The Influence of Mass Media in Shaping HIV and AIDS Risk Perceptions: The Case of Secondary School Youths in Kisumu East District

by

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In accordance with Daystar University policies, this thesis is accepted in partial fulfillment of requirements for the Master of Arts degree.

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

Signed: ____________________________  Date: ___________

Mercy Chiyumba Khasiani

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The Kenya Demographic Health Survey of 2008/09 reveals that, Nyanza Province has the highest infection prevalence in Kenya with a prevalence of 8% among youth in the age bracket of 15-24 years compared to the national prevalence of 6.3%.

The purpose of this study was to find out the influence of the mass media in shaping HIV and AIDS risk perceptions among the youth and understand how these perceptions inform their behavior with respect to sexual choices. This study was carried out in schools within Kisumu East District which has a student population of 14,140 youth in the age bracket of 15-19 years. A sample size of 375 students was selected. The study sought theoretical support from the prospect theory and health belief model to understand why young people behave the way they do with regard to sexual behaviour. To define and describe data and characteristics about the population being studied, both quantitative and qualitative data was collected using a structured questionnaire. The relationship between communication of information on HIV and AIDS, correct risk assessment and the likelihood of indulging in potentially risky sexual behaviors was examined.

The findings revealed that there were significantly low perceptions of risk of contracting HIV among the youth in Kisumu East District and that there is lack of comprehensive knowledge on HIV and AIDS. Further to this findings the study also established that the Mass Media did influence the shaping of risk perceptions with television and radio being the most popular sources of HIV and AIDS information among the youth compared to the Internet and Newspapers.
Dedication

I dedicate this work to:

My Mother, Lady Justice Sarah Chibai Ondeyo-Omolo, My children Cyril, Jayden, Grace, Judge and Diana, My husband Oscar Omoke Ochola and my brother, Leonard Alusiola Khasiani. Without your presence and encouragement I would not have made it this far.

The youth of Kenya, you are the answer to an HIV free generation and to a society with Zero new infections, Zero new deaths and Zero discrimination.
CHAPTER 1
BACKGROUND AND OVERVIEW

Introduction

Close to 50 million people including children are infected by HIV and AIDS worldwide. Where as of December 2010, 1.6 million people in Kenya were living with HIV, it is projected that this number will continue to grow and this will in turn continue to put more pressure on the country’s health and social service systems (National AIDS Control Council [NACC] & National AIDS and STI Control Program [NASCOP], 2012). The Kenya Demographic Health Survey (2008/09) reveals that in spite of the high level of HIV and AIDS awareness among Kenyans, the proportion of adolescents and young adults engaging in risky and reckless sexual practices, remains alarmingly high.

According to the UNAIDS (1999), human behavior is not a simple matter of individual choice. Since people live and act within specific communities or societies, their behavior will normally be guided and influenced by the social values of their respective societies or communities and as Kamaara (2004) puts it, human sexual behavior is a product of social cultural imposition on the biological factors within the individual being. Human sexual behavior is therefore determined and controlled by factors outside the individual human being.

Generally, the prevalence of HIV among the Kenyan youth in the age bracket of 15-24 years is 4% with Kisumu County having the highest prevalence rate of 8% (Kenya HIV and AIDS Indicator Survey [KAIS] 2007). A subsequent survey carried out in Kenya reveals that the Youth begin engaging in sexual intercourse fairly early with 47% of the women and 58% of the men surveyed, having engaged in sexual intercourse by the age of 18 years (NACC, 2007; KDHS, 2008). Kisumu East District, with a population of 54,124 young people between the ages of 15-19 years, has an HIV and AIDS prevalence rate of 12.2%
which is double the national HIV prevalence (County estimates 2011). These young people are at the risk of contracting HIV and AIDS as it is likely that most of them will have engaged in reckless sexual activity by age eighteen (18).

The high prevalence of HIV and AIDS in Kisumu County and in Kisumu East District in particular, could be attributed to various factors. Among these is the reluctance to embrace a change in behaviour despite the availability of information and widespread national campaigns to create awareness on HIV and AIDS. There is also the cultural dimension to the problem which cannot be ignored and which has a negative impact on correct decision making with regard to individual sexual behaviour. Consequently, a change in behaviour has become difficult to realize due to cultural practices such as wife inheritance and polygamy among others. Such practices are prevalent in Kisumu County home to the Luo community.

A UN Habitat Report (2006) on managing HIV and AID at the local level in Africa revealed that Kisumu is the poorest of the major towns in Kenya with an absolute poverty prevalence of 48%. The District lacks adequate shelter with approximately 60% of the urban population residing in the peri-urban and informal settlements lacking basic services. Since poverty is the leading predisposition factor to casual sex and promiscuity, this state of affairs could, among others, explain the failure to change, hence the high HIV and AIDS prevalence in Kisumu East District.

Communication as a strategy in the fight against HIV and AIDS is central to prevention strategies aimed at influencing individual and social behavior (UNAIDS, 1999). Although very little research has focused on the determinants of risk perceptions and the role of communication in particular, communication efforts have been at the core of HIV and AIDS prevention strategies (UNAIDS, 1999).

Communication strategies developed to fight the HIV pandemic in African nations in the mid 1990s mainly focused on large scale information dissemination coupled with
assurance of blood safety, access to treatment for STD’s and large scale condom availability. This was based on the presumption that lack of accurate information about HIV infection and transmission was a primary catalyst for the spread of infections and that this approach would bring behavior change and thus reduce infections (UNAIDS 1999). Strategic planning for HIV and AIDS communication therefore focused on determining the knowledge, attitudes, and practices of individuals deemed at risk for infection.

In the process of developing those communication strategies, the variables contributing to behavior were identified, and then a theory was developed to explain how these variables were related. An intervention was then designed to influence these variables with the objective of producing the desired change in behaviour with the hope of reducing new infections. In order to achieve a change in behaviour, the focus shifted to providing correct information on infections, transmission and prevention of HIV and AIDS. Unfortunately, this approach fell short of producing the desired effect as the spread of the disease continued at an alarming rate not only among the high risk behavior groups but also among the other population segments particularly women and young people. It became clear therefore that, there was need to develop multifaceted strategies and programs to fight the pandemic.

Since information was initially thought to be the key to behavior change, HIV prevention programs were developed with a focus on increasing awareness about the modes of transmission and prevention of the decease. (Cohen, 1992). An analysis of the messages adopted by the information and education programmes of National AIDS Control Programmes from 38 different countries found that over 90% of such programs focused on correcting misperceptions about AIDS, while about 80% provided information on personal risk assessment (Cohen, 1992). Many mass education efforts successfully raised AIDS awareness by informing individuals of the risks of HIV infection. Some education-based
programmes were sufficient to change high risk behaviors, increase condom sales, and reduce new HIV infections (Kalichman, 1997).

The AIDS in Kenya 2005 report revealed a significant drop in the rates and numbers of new infections in the last decade in relation to the increase in percentage of those aware of HIV and AIDS modes of transmission. The report also revealed that HIV and AIDS prevalence drastically reduced from 10% in the late 1990’s to 7% in 2003. A review of 49 studies covering 18 countries to evaluate the impact of HIV related mass media campaigns in 1996 concluded that most campaigns aiming at individual level goals of knowledge, attitude or behavioural change were generally successful at achieving these goals (Holtgrave, 1997).

Several studies have shown that the effectiveness of HIV and AIDS prevention work depends solely on the knowledge and attitudes regarding HIV infection (Mungherera, 1997; Horsman & Sheeren, 1995; Ngoumo, 1995; Louw, 1994). Risk communication is therefore prudent to promote appropriate protective behaviour by those to whom the information is directed.

Since it is often said that education is the vaccine against HIV, the media in Kenya and indeed the world over, has a critical role to play in the fight against HIV and AIDS. The media, particularly broadcast media, have tremendous reach and influence and are a very important tool in promoting awareness on HIV and AIDS and in the fight against the pandemic. Indeed, many media houses and organizations in Kenya and elsewhere have risen to the challenge and have embarked on promoting awareness of HIV and AIDS by educating listeners and viewers about the epidemic and how to prevent it (UNAIDS 2004).

HIV and AIDS and Risk Perceptions

The concept of risk is complex and difficult to communicate in ways that are convincing and that subsequently lead to effective decision-making (Betty, 2009). According to the Kenya Demographic Health Survey (2008/09), there is widespread awareness about...
HIV and AIDS. However, this has not been accompanied by a significant decline in potentially risky sexual behaviors, particularly among adolescents and young adults. Discussing sexual behavior in the context of HIV and AIDS is still a taboo in most Kenyan communities. This taboo is a barrier to communication between adults and their children or youth on this subject. This is a challenge that has left the youth vulnerable. The KDHS 2008/09 revealed that 3% of the Kenyan youth aged 15-24 are HIV positive with Nyanza province leading with the highest HIV prevalence of 8%. According to a report released by the Kenyan Government in 2002 (GoK, 2002), the HIV and AIDS epidemic poses a threat to long term sustainable economic development if the spread is not controlled. It is estimated that without HIV and AIDS, the Gross Domestic Product (GDP) would be 14.5% higher than the current value (GOK 2002)

A study by Cornia (2002) indicated that the impact of the epidemic on the country’s health systems is devastating. It has created an increased burden of disease, shifted the demand for services, caused a substantial increase in health expenditure, and eroded the capacity of the health systems to respond adequately, particularly since it also affects the health workforce.

Cohen (1998) is of the opinion that, poverty among other factors plays the leading role in accelerating the spread of HIV. A study conducted by the Kenya High School in 2009 on the consequences of insufficient pocket money amongst students revealed that many young girls have succumbed to prostitution by associating themselves with rich older men who in return provide them with pocket money.

A publication by Njogu and Castro (2009), on the persisting gap between HIV and AIDS knowledge and risk prevention among Kenyan youth reveals that widespread awareness about AIDS has not been accompanied by a significant decline in potentially risky
sexual behaviors, particularly among adolescents and young adults. Potentially risky sexual behaviors in this regard can be defined as early onset of sexual activity (before age 15), multiple sexual partners in the past 12 months, last sexual relationship with a non-regular partner, exchange of money or gifts for sex in the past 12 months, and non-use of condoms (KDHS, 2008/09).

Akwara, Madise and Hinde (2003) through a study on perception of risk of HIV and AIDS and sexual behavior in Kenya indicated a strong and positive association between perceived risk of HIV and AIDS and risky sexual behavior for both women and men. Literature from various studies suggests that people seem to make judgments about risk based on a host of factors and not just on their knowledge of AIDS risk and consequences (Nzioka, 1996; Ingham & Van Zessen, 1997).

Aakko (2004), advocate that risk perception significantly affects communication as perception equals reality. Aakko’s article on risk communication, risk perception and public health informs us that people view risks differently for different reasons. Researchers have identified several common factors that influence risk perception. For example, risks that are perceived to be familiar, voluntary, natural or under an individual’s control are more acceptable than risks perceived to be unfamiliar, involuntary or exotic (Fischhoff, 1994).

Fischhoff 1994, Acceptable Risk: A conceptual proposal informs us that:

The acceptability of risk is a relative concept and involves consideration of different factors. Considerations in these judgments may include: The certainty and severity of the risk; the reversibility of the health effect; the knowledge or familiarity of the risk; whether the risk is voluntarily accepted or involuntarily imposed; whether individuals are compensated for their exposure to the risk; the advantages of the activity; and the risks and advantages for any alternatives (p. 8).

This revelation is important as it explains the reason why Kisumu East District has a higher HIV and AIDS prevalence compared to other districts in Kenya. As postulated in the conceptual proposal on acceptable risk, the knowledge and familiarity of risk and whether the
risk is under an individual's control plays a big role in influencing a community or an individual’s perception of risk. There is also great heterogeneity with regard to culture and tradition among the various ethnic groups in Kenya. The socio cultural context can influence people’s perceptions through internalization of specific sexual beliefs, norms and practices.

In Kisumu County and specifically Kisumu East District, the practice of widow inheritance, polygamy, a belief in witchcraft and “Chira” (a Luo term for a body-wasting illness that is believed to afflict people who break cultural taboos), are entrenched components of the Luo culture which have been associated with the rapid spread of AIDS (Kenya, 1998; Ayayo, 1976). Although such practices and beliefs may increase the risk of HIV infection, they may not necessarily lead to increased perception of HIV risk if they are deemed necessary for social support, a feeling of belonging and emotional well-being of individuals and families in a particular community.

