDS prevention efforts.

AIDS prevention strategies must acknowledge social factors, which drive marginalised groups, particularly young girls and women in general, and to some extent some men resort to survival strategies such as engaging in paid unprotected sex, consequently heightening their risk to HIV infection.

Pending the discovery of an effective vaccine or therapy, reduction of risk taking behavior is the only way the spread of the AIDS pandemic will be arrested.

Although there has been evidence of penetrative influence of media in other studies conducted, such as the radio, television and newspapers and their use in BCC strategies, the same has brought about a counter-productive influence. This follows wide acceptance of western themes and their accompanying whittling down of African norms and cultures which upheld morality in the society. Hence there is a need to guard negative media imports which undermine the health of our people through tough legislation.

Respondents who indicated in their answers that they did not know anything concerning what was being stated cannot be overlooked. They represent those in the entire population whose levels of awareness and perception of being at risk of HIV/AIDS needs sensitisation and empowerment to protect themselves from the pandemic.

Based on the objectives of the study, this study concludes that socioeconomic factors hinder risk perception. There is a relationship between gender difference and risk perception in regards to HIV/AIDS as shown by various responses. Different variables influenced gender categories with some hindering risk perception of a category than the other.

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Appendix 1

Definition of Terms

Adolescent. WHO defines adolescence as the second decade of life, the period between the age of 10 and 19 is the definition that was adopted at the South Asia conference on adolescents in 1998, and followed by most other UN Organisations. However it must be stressed that adolescence is the phase, rather than a fixed time period in an individual's life.¹

Youth. The United Nations General Assembly defined 'youth', as those persons falling between the ages of 15 and 24 years inclusive. This definition was made for International Youth Year, held around the world in 1985. All United Nations statistics on youth are based on this definition, as illustrated by the annual yearbooks of statistics published by the United Nations system on demography, education, employment and health.²

Risk: The change of an adverse outcome to human health, the quality of life, or the quality of environment.

Risk Acceptance. Involves a subjective balancing of benefits with risks

Risk Perception. Refers to individual's intuitive judgment of both aspects of risk: the probability of occurrence and the severity of the associated consequences.

¹ Youth at the United Nations. Frequently Asked Questions
www.un.org/youth

² Ibid

College. Institutions for educating post secondary school students which offer courses ranging from 1-3 years and subsequently offering certificates or diplomas in various professions.

Intervention. Actions with a coherent objective to bring about behavioural change in order to produce identifiable outcomes.

Self-Efficacy. The degree to which an individual believes in his/her capacity to organize and execute the actions requires managing prospective situations to produce desired attainments.

Behavioral Change Communication Strategy-is an intervention that seeks to inform, persuade, motivate and encourage target population to adopt beneficiary health promotion programmes.

Targeting: the process of customizing the design and delivery of a communication programme on the basis of characteristics of an intended audience segment.

Seropositive individual. Someone who has been infected by HIV and whose blood has tested positive for the antibodies to the virus or for the virus itself.

Strategy .Plan or policy designed for a particular purpose or objective. Programme. A plan of what is intended to be done, it has a time frame and measurable objectives.

Appendix 2

LIST OF ACRONYMS/ABRREVIATIONS

ARRM	AIDS Risk Reduction Model
AIDSCOP	The AIDS Control And Prevention Project
ARV	Anti-retroviral
AIDS	Acquired immune Deficiency Syndrome
BCC	Behavioral change communication
CFIA	Canadian Food Inspection Agency
IEC	Information Education and Communication
VCT	Voluntary counseling and testing
UON	University of Nairobi
PLWHA	Persons/people living with AIDS.
NVP	Nevirapine
HIV	Human immuno-deficiency virus
SSA.	Sub-Sahara Africa
UNAIDS.	Joint United Nations Programme on HIV/AIDS
MSM	Men who have sex with men
PRB	Population Reference Bureau
IFRC	International Federation of Red Cross and Crescent Societies
KDHS	Kenya Demographic Health Survey
DfID	Department for International Development
FHI	Family Health International
NACC	National Aids Control Council
STI	Sexually Transmitted Infections
STD	Sexually transmitted diseases
SCT	Social Cognitive Theory

- HBM Health Belief Model.
- NASCOP National AIDS and STD control programme
- MOH Ministry of Heal
- WHO World Health Organization

Appendix 3

A Letter of Introduction

Dear Respondent,

Ref. Questionnaire on social, cultural and economic factors and aids risk perception.

This questionnaire is designed to gather information on the above mention subject for my dissertation in Master of Arts degree in Communication Studies, University of Nairobi.

Kindly feel free to provide the required information without assistance of anybody else. All information you will disclose will be treated in strict confidence and at no instance will be mentioned in the project.

NB. Please do not write your name anywhere in the questionnaire.

Your contribution and cooperation as a respondent will be highly appreciated.

Thank you.

Yours faithfully,

.....

John Mwandikwa.

Appendix 4

Confidential Information

Q No-----

Social, Cultural and Economic factors hindering HIV/AIDS risk perception among college students.