Background of Kisumu East District in relation to HIV and AIDS

Kisumu, the third largest City in Kenya, has a population of approximately 345,312 people. It is the headquarters of Kisumu East District and the entire Nyanza province. This city serves as the communication and trading convergence for the Great Lakes region. Kisumu East District has two Administrative Divisions namely, Winam Division with a population of 412,323 and Kadibo Division with a population of 61,326 people. Each of these two Divisions has a total of eight (8) administrative Locations and 43 Sub-Locations. The District therefore has a total population of 473,649 people (Kisumu East District Development Plan 2008-2012) and an HIV and AIDS prevalence of 12.2%. This is despite extensive campaigns to create awareness and educate people about HIV and AIDS.

According to a study carried out by the Institute of Policy Analysis and Research (2004) on the HIV and AIDS scourge in Nyanza province, casual sex is common among the youth and also between the youth and adults. This study also reveals that despite the
knowledge about HIV and AIDS, poor women who are majority in the community are lured into casual sex by men of higher economic status in exchange for favors such as food, clothing and money among other necessities. This state of affairs has, in the absence of effective interventions, contributed to the increase in HIV infections in the province particularly among young people (NACC, 2007).

A situation analysis by Population Council and Constella Futures on the sexual and reproductive health and HIV Risk and prevention needs of orphaned and vulnerable children in Nyanza province (2007), found that, despite the fact that many HIV and AIDS interventions have been directed to Nyanza province, the province continues to have the highest infection prevalence and therefore, the highest level of orphan hood in Kenya. It is clear therefore, that the problem is not the lack of knowledge about HIV but misplaced priorities in making correct choices.

The Department of Children Services carried out a Research in the year 2007 which revealed that poverty is one of the principal factors that increases vulnerability to sexual and reproductive Health risk among the youth in Nyanza. The inability to meet basic needs such as school fees, food, clothing, bedding, soap and body oil were thought to motivate young people to engage in transactional sex to enable them meet these needs.

A testimony by one of the respondents during the situation analysis on “sexual and reproductive health and HIV Risk and prevention needs of older orphaned and vulnerable children in Nyanza province” (2007) revealed that, while girls faced higher risks than boys, children who had been orphaned faced higher risk than children who had not been orphaned. This fact is supported by the following statement of a female widowed caregiver which appears in the situational analysis, “Personal Communication, September 20, 2007) in which she is quoted as saying that:

Poverty at the family level may put children at risk. I would like to give a practical example of what happened in my own house. I have a child-aged 17
years. She had old shoes and schools were about to open. I told her to continue going to school with the old shoes as I looked for money. She went to school but when schools closed she did not come back home. She eloped with a young man whom she felt would provide her with new shoes. Two days after closure of school, I got worried when I did not see her. I started making follow ups to know where she was. A girl who goes to the same school with her directed me to a young man’s house where she was. I probed her politely to know why she took the decision. She revealed to me that she was looking for new school shoes to use in school. That is why I am saying poverty in the house can lead a child into unbecoming behavior. I just collected my daughter and went home (p. 9)

The same study found out that poverty forced children from poor families to engage in income generating activities. This was especially so in the case of orphaned boys who were expected to bring income to the household through activities such as fishing, sand harvesting, and bicycle transport. The environment in which these boys work sometimes made them vulnerable to sexual activities, voluntarily or through coercion. In that regard, boys involved in fishing were thought to engage in transactional sex with adult women working as fishmongers. This fact is supported by the following extract from an interview conducted by the department of children services in 2007 (Male Child, Personal Communication, 2007 September):

Some of them (boys), after getting money from fishing, they use the money in taking alcohol and after taking alcohol you cannot know what is happening. You end up having sex with people whom you don’t know, whether they are your mothers or sisters. So this is because of alcohol. (p. 10)

Statement of the problem

A UNAIDS Report on Regional updates of HIV and AIDS in Africa in 2009 reveals that the HIV and AIDS epidemic has become a serious health, socio-economic and developmental problem in many African countries, including Kenya. It continues to claim lives and the youth who are the future of any nation have not been spared. The Kenya National HIV and AIDS Communication Strategy for the Youth 2007 reports that 32% of Kenya’s population consists of young people between the age of 15 and 29 years. Out of
these, 57% (5,262,000) are female while 43% (4,742,000) are male. Young people are at the
centre of the HIV and AIDS epidemic since they are more likely to engage in high risk
behavior (NACC, 2007). Kenya HIV and AIDS Indicator Survey (2007) indicates that the
overall prevalence of HIV among youth aged 15-24 years is 4% with Nyanza having the
highest prevalence of 8%.

The Kenya Demographic Health Survey (2008) tells us that youth start engaging in
sexual activity early with 47% of women and 58% of men having engaged in sex by the age
of 18. This exposes them to the many risks that come with early sex debut. The HIV Sentinel
Surveillance report 2010, found strong evidence of an increasing trend in prevalence in HIV
infections in Nyanza province compared to the other provinces over the last three rounds of
Sentinel Surveillance. Indeed, Kisumu East District alone, with a population of 54, 123
youths aged between 15-19 years, has an HIV prevalence of 12.2%.

In a bid to eliminate the HIV and AIDS pandemic and its threat in Kisumu, medical
experts, researchers, various Governmental and Non-Governmental Organizations and the
mass media have made efforts aimed at informing and educating the Kenyan public about the
gravity of the disease, how it is transmitted, and how to avoid getting infected.

Despite the public education and the widespread AIDS awareness through mass
media and other sources, the proportion of adolescents and young adults that engage in risky
sexual practices remains high (KAIS, 2007; NACC, 2007; KDHS, 2009). It is clear that all
these efforts have not had a positive impact on shaping risk perceptions of HIV and AIDS
among School going youth in Kisumu District. The study therefore seeks to find out the
influence of the mass media in shaping HIV and AIDS risk perceptions among the youth and
understand how these perceptions inform their behavior with respect to sexual choices.
Purpose of the Study

The purpose of this study was to determine the influence of mass media in shaping risk perception of HIV and AIDS among the youth in Kisumu East district. This helped in the identification of interventions and programmes to address the challenge of HIV and AIDS infections among the young people in the area of study.

Objectives of the Study

The objectives of the study are:

1. To assess the level of knowledge and awareness of HIV and AIDS among the youth in Kisumu East district.
2. To assess the HIV and AIDS risk perceptions of the youth in the area of study
3. To investigate the sources of HIV and AIDS information accessible to the youth in the area of study
4. To find out the influence of mass media communication on the risk perceptions of the youth regarding HIV and AIDS in the area of study

Research Questions

The research sought to find out the influence that the mass media has in shaping risk perceptions of HIV and AIDS and the sources of HIV and AIDS information that shape these perceptions. The research sought to ask the following questions:

1. What is the level of knowledge and awareness of HIV and AIDS among the youth in Kisumu East district?
2. What are the HIV and AIDS risk perception of youth in the area of study?
3. What are the sources of HIV and AIDS information accessible to the youth in the study area?
4. What is the influence of mass media communication on risk perception of the youth regarding HIV and AIDS in the area of study.
Significance of the Study

The youth comprise a large percentage of the Kenyan population (approximately 32%) and HIV prevalence is relatively high (NACC, 2007; MOH & ORC Macro, 2004). The youth in Kenya and indeed in any other nation represent the future generation of the nation. Therefore, the future course of the epidemic will largely depend on the success of prevention strategies adopted by this group (Zabin & Kiragu, 1998; UNICEF/UNAIDS/WHO, 2002). Furthermore, establishing safe sexual behavior from puberty becomes the most effective long-term weapon against the continued spread of HIV (NACC, 2003).

Reproductive health knowledge, sexual and contraceptive behavior of adolescents and young adults can have important implications on their health and well-being. Research has shown that in many countries, few young people are equipped with the information, skills and resources needed to deal with a healthy transition to adulthood (Ndola, 2006; NACC, 2007).

Since, communication of risk is based on information drawn from systematic risk assessments (Federal Emergency Management Agency, 1997), adequate programs including media campaigns, and quality sex education for both in-school and out-of-school youth, would provide important information that would likely enhance the ability of young people to correctly assess their risk of HIV infection and reduce risky sexual behavior.

Studying the perceptions of this target group will therefore provide insights into the development of an appropriate HIV and AIDS communication strategy for the youth in Kenya and inform policy makers on mitigation measures that will guide the development of more effective strategies to fight HIV and AIDS in the area of study.

Lastly, findings from the study will inform parents/guardians and contribute to the body of knowledge on factors that influence decision making with regard to adopting safe sexual behaviors among the youth.
Justification of the Study

KDHS 2008/09 revealed that Nyanza Province has the overall highest infection prevalence in Kenya with the highest prevalence of 8% among youth aged 15-24 compared to the overall National prevalence of 6.3%. The same study revealed that HIV prevalence increases with age from 2% among those in the 15-17 year age bracket to almost 6 percent among those in the 23-24 year age bracket.

Kisumu East District is among the 19 Districts in Nyanza province and has a prevalence of 12.2%. The Antenatal Clinic (ANC) HIV Sentinel Surveillance report 2010, found strong evidence of an increasing trend in prevalence in HIV infections in Nyanza compared to the other provinces in the country over the last three rounds of Sentinel Surveillance. Research has shown that despite the widespread AIDS awareness, the proportion of adolescents and young adults that engage in risky sexual practices remains high (KAIS, 2007; NACC, 2007; KDHS, 2008/09). It is important not only to enhance their general awareness of risks but also to influence them to transfer this knowledge into their personal experience.

Limitations of the Study

This study had limitations which affected the generalization of the results. The study targeted secondary school youth aged between 15-19 years. Young people of the same age who were out of school were not considered and subsequently their views were not captured.

Assumptions of the Study

This study made the following assumptions:

1. That HIV prevalence among the youth could be reduced if their risk perception increased.

2. That the respondents were truthful while filling in the questionnaire.
Scope of the Study

The study was conducted in Kisumu East district among Secondary school youth aged between 15-19 years. A sample size of 375 students was used. The researcher visited a total of five schools within the district.

Definition of Key Terms

Communication is the process by which information is exchanged between individuals (DeVito, 2005). Communication also refers to any interaction which leads to sharing of information, ideas and feelings between people (Montana, 2008). In this study, communication is vital as it will helped to define the course of thoughts, feelings and opinions of different people as they relate to HIV and AIDS information. The information was disseminated through various mediums which took place through a communication processes. The youths perceptions of risk helped us determine whether the information conveyed to them resulted in a change of attitude on how they assess risk or whether the information conveyed to them failed to impact a lasting effect on risk perceptions of HIV and AIDS.

Hazard is an unpleasant incident that could lead to acquiring the HIV and AIDS virus. In this case, risk related behavior can qualify as a hazard. In this study, the conveyed messages should serve as a reminder to the youth that, engaging in premature and casual sexual activities has dire consequences which include contracting the HIV virus and that ignoring the information contained in those messages exposed them to the hazard of contracting HIV and AIDS.

Mass Media are channels of communication through which messages flow, produced by a few designed to be consumed by large audiences (NACC, 2007) in the study mass media is any communication that reached and influenced a large number of people such as television, radio and newspaper
Perception is defined as a process by which individuals organize and interpret their sensory information (Milbourne, 2001). In this study therefore, the messages the youths came into contact with are expected to empower them into averting risk that comes with premature sexual contact with members of the opposite sex. Therefore, these messages helped them acknowledge the consequences and appreciate that the way they behaved after understanding the information conveyed through these messages, clearly defined their lives in the future.

Risk is the probability that the actual return of an investment will be different from the expected. It includes the possibility of losing some or all of the original investment. Different versions of risk are usually measured by calculating the standard deviation of the historical returns or average returns of a specific investment. A high standard deviation indicated a high degree of risk (Levy, 2006).

Risk can also be defined as a combination of the probability of an event (usually adverse) and the nature and severity of the event. The main aim in understanding and communicating risk is to identify and impose priorities, and take appropriate actions to minimize risk (Information Society Technologies, 2003).

In this study, risk is the probability that a person may acquire HIV infection. Certain behavior creates, enhances and perpetuates such risk. risk-related behavior can be identified as any behavior with the following highlighted characteristics among others; Initiated sexual activity at an early age, multiple or casual sexual partners, exchanging gifts or money in return for sex or never using a condom.

Risk Aversion is the unwillingness to take risk. According to the study, the messages disseminated to the youths were meant to empower them to be unwilling to take risks such as engaging in premature sexual activities. After they got to see the messages, the potential consequences of engaging in such activities dominated their thinking and hence, the
messages lead them to avoid taking risks for which they were unable to live with its consequences. By doing this, they averted the risk rather than try to heal the wounds that may arise from the particular risk.

*Risk Perception* refers to the particular judgment that people make about the characteristics and severity of the risk (Slovic, 2002). Risk perception is also the subjective assessment of the probability of a specified type of accident happening (i.e. acquiring HIV) and how concerned we are with the consequences (Trondheim, 2004). In the application to this study, risk perception were useful as the target population came into contact with HIV and AIDS information resulting in either change/lack of change of attitude about their opinions on HIV and AIDS.

*Influence* refers to the effect that something has on the way a person thinks or behaves (Oxford, 2011). In relation to the study influence is the effect of the mass media on the perceptions and behavior of the youth with regard to HIV and AIDS prevention.

*Youth* refers to any person in the age bracket 15 to 30 years (KNYP 2007). In relation to the study a youth is any person male or female in the age bracket 15-19 years.

**Summary**

Chapter one provides the background of the study and statement of the problem. It also presents the purpose, objectives, significance, limitations and delimitations to the study.
CHAPTER 2
LITERATURE REVIEW

Introduction

In this chapter, relevant literature relating to the study is reviewed and with the support of the existing literature, basic concepts and theories on the subject of study are explained. The available literature also presents various theories on behavior. The prospect theory informs the study as it attempts to explain decisions between alternatives involving risk with uncertain outcomes and known probabilities. According to the Prospect Theory, people’s attitudes towards risk concerning gains may be quite different from their attitudes toward risk concerning losses.

Communication and HIV and AIDS

Communication is central to prevention strategies aimed at influencing individual and social behavior (UNAIDS, 1999). According to Laswell (1948), all communication should be analyzed in terms of who (source), says what (Message), via what medium (the channel conveying the message), to whom (receiver) and directed at what kind of change (effect).

This model of communication helps us in understanding risk communication of HIV and AIDS as a process with clearly defined parameters regarding source, message, channel, and intended effect. More than often, the source is an authority, the message describes the surrounding hazard, and the intended effect is a change in receivers’ behavior. However, receiver characteristics have very important influences on each of the stages in the communication process. For example, the effect of a given HIV and AIDS information source is determined by the receivers’ perceptions of that source and the effect of the message is determined by receivers’ willingness and ability to understand and hold on to this information.
Recognizing the media as a powerful tool in the fight against HIV and AIDS, Kofi Annan, former United Nations Secretary General, in a publication, “The Media and HIV and AIDS” (2004) makes the following statement:

When you are working to combat a disastrous and growing emergency, you should use every tool at your disposal. HIV and AIDS is the worst epidemic humanity has ever faced. It has spread further, faster and with more catastrophic long-term effects than any other disease. Its impact has become a devastating obstacle to development. Broadcast media have tremendous reach and influence, particularly with young people, who represent the future and who are the key to any successful fight against HIV and AIDS. We must seek to engage these powerful organizations as full partners in the fight to halt HIV and AIDS through awareness, prevention, and education. (p.4)

As stipulated in the speech of Kofi Annan many communication and health promotion programs proceed on the assumption that individual behavior change could be achieved through education and awareness creating programs. This explains why initial programs to create awareness and educate the public about HIV and AIDS targeted the individual rather than the community.

Kamaara (2004), tell us that in the past, communication on HIV and AIDS emphasized on the transfer of information with the intention of affecting behavior and state of mind. Such communication, education and awareness programs targeted individuals rather than the communities and attain little success. However with the realization that communities have different traditional beliefs and practices that affect the behavior patterns of individuals living in those communities, it became necessary to shift the focus of campaigns so that communities rather than the individual became the target of communication programs. In recent years, the approach in fighting the HIV menace has focused beyond individual risks to include environmental and social factors that influence risky behavior.

While targeting the community, HIV and AIDS communication strategies must be culturally appropriate in order to be easily accepted. However, when certain dominant cultural and traditional norms and values favor the conditions for the spread of HIV and
AIDS, and in order for such communication to have a positive impact, there is need for the media and communication practitioners to target the abandonment of such norms and values.

The mass media can be instrumental in breaking the silence that surrounds HIV and AIDS and in creating an environment that encourages discussion on how individuals protect themselves through change of behavior among others. Through a variety of interventions, the media can play a critical role in the fight against HIV and AIDS by combating existing social norms, traditions, values and conditions that increase infections and the spread of the virus. The examples cited below demonstrate that in the past, such media interventions yielded positive results and resulted in positive changes in society. The task is therefore not as difficult and daunting as it might appear (UNAIDS report, 2004).

A report from the Global Media AIDS Initiative (2004), reveals that it was through media interventions, that Lutsaan village in India, turned its back on the dowry system after listening communally to a radio soap opera called “TinkaTinkaSukh” (Little steps to a better life) broadcast on all Indian radio. The same report also tells us that the popular South African soap opera, “Soul City” aired by the South African Broadcasting Corporation (SABC) since 1994 brought about social policy change at a national level. The series, which primarily deals with HIV and AIDS, examined domestic violence when, one character who was a respected teacher, abused his wife.

Advocacy pressure from Soul city and the national network on violence against women, a grass-roots coalition of activists, led to the swift implementation of the domestic violence act in 1999. Government departments and officials acknowledged that their action was influenced by the media campaign. The media is a powerful communication tool and in each of the above examples, broadcasters broke new ground and challenged domestic violence which had previously been socially acceptable. They did this in ways that did not
necessarily alienate, but rather which attracted the audience (Global Media AIDS Initiative, 2004).

According to McQuail (2005), wherever the various means of communication exert influence they also cause change. Focus is fixed on the direction and strength of the bond between the channel of communication and the changes taking place in the society.

Such change will normally depend on various factors namely; the technology used to communicate, the form and content of the media, social structure and institutional arrangement and the distribution of opinion, beliefs, values and practices among the population. One of the obvious roles of the media is to open channels of communication and foster discussion about HIV and interpersonal relationships.

Addressing HIV and AIDS in entertainment programmes can have an enormous impact on a society at risk. Coulson (2002) informs us that the radio Tanzania soap opera “Twende na wakati” (Let’s go with the times), which was first broadcast in 1993, has greatly increased the willingness of radio listeners, to discuss issues related to HIV and AIDS. The soap opera has had a very positive impact on the people as it has encouraged them to talk about AIDS. After airing the program for several seasons, evaluations reported that 65% of the respondents said they had spoken to someone about Twende na wakati and more than 8 out of 10 people reported having adopted an HIV-prevention measure as a result of listening to the soap opera.

Similarly, there is the Weekly Award-Winning television soap “SIDA dans la Cité” (AIDS in the city), produced in Côte d’Ivoire and shown on Ivorian radio and television (RTI) and across French West Africa. The series revolves around the life of a family affected by HIV and AIDS and is produced as the key part of a condom social marketing campaign by “Population Services International (PSI)”, Côte d’Ivoire and a local partner. PSI promotes condom use through the program and ensures that condoms are available to the audience
(Coulson, 2002). This program is another example of how the promotion of condoms can be linked directly to their subsequent availability and acceptance.

On the contrary not all communication programs that succeed in creating awareness on HIV and AIDS led to change in behavior. A study conducted in Nigeria by Omoera (2010) reveals that, by airing the programs that address HIV and AIDS, the media in Nigeria, succeeded in creating awareness of the consequences of casual sex and other issues associated with HIV and AIDS. The same study however revealed that the high education and awareness created by the media was not reflected in the conduct of the people in the Edo locality since they continued to engage in casual sex despite the awareness and education on HIV and AIDS.

In Kenya for example, there are various programmes and paid advertisements running on both television and radio media with the aim of increasing the HIV and AIDS awareness and education among the general public. Programmes such as “Siri” and “Shuga” aired on television stations around the country are helping in creating awareness on HIV and AIDS making easy for the society to accept people living with HIV and AIDS.

KDHS 2008/09 informs us of the high prevalence of HIV and AIDS in Nyanza province and in Kisumu East district in particular, despite the availability of information and widespread National campaigns in this region. The HIV Sentinel Surveillance report 2010 goes further to bring out strong evidence of an increasing trend in prevalence in HIV infections in Nyanza province. This therefore illustrates that risk perceptions of the people in Kisumu East district may be influenced by the value orientations that the Luo community has regarding sex and not caring about the consequences of contracting or spreading the HIV and AIDS virus.
Communication and risk perception of HIV among the youth in Kenya

Numerous studies in Kenya such as KAIS (2007), KDHS (2008/09) and a situation analysis on youth and HIV and AIDS Behavior Change Communication (BCC) in Kenya reveal that despite the widespread AIDS awareness, the proportion of Kenyan adolescents and young adults that engage in risky sexual practices remains high.

In the context of HIV, risk is defined as the probability that a person may acquire the HIV virus. Certain behavior can create, enhance and perpetuate such risks (UNAIDS, 1998). Such behavior includes; sharing needles while injecting drugs, unprotected casual sex and multiple concurrent long term sexual partners with low and inconsistent condom use (UNAIDS 2007). In addition, risk will also arise when individuals engage in risky behavior for a variety of other reasons which include lack of accurate information, inability to negotiate safe sex, cultural practices like widow inheritance and polygamy and unavailability of condoms among others.

Many Kenyan women may feel that changing their partner’s sexual habits is something that is beyond their control and that negotiating protective measures, such as condom use, is not acceptable because of established gender norms (KDHS, 2003). These among other factors increase the risk of contracting HIV.

NACC and NASCOP (2011) in their Kenya AIDS Update report informs us that over 80 per cent of HIV transmissions in Kenya occur through unsafe sexual contact and yet in Nyanza Province, sex is so deeply entrenched in the cultural framework that, it cannot be understood in isolation. In order to understand the spread of HIV and AIDS better, it is critical to examine socio-cultural aspects such as marriage patterns, types and forms of sexual association, widow inheritance and power relations between men and women, especially regarding negotiation for safe sex. As a result of all these issues, even though the pandemic has attracted multidisciplinary studies and multisectoral responses, information on a socio-
cultural explanation of the spread of the virus in Nyanza though critical, remains scanty and outdated.

Apart from the social cultural aspects, the key role that power relationships and gender inequalities play in influencing risk has also been a subject of investigation. Around the world, while both young and old women are increasingly at the risk of contracting HIV, they also bear the burden of stigma and discrimination. Although many women, particularly poor women, both young and old, may be aware of the necessary precautions required to protect themselves against the HIV and AIDS, they continue to contract HIV and AIDS at an alarming rate and for various reasons. The socio economic environment prevailing in most countries of Sub-Saharan Africa has been identified as promoting risky sexual behavior particularly among young girls (Luke, 2003; Tyndale et al., 2002; Tyndale et al., 2005; Okonofua, 2000; Orobuloye et al., 1994).

When women lack economic empowerment, this relegates them to subordinate positions where they are left with no option but to rely on their husbands or other male partners generally for economic support. Having been so relegated, such women lack the capability of taking precautions particularly when it comes to negotiating safe sex and are therefore at a very high risk of contracting the HIV virus.

Apart from lack of economic empowerment, fear of violence if they refused sex, is another reason why some women engage in risky sexual behavior (UNAIDS, 2004). In the book, “AIDS and Men: Taking Risks or Taking Responsibility? (1999)” by Martine Foreman, a Kenyan husband was quoted as saying that a woman has no freedom of choice. He was further quoted as saying that he was the lion of the house and his wife had no right to say no to sex. (p. 30). This is the kind of person who can beat up his wife if she were to refuse to engage in a risky sexual activity with him. Given the attitude such as the one displayed
above, the wife of such man remains exposed to the risk of infection particularly if she cannot walk out of the relationship for lack of economic empowerment.

A study conducted by Njogu and Castro (2006) on the “Perception gap between HIV and AIDS knowledge and risk perception among Kenyan Youth,” reveals that one possible explanation for the lack of solid evidence on the link between AIDS related knowledge and reduced risk behavior, is the individual’s perception of infection as a remote threat (Venier et al., 1998). Once an individual perceives getting infected as a remote threat, then automatically he/she will engage in biased processing of any HIV messages or information that is consistent with their behavior. This particularly is the case during adolescence, when inexperience and psychological developmental factors promote a certain sense of invulnerability (Bankole et al., 2004). Since individuals are unlikely to adopt “safe” sexual behavior unless they believe that they are susceptible to infection, it is important to understand how they evaluate their personal risk.