Students questionnaire

Section A: Bio Data

Please answer the following questions. (Tick an appropriate answer)

1. Institution
2. Programme [e.g. **Dip in Mass Comm., Dip in Architecture, etc**]
3. Year OF Study.....
4. Gender..... 1] Male 2] Female
5. Age.....
6. Marital status [**1. single 2 married 3. widowed 4. divorced**]

Section B: Media influence

7. What are your preferred media sources of entertainment?

[1] Local

[2] Western

[a] Please list your favourite **TV programmes/movies** that you think influence your lifestyle.

Appendix 4

Confidential Information

Q No-----

Social, Cultural and Economic factors hindering HIV/AIDS risk perception among college students.

Students questionnaire

Section A: Bio Data

Please answer the following questions. (Tick an appropriate answer)

1. Institution
2. Programme [e.g. **Dip in Mass Comm., Dip in Architecture, etc**]
3. Year OF Study.....
4. Gender..... 1] Male 2] Female
5. Age.....
6. Marital status [**1. single 2 married 3. widowed 4. divorced**]

Section B: Media influence

7. What are your preferred media sources of entertainment?

- [1] Local [2] Western

[a] Please list your favourite **TV programmes/movies** that you think influence your lifestyle.

[1].....

[2].....

[3].....

[4].....

[5].....

b] Mention briefly what you find gratifying in the contents of the programmes.

.....
.....
.....
.....
.....

[c] To what extent would you term them as sex-oriented?

1. A little 2. Moderately 3. Greatly
4. Not at all

[d] To what extent do you think the programmes interest students in your college?

1. A little 2. Moderately 3. Greatly 4. Not at all

[e] Do you think the programmes you have mentioned influence your sexual behaviour in any way?

1. A little 2. Moderately
3. Greatly 4. Not at all

3 [a] What are your favourite magazines that you find influencing your life style?

- (a).....
- (b).....
- (c).....
- (d).....

[b] Mention briefly what you find gratifying in the contents of these magazines.

.....

.....

.....

.....

.....

[c] To what extent would you say the magazines interest other students in your college?

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EAST AFRICANA COLLECTION

1. A little 2. Moderately 3. Greatly 4. Not at all

9. What are your favourite **FM Radio** programmes? Please rank them.

- (a).....
- (b).....
- (c).....
- (d).....
- (e).....

10. To what extent would you term the programmes as sex-oriented?

1. A little 2. Moderately 3. Greatly 4. Not at all.

1. In your opinion do you think the same programmes interest students in your college?

1. A little 2. Greatly 3. Moderately 4. Not at all?

12 [a] List your favourite **video/VCD/DVD** movies. Please rank them.

- (a).....
(b).....
(c).....
(d).....
(e).....
(f).....

[b] Would you term them sex-oriented?

- 1) A little 2) Greatly 3) Moderately 4) Not at all

[c] To what extent do think students in your college like them?

1. A little 2. Greatly 3. Moderately 4. Not at all

Section C: Social and Economic factors

13. To what extent would you say the following factors contribute to the spread of HIV/AIDS in your college?

[a] **Peer Pressure**

1. Great 2. Somewhat 3. Not much 4. Not at all
5. Don't know

] Need to affirm sexuality [i.e. need to reaffirm ones manhood or womanhood]

1.Great 2.Somewhat 3.Not much 4.Not at all 5.Don't know

] Alcohol/Drug abuse

1. Great 2. Somewhat 3Not much 4.Not at all 5.Don't know

14. To what extent would you say the following factors hinder risk perception among college students?

[a] Poverty

1.A little 2.Greatly 3.Moderately 4.Not at all

[b] inadequate accommodation

1.A little 2. Greatly 3.Moderately 4.Not at all

15. Do some students engage in transactional sex due to insufficient pocket money?

1. Yes 2. No

16. What reasons do college students give as to why they engage in paid sex?

Section D: Gender factors

17[a] Do you know someone in your college who has been involved in a situation of non-consensual sex or has tried to force that person into sexual act?

1. Yes 2. NO

[b] IF yes, please state the victim's gender (1) **Male** (2) **Female**

[c] Please mention the circumstances that led to the sexual attack?

[d] In your stay at the college, have you ever been involved in a situation of non-consensual sex or has someone tried to force you in to sexual act?

1.Yes 2.No

18. In your opinion, do you consider female students in your college to be at higher risk than male students of contracting HIV/AIDS?

1. Yes 2. No

19. Do you consider yourself to be at risk of contracting HIV/AIDS on account of your gender?

1. Yes 2.NO

IF Yes Why?

.....
.....
.....
.....

IF No Why?

.....
.....
.....
.....

20. Who has the power to decide condom use during sexual encounter?

(a) Boyfriend (b) Girlfriend (c) Both

21. Do you support the use of condom for college students?

1. Yes 2. No

IF Yes Why?

.....
.....
.....
.....

IF No Why?

.....
.....
.....
.....

22. [a] Thinking of your own personal sexual behaviour, do you think your chances of getting HIV/AIDS are:

1) Small 2) Moderate 3) Great 4) No risk at all

[b] If the answer to the question 22(a) is 2 or 3, please give reasons why you think so.

- 1).....
- 2).....
- 3).....
- 4).....
- 5).....

[c] Finally, do you feel it has been difficult to protect yourself against getting HIV/AIDS?

- 1. Yes
- 2. No

[e] If the answer is Yes state why

Thank you for your co-operation.