Njogu and Castro (2006), analyze perceived and actual risk among young people and came to the conclusion that, perceived risk is to some extent socially constructed because, despite widespread knowledge about AIDS, personal risk tends to be underestimated for various reasons. According to the above analysis, a majority of young adults involving themselves in risky sexual behavior such as indulging in sexual activity at an early age, having multiple or casual sexual partners, exchanging gifts or money in return for sex or not using a condom, perceived themselves to be at no risk at all.

A study by Tenkorang & Tyndale (2008) informs us that a variety of factors were identified as motivating the youth to indulge in sexual behaviors that carry some risk of HIV infection. Pressure from peers and community members to engage in sex, together with the consequences of not doing so, have been shown to motivate Kenyan youth to engage in early sexual activity. This study examined the factors that influence the timing of first sexual
intercourse among the youth in Nyanza Province. The study revealed that endorsement of local myths such as portraying HIV as transmitted through supernatural or ordinary daily contacts led to earlier sexual intercourse with implications for HIV transmission particularly if prevention requires individuals to behave contrary to local customs.

Factors that could motivate the Youth to take up risk-reducing behavior such as abstaining from sexual activity or adopting the use of condoms include perception of AIDS as serious and an understanding the fact that one is at risk of contracting HIV if one behaves in a reckless manner (Ajzen & Fishbein, 1980; Bandura, 1994; Catania et al., 2004; Rosenstock, 1974). Studies in South Africa, for instance, have shown that perceiving oneself as being at risk or knowing someone who has died of AIDS (evidencing its seriousness), delayed first sexual intercourse among young people (Anderson et al., 2007; Tenkorang et al., 2009).

Risk is sometimes defined as insufficient controllability (Brun, 1994). Illusion of control has been found to be related to unrealistic optimism. Unrealistic optimism is a general optimism about the outcome of an event (Weinstein, 1980) and exists for both men and women and across age and educational level (Weinstein, 1987). People are found to believe that they are more in control than they actually are and so, when in a group and the vast majority of people perceive their chances of a negative event to happen to them as less than average.

In the 1970s, a small group of cognitive psychologists with a background in the experimental study of decision making investigated how people react with regard to risks. One of the inputs of the study was experimental studies of lotteries and other forms of gambles. When people viewed the risk of winning the lottery as higher if they pick the numbers themselves – this is known as illusion of control (Langer, 1975).
Theoretical Framework

A theoretical framework is a collection of interrelated ideas based on theories (Kombo and Tromp 2006). It is a reasoned set of propositions, which are derived from and supported by data or evidence. A theoretical framework accounts for or explains phenomena while, based on theories, attempts to clarify why things are the way they are. A theoretical framework is a general set of assumptions about the nature of phenomena (Kombo & Tromp, 2006). This study seeks theoretical support from the prospect theory and health belief model to understand why young people behave the way they do with regard to safe sexual behavior.

Using the prospect theory to understand risk perception and the influence of communication on HIV and AIDS transmission

According to the article “Health communication and care giving research policy and practice” Sparks (in press), in recent years, health communication scholars and health practitioners have utilized the prospect theory by using message framing to understand the communication involved in risky decisions.

According to the prospect theory, “gain-framed” messages (messages about the benefits of adopting a particular behavior), are more effective than “loss framed” (messages about negative consequences of not adopting a particular behavior) (Benjamin, 2007). The prospect theory was developed by two psychologists Daniel Kahneman and Amos Tversky, and published in the Econometrica in 1979. Kahneman and Tversky (1979) proposed the prospect theory as a descriptive model of decision making under uncertainty. Han and Hsu (2004) point out that “The prospect theory, also known as the message framing theory, is not a normative theory but a descriptive approach to explain real world behavior.” (p. 1) According to Han and Hus (2004), the framing of alternatives affects choices in the prospect theory because it implies a unique relationship of risk taking to positive and negative framing where negatively framed problems decrease risk bearing and encourage risk seeking.” (p.6)
Tversky and Kahneman (1984) conducted an experimental design that illustrated how message framing affected decision-making. In this experiment, a representative sample of physicians was asked the following question:

Imagine that the U.S is preparing for the outbreak of an unusual Asian disease which is expected to kill 600 people. Two alternative programmes to combat the disease have been proposed. Assume that the exact scientific estimates of the consequences of the programmes are as follows: If program A is adopted 200 people will be saved. If program B is adopted, there is one-third probability that 600 people will be saved and two thirds probability that no people will be saved. Which of the two programs would you favor? (P. 6)

The first alternative is positively framed and views the predicament in terms of lives saved. 72% of the physicians chose alternative “A” which they considered was a safe and sure strategy while only 28% chose alternative B which was the risky strategy.

An equivalent set of physicians considered the same dilemma, but with the question framed negatively:

Imagine that the U.S is preparing for the outbreak of an unusual Asian disease which is expected to kill 600 people. Two alternative programmes to combat the disease have been proposed. Assume that the exact scientific estimates of the consequences of the programmes are as follows: If program C is adopted, 400 people will die. If program D is adopted, there is one-third probability that nobody will die and two thirds probability that 600 people will die. Which of the two programs would you favor? (P. 6)

These two questions examine the same problem. Two hundred of 600 people saved is the same as 400 of 600 lost. Yet when the question is framed negatively 22% of the physicians preferred a conservative strategy and 72% of them opted for a riskier strategy. The result of their experiment is undeniably clear that the framing of options has important consequences on decision-making (Kahneman & Traversky, 1979). They demonstrate that, although risk communication is a key factor in improving risk behavior, such communication may not always be sufficient (Murrow, 2009).

The root of risk communication is understanding how risk is perceived and knowing what it takes for people to be concerned enough to take mitigating action (Morrow, 2009).
The same object can be viewed from many different perspectives. Half a glass of water can be described as half full or half empty. In a decision context, different perspectives (or frames) can lead to different choices. This well known framing effect occurs because individuals tend to be more risk averse when the alternatives are described in positive domain for example but more risk-seeking when the alternatives are described in negative domain (Traversky & Kahneman, 1981).

The prospect theory describes decisions between alternatives that involve risk where the probabilities are known. It allows one to describe how people make choices in situations where they have to decide between alternatives that involve risk. This implies that if decision makers are provided with adequate information (communication) about the hazard itself (such as HIV), correct information on their level of exposure (such as whether they are located in a high risk area) and estimations of the probability of being impacted at that location, they can make reasonable estimations of personal risk.

Health communication scholars, in trying to understand how individuals process information, have identified the factors which contribute to appropriate behavior change (Brown et al., 2006). Some of these scholars presume that if individuals were provided with the right information, they would adopt the recommended behavior. Others like Morrow (2009) disagree and are of the view that if giving information is all it took, then any two people given the same information and set of circumstances would make similar decisions regarding high risk behavior. Apart from reliable information therefore, it is important to provide the people with behavioral skills so that individuals are able to change to the desired behavior.

Breyer and Fuchs (1982), through an investigative study on risk attitudes in health examined the principles that govern choice behavior when the consequences (“pay off”) are not monetary but involve a different dimension such as the health of the decision maker. The
study aimed at finding out whether there was a general law of decision making under uncertainty. The study revealed that the function relating utility to health changes resembles the utility of money function. From the results of this study, Breyer and Fuchs noted that people display risk aversion with respect to gains and risk seeking towards losses.

Melkote and Steeves (2001) in the book, “Communication for development in the third world” hypothesize that communication plays an important role in the prevention of HIV and AIDS because it disseminates information that may prevent risk behavior and spreads awareness leading to reduction of social stigma. As the transmission of HIV is affected significantly by an individual’s behavior, individual behavior change theories have remained the theoretical anchor for most preventive efforts (UNAIDS, 1999).

Examining some of the mass media HIV and AIDS campaigns accessible to the youth in Kisumu, one will recognize that the health behavior targeted is illness protection. Hence, the messages use frames that present the need for abstinence and protection. A good example is the “Love bila regret- Trust Condom Campaign” where audience is told that using a condom will yield a life that has no regrets. The type of regret is however not clarified and is left to the audience to conclude and make an appropriate choice. There is on the other hand, the “Tume chill” abstinence campaign which uses frames that present the need to abstain from sex. Lastly, the “G-Pange” campaign is positively framed and uses frames that call young people to act by taking control of their lives, promoting personal action and to embrace full responsibility for their lives, whether as individuals or groups.

Conceptual Framework: Health Belief Model

The Health Belief Model (HBM) is a conceptual framework used to understand Health behavior and possible reasons for non compliance with recommended Health action (Becker &Rosen stock, 1984). The HBM was first developed in the United States of America
in the early 1950s after it became evident that the continent had experienced widespread “failure” to convince people to accept disease preventive behavior including screening tests for early detection of asymptomatic diseases, such as tuberculosis (Rosenstock, 1974a). There appears to be an obvious connection between experience and behavior as experiences tend to drive most of the risk perceptions and outcomes (Leventhal 1983).

The HBM provides a framework for understanding the effect of experience on perception and outcomes and addresses six major components for compliance with recommended health actions: Perceived barriers of recommended health actions, perceived Benefits of the recommended health action, perceived susceptibility of the disease, perceived severity of the disease, cues to action and demographics or psychological structures. According to the Health Belief Model (HBM), people are most likely to make health behavior changes when they perceive that the disease is serious and are less likely to practice healthy behavior if they believe that the disease is not severe (Maddux & Rogers, 1998).

Severtson (2006), postulates that experiential information is more meaningful to change behavior than abstract information. Studies have shown that, one of the factors that influence whether or not people will adopt safe behavior in order to protect themselves from acquiring the HIV virus is; ‘whether or not they have experienced a personal health effect’ (Lichtenberg et al, 1999). According to Williamson (2003), most of the knowledge in our lives comes from actual personal and relevant experiences rather than from intellectual exercises.

Communication researchers recommend the application of behavioral theory in order to understand psychological processes that explain the relationship between experience and behavior (Severtson, 2006). This theory is therefore applicable to this study since it explains some of the reasons for non compliance with a recommended health action in this case youth
engaging in potentially risky sexual behaviors. Behavior is seen as a function of subjective value (desire to avoid illness) and as an outcome of subjective probability or expectation (remedial or preventive action to ward off the illness). The model assumes that individuals will take preventive actions (risk reduction behavior) when: they believe they are susceptible to a disease (self perception of risk) and the consequences will be severe. They believe that taking preventive action will be beneficial in reducing the threat of contracting the disease.

This study used the HBM to establish HIV and AIDS risk perception of the youth in Kisumu East district and found out their perceptions on susceptibility and severity of the disease. The study also examined the factors that inhibit individuals from adopting safe behavior.

Conceptual frame work of the HBM and prospect theory

Source: The Health Belief Model (Rosenstock 1966, revised by Becker et al)
This model also assumed that the perceived benefit would be sufficient to overcome perceived barriers such as cost or the inconvenience of undertaking the action (e.g. using a condom) and the perceived stimulus, either internal such as pain or external such as mass media campaigns, newspaper articles or personal involvement that serve as cue for action (Rosenstock et al., 1994; UNAIDS, 1999). HBM suggests that behavior is also influenced by a reminder to take action. Such reminders could be events, people or things that move people to change their behavior. Examples include illness of family member(s), advice from others or media reports (Graham, 2002). This study used these variables to determine the sources of HIV and AIDS information accessible to the youth in the study area and help explain why the youth behave the way they do. It also found out how this information as a cue to action, influenced perception of HIV and AIDS risk and the personal factors that affect behavior adoption.

Relationship between Prospect Theory and Health Belief Model

The two theories go hand in hand as they both explain how individuals make decisions. Perception of risky behavior and prospects of gain and loss are common between both theories as they determine if an individual will adopt less risky behavior or otherwise. The theories however differ in their intended scope as the HBM grew out of research on disease prevention while the prospect theory emerged out of research on the decision making process in the context of risk.

According to the HBM, people are most likely to make health behavior changes when they perceive that the disease is serious and are less likely to practice healthy behavior if they believe that the disease is not severe (Maddux & Rogers, 1998). The HBM explains health behavior from a social-psychology perspective using the theories of value-expectancy and decision-making (Becker, 1974; Kronenfeld & Glik, 1991; Maiman & Becker, 1974). The Model focuses on dimensions that influence an individual’s control over a specific action.
These dimensions (or variables) are then used to predict behavior. The original six construct of the Model include perceived susceptibility, perceived severity, and perceived benefits, perceived barriers, cues to action and demographics or psychological structures.

The Prospect Theory on the other hand postulates that when a communication regarding behavior emphasizes the prospect of gain, as a result of performing or not performing a specified action, individuals tend to reject risky behavior, but when the attempt to curb losses is highlighted, individuals tend to prefer risky behavior (Kahneman & Traversky, 1979). Perceived benefit and threat, gain and loss, and certainty and risk from performing or not performing a given action are central to decision making and the Prospect Theory incorporates the aspect of individual perception of risk into our understanding of how people make decisions.

People are not always purely rational in developing preferences. Preferences are conditioned by mediating factors such as an individual’s perception or evaluation of a prospect which is subject to many biases such as the heuristic processes (i.e., intuitive, subjective rules of thumb) by which a person evaluates information concerning a prospect, the context in which the prospect arises, and how the prospect is elicited (Tversky and Kahneman, 1992). For example, some people strongly hold onto long-held beliefs when they are challenged with information that contradicts those beliefs. Such people will process the information differently and arrive at a different perception of a prospect’s risk than those who are quick to adjust their beliefs.

With respect to context, a person’s perception of their personal risk upon being exposed to a message depends upon their life experience with the content of the message. For example, someone who has personal experience with HIV and AIDS illness when exposed to a message about the link between HIV and safe sexual behavior will process the prospect differently than someone who has no such experience. With respect to how a prospect is
elicited, a person’s perception of the message may be biased by how and when they receive the message. For example, receiving the message from a doctor during an HIV test will obviously affect a person’s judgment differently than exposure to the same message on a bus ride to home from work.

Message framing theories predict that when a procedure is perceived to be risky (e.g., HIV screening tests may cause a patient to find out that they have HIV), loss-framed messages will promote testing more strongly than gain framed messages. This is because people favor risky prospects over sure prospects in the domain of losses. On the other hand, when a procedure is perceived as safe (e.g. using a condom prevents HIV), gain-framed messages are predicted to be more effective because people prefer sure prospects to risky prospects in the domain of gains. (Apanovitch, McCarthy & Salovey, 2003; Moxey, O’Connell, McGettigan, et al., 2003; Rivers, Salovey, Pizzaro, et al., 2005; Finney & Iannotti, 2002).

According to the HBM, individuals weigh the benefits and costs in an effort to decide whether or not to adopt a Health-related behaviour. In this process, perceived susceptibility and perceived severity should be high for the individual to consider changing his or her behavior (Dutta-Bergman, 2005). In order for a new behaviour to be adopted, both susceptibility and severity need to be high, but not higher than perceived efficacy (Silk et al., 2006).

Summary

This chapter reviewed literature related to the study under two sub-headings namely: Communication and HIV and AIDS and Communication and Risk Perception of HIV among the Youth in Kenya. Within the same chapter, a Theoretical Framework has been entrenched. This framework is explained in two sub-headings: Using the prospect theory to understand
risk perception and the influence of communication on HIV and AIDS transmission. The next chapter describes the methods and procedures used for data collection and analysis.
CHAPTER 3
METHODOLOGY

Introduction

This study aimed at finding out the perceptions of the youth on the subject of HIV and AIDS. Research has shown that the absence of effective interventions has led to the continued rise of HIV among young people (NACC, 2008). The health behaviour model and prospect theory were employed in the study to explore decisions made or the chosen behavior that affects health status. The study took a descriptive approach and used both quantitative and qualitative data.

Research Design

This section describes the research design and methodology in terms of population, sampling and administration of research instruments, data collection procedures, and the description of technique used in data analysis. Mugenda and Mugenda (1999), observes that qualitative research is critical when it comes to information transfer:

Because of the tendency of African communities to pass information orally, there is a strong argument that the most appropriate Research and Evaluation approach in Africa is the qualitative approach because it emphasizes oral communication and gives respondents a chance to state their problems the way they perceive them and participate in seeking solutions to these problems as well as in effecting such solutions (p 202).

The study took a descriptive approach and collected both quantitative and qualitative data which sought to define and describe information and characteristics about the population being studied. Quantitative data defined the relationship between risk perceptions (the independent variable) and how communication of HIV and AIDS information shaped these perceptions (Dependent variable). Data was collected using a self administered structured questionnaire as it provided greater anonymity for the respondent.
According to Mugenda and Mugenda (1999), human phenomenon that cannot be investigated by direct observation such as perceptions and other human emotions are best studied using the qualitative method. In this study, qualitative data described a detailed picture about why the youth act in certain ways, and their feelings about these actions. This data was collected using open ended questions from the questionnaire that was provided to the research participants. To achieve the research objectives, the study design was based on the descriptive research approach. The study collected descriptive statistics on sources of HIV and AIDS information and how this information shaped the perception of risk to uncover patterns that emerged during analysis. Survey method of primary data collection was employed during the study as it was cheaper and allowed similar data to be collected from existing population units.

Target Population

Mugenda and Mugenda (2003), defines population as the entire group of individuals having common observable characteristics. The study population in this case comprised of 14,140 youths in school (Census, 2009) between the ages of 15-19 years.

Sampling frame

The sampling frame was drawn from a list of Secondary schools within Kisumu District. This list was obtained from the Directorate of Secondary and Tertiary Education at the Ministry of Education. Simple random sampling method was used to identify the institutions to be visited as this method gave each institution an equal chance of being selected. Each of these institutions was visited and information obtained from the students using a questionnaire.

The study sought permission from the head teacher to distribute questionnaires to the classes identified at a time appropriate to the school. With the help of a research assistant,
identified students who gave their consent were provided with the questionnaires and requested to fill them.

Sample size

According to Salant and Dillman (1994), the size of the sample is determined by four factors: (1) how much sampling error can be tolerated; (2) population size; (3) how varied the population is with respect to the characteristics of interest; and (4) the smallest subgroup within the sample for which estimates are needed. Estimation of sample size in research using Krejcie and Morgan is a commonly employed method. Krejcie and Morgan (1970) used the following formula to determine sampling size:

\[ S = \frac{X^2NP}{d^2(N-1)} + \frac{X^2P}{1-P} \]

where

- **S** = required sample size
- **X^2** = the table value of chi-square for one degree of freedom at the desired confidence level
- **N** = the population size
- **P** = the population proportion (assumed to be .50 since this would provide the maximum sample size)
- **d** = the degree of accuracy expressed as a proportion (.05)

In the article Small Sample Techniques (1960), the research division of the National Education Association published a formula for determining sample size. 

\[ s = \frac{X^2NP}{1-P} \div d^2(N-1) + X^2P(1-P) \]
Table 3.1: Table for determining sample size from a given population

This table was constructed using the same formula for easy reference.

<table>
<thead>
<tr>
<th>N</th>
<th>S</th>
<th>N</th>
<th>S</th>
<th>N</th>
<th>S</th>
<th>N</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>10</td>
<td>100</td>
<td>80</td>
<td>280</td>
<td>162</td>
<td>800</td>
<td>260</td>
</tr>
<tr>
<td>15</td>
<td>14</td>
<td>110</td>
<td>86</td>
<td>290</td>
<td>165</td>
<td>850</td>
<td>265</td>
</tr>
<tr>
<td>20</td>
<td>19</td>
<td>120</td>
<td>92</td>
<td>300</td>
<td>169</td>
<td>900</td>
<td>269</td>
</tr>
<tr>
<td>25</td>
<td>24</td>
<td>130</td>
<td>97</td>
<td>320</td>
<td>175</td>
<td>950</td>
<td>274</td>
</tr>
<tr>
<td>30</td>
<td>28</td>
<td>140</td>
<td>103</td>
<td>340</td>
<td>181</td>
<td>1000</td>
<td>278</td>
</tr>
<tr>
<td>35</td>
<td>32</td>
<td>150</td>
<td>108</td>
<td>360</td>
<td>186</td>
<td>1100</td>
<td>285</td>
</tr>
<tr>
<td>40</td>
<td>36</td>
<td>160</td>
<td>113</td>
<td>380</td>
<td>181</td>
<td>1200</td>
<td>291</td>
</tr>
<tr>
<td>45</td>
<td>40</td>
<td>180</td>
<td>118</td>
<td>400</td>
<td>196</td>
<td>1300</td>
<td>297</td>
</tr>
<tr>
<td>50</td>
<td>44</td>
<td>190</td>
<td>123</td>
<td>420</td>
<td>201</td>
<td>1400</td>
<td>302</td>
</tr>
<tr>
<td>55</td>
<td>48</td>
<td>200</td>
<td>127</td>
<td>440</td>
<td>205</td>
<td>1500</td>
<td>306</td>
</tr>
<tr>
<td>60</td>
<td>52</td>
<td>210</td>
<td>132</td>
<td>460</td>
<td>210</td>
<td>1600</td>
<td>310</td>
</tr>
<tr>
<td>65</td>
<td>56</td>
<td>220</td>
<td>136</td>
<td>480</td>
<td>214</td>
<td>1700</td>
<td>313</td>
</tr>
<tr>
<td>70</td>
<td>59</td>
<td>230</td>
<td>140</td>
<td>500</td>
<td>217</td>
<td>1800</td>
<td>317</td>
</tr>
<tr>
<td>75</td>
<td>63</td>
<td>240</td>
<td>144</td>
<td>550</td>
<td>225</td>
<td>1900</td>
<td>320</td>
</tr>
<tr>
<td>80</td>
<td>66</td>
<td>250</td>
<td>148</td>
<td>600</td>
<td>234</td>
<td>2000</td>
<td>322</td>
</tr>
<tr>
<td>85</td>
<td>70</td>
<td>260</td>
<td>152</td>
<td>650</td>
<td>242</td>
<td>2200</td>
<td>327</td>
</tr>
<tr>
<td>90</td>
<td>73</td>
<td>270</td>
<td>155</td>
<td>700</td>
<td>248</td>
<td>2400</td>
<td>331</td>
</tr>
<tr>
<td>95</td>
<td>76</td>
<td>270</td>
<td>159</td>
<td>750</td>
<td>256</td>
<td>2600</td>
<td>335</td>
</tr>
</tbody>
</table>

Note: “N” is population size and “S” is sample size.

The table is applicable to any defined population and no calculations are needed to use it. For instance to, obtain the required sample size enter the table at N = 15,000. The sample size representative of young people in this study is 375.
Table 3.2: Sampling Technique

<table>
<thead>
<tr>
<th>Category</th>
<th>No. of Schools</th>
<th>Sample Size</th>
<th>Total No. of Students</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Schools) 10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary School</td>
<td>45</td>
<td>5</td>
<td>14,140</td>
<td>375 (when N=15,000)</td>
</tr>
<tr>
<td>Boys school only</td>
<td>4</td>
<td>4/45*375=33.3/4=8.325</td>
<td>2,442</td>
<td>Form 1 611 Form 2 657 Form 3 617 Form 4 557</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls school only</td>
<td>5</td>
<td>5/45*375=41.6/4=10.4</td>
<td>2,202</td>
<td>Form 1 593 Form 2 617 Form 3 519 Form 4 471</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed school</td>
<td>36</td>
<td>36/45*375=300/4=75</td>
<td>9,987</td>
<td>Form 1 3,056 Form 2 2,540 Form 3 2,222 Form 4 1,663</td>
</tr>
</tbody>
</table>

Stratified sampling was used to select the schools that were included in the study. Disproportionate stratified random sampling was used to calculate the sample size in each school. The sampling frame was divided into three categories. These are: boy’s schools only, girl’s schools only and mixed schools. These categories were then further divided into four classes. These are; Form 1, 2, 3 and 4. A sample was then randomly drawn from the four classes in each school.

Sampling technique

For schools with more than one stream simple random sampling was used to identify the class from which students were selected for interview. Once the class was identified students were selected randomly to give each student an equal chance of being selected. Each student was assigned a unique number which was placed in a bowl and mixed thoroughly. The blind-folded researcher then picked numbered tags from the bowl. All the individuals bearing the numbers picked by the researcher were identified as subjects for the study.
Data Collection

Primary data was collected for this study. The main method of obtaining data was a self administered structured questionnaire developed and administered by the researcher.

Pre Testing the Questionnaire

A pre test refers to a trail administration of an instrument to identify flaws (Polit & Hungler, 1995). When a questionnaire is used as a data gathering instrument, it is necessary to determine whether questions and directions are clear to subjects and whether they understand what is required from them.

The questionnaire was pilot tested prior to the commencement of data collection to discover and correct any weaknesses. This pilot was done in Kakamega District among students of Kakamega High School who were between the ages of 15-19 years.

Ethical Consideration

To recognize and protect the rights of human subject’s diligence honesty and integrity are required. To render the study ethical, the rights to self determination, anonymity, confidentiality and informed consent was observed.

Burns and Grove (1993) define informed consent as the prospective subject’s agreement to participate voluntarily in a study which is reached after assimilation of essential information about the study. The subjects were informed of their right to voluntarily consent or decline to participate, and to withdraw participation at anytime without penalty.

Written permission to conduct the study was obtained from Daystar University while verbal permission was obtained from the head teachers of the various schools visited. The subjects consent was obtained before they completed the questionnaire.
Data Analysis

Data was analyzed using the SPSS software. Statistical treatment of data included descriptive analysis and frequency distributions. Chi-square tests were also used to determine if there were any significant relationships between different variables in the study. Data was then presented using tables, graphs, and pie charts.
CHAPTER 4
RESEARCH FINDINGS, ANALYSIS AND INTERPRETATION

Introduction

This chapter presents the findings of the research as well as their analysis and interpretation. Where necessary, aids such as tables and graphs are used to elucidate the meaning of the data presented. The findings presented in tables and figures are further explained to enable the reader have a clear picture and understanding of the phenomenon under analysis. A total of 375 questionnaires were administered to school youth between the ages 15-19 years within Kisumu East district.

Out of the 375 questionnaires distributed 345 questionnaires were used for analysis of this study. Given the 91.7% response rate, the information gathered was adequate for data analysis (Miller 1991). Thirty one questionnaires were classified as spoilt as they were either not completely filled or they were completed by respondents below or above the required age of 15-19 years. The data collected was analyzed using SPSS software and information is presented in forms of graphs charts and frequency tables.

Social demographic characteristics of the sample

Figure 4.1 presents the age and number of respondents that participated in the study. The study targeted school youths between the ages of 15-19 years in Kisumu East District.
Figure 4.1 Age and Number of Respondents in percentage

As Figure 4.1 shows, 12.5% of the respondents were 15 years of age, 25.3% were 16 years of age, 27.3% were 17 years of age, and majority 28.5% were 18 year of age while only 6.4% were 19 years of age. Figure 4.1 reveals that majority of respondents were between the ages of 16 and 18 years which is the prime age youth in high school. The results from the study indicate that very little information has been acquired from respondents who are 19 years of age as most of the youths within this age set are assumed to have finished secondary education.

Table 4.1: Statistics of age

<table>
<thead>
<tr>
<th>Age in years</th>
<th>N</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Std. Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>344</td>
<td>16.91</td>
<td>17</td>
<td>18</td>
<td>1.135</td>
<td>4</td>
</tr>
</tbody>
</table>
Table 4.1 describes characteristics of the respondents under review. The mean age of the respondents is 16.91 years while the median and mode age of the respondents is 17 and 18 years respectively. The standard deviation is 1.135 with a range of 4 years. From the data represented in table 4.1 it is evident that most respondents were 18 years of age with the average age of respondents being 16 years. Most of those who participated in the study were 18 years of age.

Table 4.2: *Schools, Gender and Number of Respondents*

Table 4.2 shows a cross tabulation of the schools represented in the study, gender and number of respondents that took part in the study.

<table>
<thead>
<tr>
<th>Name of school</th>
<th>Gender</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>Xaverian Mixed</td>
<td>46</td>
<td>42</td>
<td>88</td>
</tr>
<tr>
<td>Kisumu Boys</td>
<td>29</td>
<td>0</td>
<td>29</td>
</tr>
<tr>
<td>ST. Teresa's Girls</td>
<td>0</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Joel Omino Mixed</td>
<td>53</td>
<td>54</td>
<td>107</td>
</tr>
<tr>
<td>Mayenya Mixed</td>
<td>43</td>
<td>40</td>
<td>83</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>171</strong></td>
<td><strong>173</strong></td>
<td><strong>344</strong></td>
</tr>
</tbody>
</table>

Table 4.2 shows that 5 schools took part in the study with 3 mixed schools, 1 girls school and 1 boys school. Joel Omino mixed school had the largest respondents of 107 followed by Xaverian Mixed, Mayenya Mixed and St Teresa's respectively. Kisumu Boys had the least (29 respondents). Xaverian Mixed had a total of 88 respondents; 46 male and 42 female, Kisumu boys had a total of 29 respondents all of them male, St Teresa's girls had a total of 37 respondents all of them female, Joel Omino mixed had a total of 107 respondents 53 male and 54 female and finally Mayenya mixed had a total 83 respondents 43 male and 40
female. For mixed schools, the study sought to give both genders equal opportunity to participate in the study.

Figure 4.2 represents the findings from the respondents with regard to their perceptions on the current HIV and AIDS situation in Kisumu East District.

Figure 4.2 Perception on current HIV and AIDS situation in Kisumu East

Figure 4.2 shows that 87% of respondents felt that HIV and AIDS was a serious problem in Kisumu while 4% felt that it was not a problem at all. It may be said that a large proportion of the students have the correct view of the seriousness of HIV and AIDS.
Table 4.3: Knowledge and awareness of HIV & AIDS

Table 4.3 presents the responses on knowledge and awareness of HIV and AIDS among the students.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate by responding yes or no regarding the following modes of transmission of HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needle Sharing</td>
<td>91.2</td>
<td>7.6</td>
<td>1.2</td>
<td>100</td>
</tr>
<tr>
<td>Unscreened blood</td>
<td>97.1</td>
<td>2.3</td>
<td>0.6</td>
<td>100</td>
</tr>
<tr>
<td>Unprotected anal sex</td>
<td>78.2</td>
<td>7.8</td>
<td>14</td>
<td>100</td>
</tr>
<tr>
<td>Kissing/Touching</td>
<td>3.5</td>
<td>94.4</td>
<td>2.1</td>
<td>100</td>
</tr>
<tr>
<td>Mosquito bite</td>
<td>3.8</td>
<td>94.1</td>
<td>2.1</td>
<td>100</td>
</tr>
<tr>
<td>Unprotected vaginal sex</td>
<td>95.6</td>
<td>2.1</td>
<td>2.3</td>
<td>100</td>
</tr>
<tr>
<td>Sneezing/coughing</td>
<td>2.6</td>
<td>93.3</td>
<td>4.1</td>
<td>100</td>
</tr>
<tr>
<td>Drinking or eating together</td>
<td>3.5</td>
<td>93.3</td>
<td>3.2</td>
<td>100</td>
</tr>
<tr>
<td>Working in same room</td>
<td>0</td>
<td>100</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Unprotected sex with a healthy looking person</td>
<td>52.8</td>
<td>24.8</td>
<td>22.4</td>
<td>100</td>
</tr>
<tr>
<td>Pregnant Mother to unborn baby</td>
<td>49.6</td>
<td>43</td>
<td>7.4</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.3 demonstrates that hundred per cent of the students were aware that working in the same room with an infected person cannot lead to HIV infection. The table also reveals that some of the respondents did not have correct knowledge on HIV and AIDS with 7.8% and 24.8% respectively failing to know that HIV can be transmitted by having unprotected anal sex and having unprotected sex with a healthy looking person. Also noted was that a large number of the respondents (43%) had incorrect knowledge regarding whether a mother can infect an unborn child with HIV.

The table further shows that there is a percentage of the respondents that had incorrect perceptions. For instance, 22.4% of respondents did not know that unprotected sex with a healthy looking person can lead to HIV infection. This may in turn influence the perceptions of risk thus increasing chances of the youth engaging in unprotected anal sex or having unprotected sex with a healthy looking person with the perception that they are at low risk or no risk at all.
Table 4.4: Knowledge about AIDS

Table 4.4 measures knowledge of respondents about AIDS by testing their knowledge using three questions commonly used as a composite measure of knowledge about AIDS. Knowledge about HIV and AIDS is defined as knowing that a healthy looking person can have the AIDS virus and knowing that AIDS cannot be transmitted by mosquito bites or sharing food with a person who has AIDS (KDHS 2008/09).

The results from Table 4.4 show that some of the students do not have correct knowledge on HIV and AIDS across all ages. Further analysis of knowledge among the two genders shows that both genders have poor knowledge on whether having unprotected sex with a healthy looking person can lead to an HIV infection with 46.8% of male and 50.3% of
the females saying that having unprotected sex with a healthy looking person cannot lead to an HIV infection.

The results further confirm that few respondents across all ages and sex had incorrect perceptions when asked if a mosquito bite or sharing food with a person who has AIDS can lead to an HIV infection. Lack of inadequate knowledge on HIV may lead to reduced risk perceptions of acquiring HIV infections among the youth. This may increase the indulgence of the youth in risky sexual behaviors with the view that having unprotected sex with a healthy looking person cannot lead to an HIV infection.

Figure 4.3 shows results of responses from participants when asked if one can tell that someone has HIV and AIDS by looking.

![Pie chart showing the results of responses](image)

**Figure 4.3 Can you tell someone has HIV by looking?**

Figure 4.3 reveals that a greater majority of the respondents (90%) perceived that one cannot tell that someone has HIV and AIDS by looking. However, a small number (10%) were of the opinion that one can tell that someone has HIV by looking. A large number of students correctly reported that one cannot tell that someone has HIV by looking with a
small proportion of respondents 10% more likely to make wrong choices with regard to indulging in unsafe sexual behavior as they were of the opinion that you can tell someone has HIV by looking.

Figure 4.4 presents findings from the respondents on whether HIV and AIDS can be cured.

![Pie chart showing 94% believe HIV and AIDS cannot be cured and 6% believe they can be cured.]

**Figure 4. 4- HIV and AIDS be cured**

Figure 4.4 shows that nearly all (94%) respondents are of the view that HIV and AIDS cannot be cured. However, a small percentage (6%) is of the opinion that HIV and AIDS can be cured. Some of the reasons they gave for their answer included seeking immediate medical attention, taking ARV medication and that HIV was like any other disease equating it to malaria. The information obtained from figure 4.4 shows that a small percentage of the students (6%) have incorrect knowledge on HIV and believe that it can be cured. These proportion of students are more likely to have wrong perceptions of the risk of acquiring HIV and AIDS and more likely to indulge in risky sexual behavior.
Figure 4.5 represents findings from the respondents on individual risk perceptions of contracting HIV.

Figure 4.5 shows that majority of respondents at 57% perceive themselves to be at risk of contracting HIV while 43% of respondents felt that they were not at risk of contracting HIV. This results indicate that a relatively large number of students (57%) felt that they were at risk of contracting HIV and AIDS and may as a result refrain from indulging in risky sexual behavior. However a fairly large percentage (43%) also felt that they were not at risk. Reasons for this perception are presented on tables 4.5 and 4.6.
Quantitative data

Table 4.5: *Reason for individual perception of risk*

Table 4.5 and table 4.6 represent responses from respondents when asked for the reasons for the perceptions they hold on their HIV and AIDS risk as an individual. Table 4.5 presents reasons given by respondents who felt that they were at risk of contracting HIV. The table shows that accidents, having unprotected sex, rape, blood safety and peer pressure were among the most common reasons that made respondents perceive themselves to be at risk.

<table>
<thead>
<tr>
<th>Reasons for students perception that they are at risk of contracting HIV and AIDS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidents can lead to mixing of blood</td>
<td>100%</td>
</tr>
<tr>
<td>Unprotected Sex</td>
<td>97.30%</td>
</tr>
<tr>
<td>Lack of comprehensive knowledge</td>
<td>42.10%</td>
</tr>
<tr>
<td>In rape cases</td>
<td>100%</td>
</tr>
<tr>
<td>Contaminated blood</td>
<td>100%</td>
</tr>
<tr>
<td>Peer Pressure can lead having unprotected sex</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table also reveals that 42.1% of the respondents identified lack of comprehensive knowledge as a reason why they perceived themselves to be at risk of contracting HIV. Although the students have increased risk perceptions of contracting HIV and AIDS, lack of comprehensive knowledge on HIV aggravates the probability of the students to correctly identify and make informed choices with regard to risky sexual behavior. It therefore implies that more information should be availed to the students.
Table 4.6: *Reason for individuals perceiving themselves as not at risk*

Table 4.6 reveals that out of the respondents who perceived themselves not to be at risk of contracting HIV 100% mentioned condom use as a reason for their answer while 96.90% and 90.90% identified abstinence and being faithful as a reason for their perception of risk.

<table>
<thead>
<tr>
<th>Reasons for individual perception of not being at risk</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td>96.90%</td>
</tr>
<tr>
<td>Being Faithful</td>
<td>90.90%</td>
</tr>
<tr>
<td>Have comprehensive knowledge</td>
<td>57.90%</td>
</tr>
<tr>
<td>Condom Use</td>
<td>100%</td>
</tr>
</tbody>
</table>

Close to sixty percent (57.90%) believe that they have comprehensive knowledge on HIV and AIDS and hence were not at risk. Students with comprehensive knowledge on HIV and AIDS are likely to perceive themselves to be at risk of contracting HIV and for that reason more probable to take preventive action to reduce the threat of acquiring the virus.
Table 4.7: Perception of risk of contracting HIV

Table 4.7 below shows the responses of respondents when asked to measure their level of risk of contracting HIV. The level of risk was categorised into five levels which are; low risk, medium risk, high risk and not at risk at all as presented in the table below.

<table>
<thead>
<tr>
<th>Level of risk</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at risk at all</td>
<td>55</td>
<td>16.0</td>
</tr>
<tr>
<td>Medium risk</td>
<td>56</td>
<td>16.3</td>
</tr>
<tr>
<td>High risk</td>
<td>91</td>
<td>26.5</td>
</tr>
<tr>
<td>Don't know</td>
<td>55</td>
<td>16.0</td>
</tr>
<tr>
<td>Total</td>
<td>344</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Results from table 4.7 shows that a relative majority of the respondents at 26.5% perceive themselves to be at high risk of contracting HIV while 16.3% perceive themselves to be at medium risk. On the other hand a minority of the respondents at 16.0% perceive themselves not to be at risk at all while 16.0% do not know their level of risk and finally 25.3% perceive themselves to be at low risk. Although a majority of respondents perceive themselves to be at a substantial risk of contracting HIV and AIDS a quite large proportion of the respondents do not perceive themselves as being at risk and are less likely to practice safe sexual behaviour. This then makes them susceptible to HIV and AIDS.
Figure 4.6 presents responses from participants on their attitude of HIV and AIDS severity in Kisumu East District. Analysis of their responses is highlighted below.

Figure 4.6: Severity of AIDS in Kisumu District

According to figure 4.6 most of the respondents at 55% felt that HIV is severe in Kisumu, 38% felt it is fatal while only 7% felt that it is not severe. Most of the respondents perceived the severity of HIV in Kisumu East district as being dire and deadly whereas a small proportion deemed it as not severe therefore majority of respondents are more likely to shun risky behaviour that may expose them to HIV infection.
When respondents were asked about the methods they use to reduce risk of contracting HIV, they responded as shown in figure 4.7 below.

According to figure 4.7, a majority of the respondents (87%) abstained from sex as a way to reduce individual risk of Contracting HIV. Close to ten percent (11%) used a condom while 2% of the respondents did nothing to reduce their risk of contracting HIV. Although a large number of respondents used abstinence from sex and the use of a condom to reduce their individual risk of contracting HIV, some took no precautions and may therefore be exposed to the HIV virus.
Methods used to reduce risk

Table 4.8: Methods Used to reduce Individual risk

Table 4.8 shows an analysis of results from respondents on methods used to reduce the risk of being infected by HIV and AIDS by age, gender and school. The table reveals that more females (92.6%) of the respondents abstain as compared to 82.1% of the male respondents as a method of reducing HIV infection. The results further show that more males respondents (16%) in contrast to 6.2% of the female respondents use the condom as a way to reduce HIV infections. A small number of respondents at 1.9% males and 1.2% of females respectively did nothing to reduce the risk of being infected by HIV.

<table>
<thead>
<tr>
<th>Methods you use to reduce your risk of being infected by HIV and AIDS?</th>
<th>Abstinence</th>
<th>Use a condom</th>
<th>None</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age in years</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>90.2%</td>
<td>9.8%</td>
<td>.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>16</td>
<td>94.0%</td>
<td>4.8%</td>
<td>1.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>17</td>
<td>90.9%</td>
<td>8.0%</td>
<td>1.1%</td>
<td>100.0%</td>
</tr>
<tr>
<td>18</td>
<td>79.1%</td>
<td>17.6%</td>
<td>3.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>19</td>
<td>75.0%</td>
<td>25.0%</td>
<td>.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>82.1%</td>
<td>16.0%</td>
<td>1.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Female</td>
<td>92.6%</td>
<td>6.2%</td>
<td>1.2%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Analysis by age also shows that the older respondents were more likely to use a condom to reduce their risk of contracting HIV. Another observation from the table above is that abstinence reduces with age. It means that young people become sexually active with age.

Figure 4.8 represents responses from participants when asked if they had seen or heard any HIV and AIDS message. It shows that a small percentage of the respondents (6%) had not seen or heard any HIV and AIDS messages while 94% of the respondents had heard or seen a message on HIV and AIDS.
The small percentage of respondents that had not heard or seen any HIV and AIDS message is at a disadvantage when it comes to making correct choices with regard to indulging in safe sexual behaviour as they may have incorrect and insufficient knowledge on the various modes of HIV transmission. Also noted was that the large number of respondents who had seen or heard messages on HIV may be in a better position to negotiate safer sex as they had knowledge on HIV and AIDS.

Figure 4. 8: *Seen or heard any HIV and AIDS message*

The small percentage of respondents that had not heard or seen any HIV and AIDS message is at a disadvantage when it comes to making correct choices with regard to indulging in safe sexual behaviour as they may have incorrect and insufficient knowledge on the various modes of HIV transmission. Also noted was that the large number of respondents who had seen or heard messages on HIV may be in a better position to negotiate safer sex as they had knowledge on HIV and AIDS.
Table 4.9: Source of HIV and AIDS Prevention Information

In response to their source of HIV and AIDS prevention information, most respondents (66.9%) stated that they get information on HIV prevention from the television. This is followed by HIV and AIDS materials and newspapers at 33.1% and 30.2% of respondents respectively. The table also shows that most respondents do not discuss HIV and AIDS issues with their peers as only 22.2% get information on prevention from this mode.

<table>
<thead>
<tr>
<th>Prevention Information</th>
<th>Yes %</th>
<th>No %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>T.V</td>
<td>66.9</td>
<td>33.1</td>
<td>100</td>
</tr>
<tr>
<td>Radio</td>
<td>43.0</td>
<td>57.0</td>
<td>100</td>
</tr>
<tr>
<td>Newspaper</td>
<td>30.2</td>
<td>69.8</td>
<td>100</td>
</tr>
<tr>
<td>Internet</td>
<td>20.1</td>
<td>79.9</td>
<td>100</td>
</tr>
<tr>
<td>HIV and AIDS Materials</td>
<td>33.1</td>
<td>66.9</td>
<td>100</td>
</tr>
<tr>
<td>Road Shows/Campaigns</td>
<td>28.2</td>
<td>71.8</td>
<td>100</td>
</tr>
<tr>
<td>Peers</td>
<td>22.2</td>
<td>77.8</td>
<td>100</td>
</tr>
</tbody>
</table>

The communication medium that is least utilised by respondents is the internet as only 20.1% get their information on prevention from this source. This may imply that television and radio are the best mediums to communicate HIV and AIDS information for the youth as they were identified as the most popular sources of HIV and AIDS Information.
Table 4.10: Correlation between the influence of Mass Media and Risk Perceptions

Table 4.10 shows an analysis of the relationship between the influence of Mass Media Communication and Risk Perception of HIV and AIDS. Responses on risk perception were coded as either no risk=4, low risk=1, medium risk=2 or high risk=3 while the responses on the influence of mass media communication was coded as no influence=4, little influence=1, moderate influence=2 and great influence=3.

<table>
<thead>
<tr>
<th>Risk Perception</th>
<th>Pearson Correlation</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
<th>Influence Mass Media Communication</th>
<th>Pearson Correlation</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Perception</td>
<td>1</td>
<td>0.016</td>
<td></td>
<td>Influence Mass Media Communication</td>
<td>0.016</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td>0.769</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>344</td>
<td>329</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Correlation analysis in table 4.10 reveals that Risk Perception is positively correlated with Mass Media Communication, though this is not significant at the 10% level. This means that respondents who have received messages on HIV and AIDS perceive themselves as at risk more than those who did not though the relationship is not significant.

Table 4.11: Chi square for methods used to reduce risk and early onset of sexual activities

<table>
<thead>
<tr>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>15.314^a</td>
<td>2</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>11.423</td>
<td>2</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>13.681</td>
<td>1</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>308</td>
<td></td>
</tr>
</tbody>
</table>

^a. 3 cells (50.0%) have expected count less than 5. The minimum expected count is .38.

Table 4.11 shows a Pearson chi square significant value of 0.000, the value is less than 0.05 indicating that there is a significant relationship between methods used by the respondents to reduce their risk of being infected by HIV such as abstinence and condom use.
and the influence of Mass Media Communication of HIV and AIDS information on the respondents lifestyle regarding early onset of sexual activities. This means that mass media has a positive and significant impact on risk of being infected by HIV.

Table 4.12: Chi square test for Mass Media Influence on Multiple sexual partners

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>8.702</td>
<td>2</td>
<td>.013</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>4.750</td>
<td>2</td>
<td>.093</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>.697</td>
<td>1</td>
<td>.404</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>303</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.12 shows a Pearson chi square significant value of 0.013. The value is less than 0.05 indicating that there is a significant relationship between the risk of being infected with HIV through multiple sexual partners and the influence of Mass Media Communication. This means that mass media has a positive and significant impact on the risk of being infected by HIV.

Table 4.13: Chi square test for Mass Media Influence on Exchange of money or gifts for sex

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>.375a</td>
<td>2</td>
<td>.829</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>.703</td>
<td>2</td>
<td>.704</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>.062</td>
<td>1</td>
<td>.804</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>304</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 3 cells (50.0%) have expected count less than 5. The minimum expected count is .33.

Table 4.13 shows a Pearson chi square value of 0.829, which is greater than 0.05 indicating that there is no significant relationship between mass media and exchange of money or gifts for sex. This implies that mass media has no influence on the respondents risk of being infected with HIV through exchanging money or gifts for sex.
Table 4.14: *Chi square test for mass media Influence on the use of condoms*

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>24.260a</td>
<td>2</td>
<td>.000</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>5.645</td>
<td>2</td>
<td>.059</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>5.855</td>
<td>1</td>
<td>.016</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>306</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: 4 cells (66.7%) have expected count less than 5. The minimum expected count is .04.*

Table 4.14 shows a Pearson chi square significant value of 0.000, (the value is less than 0.05) indicating that there is a significant relationship between Mass Media Communication of HIV and AIDS information and use of Condom. This implies that mass media has a positive and significant impact on condom use among the youth.

Chapter Summary

Chapter four has provided quantitative and qualitative analysis of findings from the research that was conducted. The following chapter discusses the research findings in the light of the study objectives. It also presents the conclusions of the study and the recommendations drawn from the study.
CHAPTER 5

DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

Introduction

This chapter discusses the findings with a view to arriving at conclusions and recommendations for this study. These conclusions and recommendations are made against the objectives of the research which formed the basis of this research.

HIV and AIDS risk perceptions

This study found out that 57% of the respondents perceived themselves to be at risk of contracting HIV while 43% thought they were not at risk. The large percentage that did not perceive themselves at risk of contracting HIV is a cause for concern as Kisumu East District has an HIV and AIDS prevalence rate of 12.2% which is double the national HIV prevalence. This group may engage in risky sexual behaviour in line with the findings of KDHS (2008/2009) which notes that such a group is more likely to engage in reckless sexual activity.

Bankole et al., (2004) also reports that once an individual perceives getting infected as a remote threat, then the individual will begin to engage in biased processing of any HIV messages or information that is consistent with their behavior. This particularly is the case during adolescence, when inexperience and psychological developmental factors promote a certain sense of invulnerability.

Further, according to the Health Belief Model, individuals are unlikely to adopt “safe” sexual behavior unless they believe that they are susceptible to infection. It is therefore important to understand and correctly evaluate their personal risk. However with 43% of respondents in the study evaluating themselves as being at low risk or not at risk at all it is possible to see one of the factors contributing to the high HIV prevalence among the youth in Kisumu East District.
Kisumu East District. In addition it is important to note that among participants of the Kenya Demographic Health Survey 2008/09 who said they had "no risk" for HIV, nearly 1 in 20 (4.6%) were HIV infected.

Level of knowledge and awareness

Results from the study indicate that awareness of HIV and AIDS among the youth is high. However the youth were found to lack knowledge about HIV and AIDS with majority of the youth (43%) who participated in the study not knowing that a mother can transmit HIV infection to her unborn child and 46% of youth who participated in the study either believing that having unprotected sex with a healthy looking person cannot lead to an HIV infection or not knowing at all. This finding is in agreement with KDHS 2008/09 findings that indicated that knowledge of HIV prevention methods is lower among youth aged between 15-19 years of age. It also concurs with Tegang (2007) who reported that young people are less likely than adults to exhibit accurate, comprehensive understanding of how to prevent HIV transmission.

With poor knowledge on HIV and AIDS the youth are therefore unable to effectively make the right decision to perform or not perform a given action as the prospect theory clearly postulates that an individual needs to understand the benefit, threat, gain and loss, of performing or not performing a given action in order to make a decision. This may therefore explains why the youth in Kisumu East district are at risk of getting infected with HIV as they lack comprehensive knowledge on HIV and AIDS to help them make the right choices with regard to risky sexual behaviour.

Sources of HIV and AIDS information

Television and radio were identified as the most popular sources of HIV and AIDS information accessible to the youth in Kisumu East District. The youth relied on these media
for most of their HIV prevention information. There is need to improve the quality and
coverage of youth focused HIV and AIDS communication programmes through the various
media. The UNAIDs (2004) global report on the media and HIV concurs with the study
findings as illustrated in a national surveys conducted in the United States where 72% of
respondents in America identified television, radio and newspaper as their primary source of
information about HIV and AIDS. The report further says that the media, particularly
broadcast media, has tremendous reach and influence and is a very important tool in
promoting awareness on HIV and AIDS and in the fight against the pandemic.

The influence of mass media communication on risk perceptions

The study also revealed that mass media has influence on the perceptions of youth
with regard to the risk of contracting HIV. Close to sixty percent (57%) of the youth who
rated themselves as being at risk of contracting HIV had received information on HIV
prevention from the media. This finding concurs with McQuail (2005) who said that
wherever the various means of communication exert influence they also cause change.

Literature on the influence of Mass Media has also shown that through media
interventions there has been a lot of change with different communities acknowledging that
their actions were influenced by the media. A report from the Global Media AIDS Initiative
(2004) for instance revealed that it was through media interventions, that a village in India,
turned its back on the dowry system after listening communally to a Radio Soap Opera called
“TinkaTinkaSukh” (Little steps to a Better Life). The same report says that the popular South
African soap opera, “Soul City” brought about social policy change at a National Level as the
series, highlighted domestic violence when, one character, a respected teacher, abused his
wife. Government Departments and Officials acknowledged that the Domestic Violence Act
in 1999 came into being as a result of Media Campaigns.
Furthermore the health belief model informs us that behavior is influenced by a reminder to take action. Information from the mass media acts as a cue to action hence influencing an individual’s perception on the risk of contracting HIV. This study found out that majority (57%) of respondents who perceived themselves to be at risk of contracting HIV had received information on HIV prevention from the media.

Conclusions

The Mass Media has influence on risk perceptions with regard to sexual behavior of the youth in Kisumu East District. Findings from the study have confirmed that the youth perceive the HIV situation in Kisumu East District as serious. However 43% do not perceive themselves to be at risk of contracting HIV. It is more likely that the youth will take risk reduction behavior when they perceive themselves to be at risk of contracting HIV than when they do not perceive themselves to be at risk.

The youth exhibited poor knowledge on some of the questions asked with regard to how HIV is transmitted. Out of eleven questions asked only one question was answered correctly by all the respondents. The Kenya AIDS epidemic update (2012) reports that awareness of HIV, an understanding of how it may be transmitted and perception of individual risk are three key essentials to sexual risk reduction. An evaluation on the knowledge of modes of transmission of HIV revealed that the youth in Kisumu East district do not have comprehensive knowledge on modes of transmission.

Television and radio are the best mediums to communicate HIV and AIDS information for the youth as they were identified as the most popular sources of HIV and AIDS Information. This finding is similar to the findings in the UNAIDs (2004) global report on the media and HIV that illustrated a national surveys conducted in the United States where 72% of respondents in America identified television, radio and newspaper as their primary source of information about HIV and AIDS.
Recommendations

This study has shown that mass media has influence on risk perceptions of youth and that the media has a pivotal role to play in the fight against HIV. The media therefore needs to open more channels of communication and foster discussions about HIV and interpersonal relationships clearly demystifying myths and misconceptions that the youth may have about the disease. As reflected in the literature review addressing HIV in entertainment programmes can have an enormous impact on a society at risk. Also important to note is that messaging about HIV and AIDS is critical as it will determine the impact of the information. Development of a communication strategy for the youth would be the starting point.

To ensure the youth have knowledge on transmission of HIV and AIDS, the government through Ministry of Education needs to ensure that an examinable topic on HIV and AIDS in embedded in the curriculum from primary level through to secondary level. This will ensure that the youth read and understand the epidemiology of HIV and AIDS hence giving them an upper hand when faced with a situation that will require them to make a decision that may involve risk. It will also help the youth make accurate assessment of their own risk which is prudent in the adoption of safe sexual behavior.

Recommendation for Further study

The current study can be used to build upon other studies that may want to investigate the effectiveness of mass media communication in fostering behavior change or as a prevention strategy to further reduce new infections among the youth. Further research can also be conducted on the influence of mass media on risk perceptions of out of school youth as this will paint a clearer picture of the influence of the mass media on risk perceptions.

Given that the field of risk communication is fairly new, this study has contributed immensely to this field by providing a basis of understanding decisions made between
alternatives involving risk and hence improving communication of risk information among
the youth.

Chapter Summary

This chapter has discussed the findings of the research in relation to the study
objectives. It has also presented conclusions drawn from the study objectives,
recommendations on how to Mass media can help further influence risk perceptions of the
youth and recommendations for further studies.
REFERENCES


APPENDICE 1:

QUESTIONNAIRE

Introduction

My name is Mercy Khasiani-Omoke. I am a master’s student undertaking communication at Daystar University. I am carrying out research for my Master’s thesis on the Influence of Communication in Shaping HIV and AIDS Risk Perceptions among the Youth in Kisumu District, Kenya. Kindly take a few minutes to help me fill this questionnaire. All answers provided will be treated with confidentiality. Where choices are provided please tick as appropriate; where there are no options, please feel free to respond in your own words.

Section 1: Personal Information

Age in Years: _________________________________________________

Gender: Male ☐ Female ☐

Form: _______________________________________________________

Section 2: Knowledge and Awareness of HIV and AIDS

1. What is your view on the current HIV and AIDS situation in Kisumu?
   ☐ Not a problem
   ☐ A serious problem
   ☐ I don’t know

2. For each of the following statements, state either Yes, No or Don’t know choosing the option that best describes your view.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing needles with others can lead to HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving blood transfusion of unscreened blood can lead to HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having unprotected anal sex with a person who is infected with HIV can lead to HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kissing on the cheek /Touching someone who is HIV positive can lead to HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A mosquito bite can lead to HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having unprotected vaginal sex with a person who is infected with HIV can lead to HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being near an HIV positive person who is sneezing or coughing can lead to HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section 3: HIV and AIDS Risk Perceptions

#### 3. Can you tell someone has HIV by looking?
- [ ] Yes
- [ ] No
- [ ] Don’t know

#### 4. a) Can HIV and AIDS be cured?
- [ ] Yes
- [ ] No
- [ ] Don’t know

4(b) If your answer is “yes” explain how HIV and AIDS can be cured
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

#### 6. In your opinion how would you measure your level of Risk of contracting HIV?
- [ ] Low Risk
- [ ] Medium Risk
- [ ] High Risk
- [ ] Not at Risk at all
- [ ] Don’t Know

6(b) Give reason for your answer above
7. In your opinion how severe is HIV and AIDS as a disease in Kisumu East District?
   - [ ] Not Severe
   - [ ] Severe
   - [ ] Fatal
   - [ ] Other (Specify) ________________________________

8. What methods do you use to reduce your risk of being infected by HIV and AIDS?
   - [ ] Abstinence
   - [ ] Use a condom
   - [ ] None
   - [ ] Other (Specify) ________________________________

---

### Section 4: Sources of HIV and AIDS Information

9. Have you seen or heard of any HIV and AIDS messages?
   - [ ] Yes
   - [ ] No

10. Where do you get your information on HIV and AIDS? Tick where appropriate

<table>
<thead>
<tr>
<th>Source</th>
<th>Prevention (Chill, Mpango wa Kando, Trust Condom)</th>
<th>Abstinence (Chill, G Pange)</th>
<th>Treatment and Care</th>
<th>HIV Testing and Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>TV</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radio</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newspaper</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS materials and booklets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Road Shows/Campaigns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other sources (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10(b) How effective was the message on prevention and how did it affect your lifestyle?

<table>
<thead>
<tr>
<th>Source</th>
<th>Effectiveness of the Message</th>
<th>(Action) Behavior Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Effective</td>
<td>E.g. what did you do after you got the message e.g. Abstain, Did nothing, Used a condom, went for HIV Test, stick to one partner or any other response</td>
</tr>
<tr>
<td></td>
<td>Fairly Effective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Effective</td>
<td></td>
</tr>
<tr>
<td>TV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radio</td>
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<td>Internet</td>
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<tr>
<td>HIV and AIDS materials &amp; booklets</td>
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<tr>
<td>Road Shows/campaigns</td>
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<tr>
<td>Peers</td>
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<tr>
<td>Other sources(specify)</td>
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</tbody>
</table>

10(c) How effective was the message on Abstinence and how did it affect your lifestyle?

<table>
<thead>
<tr>
<th>Source</th>
<th>Effectiveness of the Message</th>
<th>Action) Behavior Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Effective</td>
<td>(what the student did after they got the message) i.e. Abstain, Did nothing, Stick to one Partner, or any other response</td>
</tr>
<tr>
<td></td>
<td>Fairly Effective</td>
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<td></td>
<td>Not Effective</td>
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<td>Peers</td>
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</table>
10(c) How effective was the message on Treatment and Care and how did it affect your lifestyle?

### Treatment and Care

<table>
<thead>
<tr>
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</thead>
<tbody>
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<tr>
<td>Not Effective</td>
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</table>

(what the student did after they got the message) i.e. Went for HIV Test, embrace HIV and AIDS Treatment, or other response

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</tbody>
</table>

10(d) How effective was the message on HIV Testing and Counseling and how did it affect your lifestyle?

### HIV Testing and Counseling

<table>
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<th>(Action) Behavior Change</th>
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</thead>
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<tr>
<td></td>
<td>Very Effective</td>
<td>Fairly Effective</td>
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<tr>
<td></td>
<td>Not Effective</td>
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</tbody>
</table>

(what the student did after they got the message e.g. Abstain, Ignored or did nothing, Used a condom, went for HIV Test, Stick to one Partner, other response)

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<tbody>
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</tbody>
</table>
Section 5: The influence of communication on HIV and AIDS risk perceptions

11. Do you think that Mass Media Communication has any influence on the decisions you make concerning potentially risky sexual behaviors?
   - Yes
   - No
   - I don’t know

11 (b) If your answer is yes how much influence do you think Mass Media Communication has on the decisions you make concerning potentially risky sexual behaviors?
   - Little Influence
   - Moderate Influence
   - Great influence
   - None

11 (c) Give reasons for your answer above

_____________________________________________________________________
_____________________________________________________________________

12. How has Mass Media Communication of HIV and AIDS information influenced your lifestyle with regard to:
   a) Early onset of sexual activity (before age of 18)
      - I Abstain from sex
      - I Use a condom
      - I Have one sexual partner
      - No influence at all
   b) Multiple sexual partners
      - I Abstain from sex
      - I Use a condom
      - I Have one sexual partner
      - No influence at all
   c) Exchange of money or gifts for sex
      - I Abstain from sex
      - I Use a condom
      - I Have one sexual partner
      - No influence at all
   d) Non-use of condoms
      - I Abstain from sex
      - I Use a condom
      - I Have one sexual partner
      - No influence at all