

**THE IMPACT OF HIV/AIDS ON EDUCATION IN KENYA, AND
THE POTENTIAL FOR USING EDUCATION IN THE WIDEST
SENSE FOR THE PREVENTION AND CONTROL OF HIV/AIDS**

A Government of Kenya and UNICEF Kenya Country Office Study

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GLOSSARY

Definition of terms

Defined as a child under the age of 18 who has lost his/her mother or father or both.

Child Labour: As defined as any form of economic exploitation or any work that is likely to be hazardous or interfere with a child's physical mental, spiritual or social development.

Child work. Light work after school or legitimate apprenticeship opportunities for young people in the family or communities

Child: All persons under the age of 18

CRC: Convention on the Rights of the child: - An Agreement by all member states of the United Nations on what all children should have and are entitled to for their growth and well being.

Children's Right: These are entitlements that all children should have and are entitled to for their growth and well being regardless of their age, sex, race, nationality, religious, political beliefs & Language.

HIV: (Human Immune Deficiency Virus). A virus, which leads to AIDS (Acquired Immuno-deficiency Syndrome)

AIDS : Refers to Acquired Immune deficiency Syndrome. It is caused by a virus (HIV) which attacks the body's defense mechanisms, weakening it thus exposing one to various infections such as T.B., persistent diarrhoea and vomiting, skin infections, pneumonia, etc. The progression of these infection leads to death.

Sexual Abuse: A term that refers to the following

- i. Rape or forced sex, involving children whether with peers or adults.
- ii. Sodomy, that is, forced anal sex.

Sexual harassment: To include touching a child's body in a sexual manner; using language with sexual connotations with children, and exposing children to pornographic materials.

ACRONYMS

ACRWC	African Charter on the Rights and Welfare of the Child.
AIDS	Acquired Immune Deficiency Syndrome
ASAL	Arid and Semi Arid Lands
CAA	Children Affected by AIDS
CBOs	Community Based Organizations
CBS	Central Bureau of Statistics
CESA	Comprehensive Education Sector Analysis
CNSP	Children in need of special protection
COTU	Central Organization of Trade Unions
CRC	Convention on the Rights of Children
DASCO	District AIDS STIs Committee
DC	District Commissioner
DEB	District Education Board
DEO	District Education Officer
DIAC	District Inter – Sector AIDS Committee
GOK	Government of Kenya
GTZ	German Technical Corporation
HIV	Human Immuno-deficiency Virus
ILO	International Labour Organisation
IEC	Information, Education and Communication
IPEC	International Program on the Elimination of Child Labour
KAACR	Kenya Alliance of Advancement of Children Rights
KAP	Knowledge Attitudes and Practices
KCPE	Kenya Certificate of Primary Education
KCSE	Kenya Certificate of Secondary Education
KDHS	Kenya Demographic and Health Survey
KIE	Kenya Institute of Education
KNUT	Kenya National Union of Teachers
MOEST	Ministry of Education Science and Technology
MOH	Ministry of Health
MOHCS	Ministry of Home Affairs Culture and Sports
MOLHRD	Ministry of Labour, and Human Resource Development
MOPND	Ministry of Planning and National Development
NACC	National AIDS Control Council
NASCOP	National AIDS STIs Control Programme
NCPD	National Council for Population and Development
NFE	Non –Formal Education
NGOs	Non Governmental Organizations
OAU	Organization of African Unity
OP	Office of the President
OVP	Office of the Vice President
PTA	Parents Teachers Association
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TSC	Teacher Service Commission
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund

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Dedicated

To

the Children of Kenya

EXECUTIVE SUMMARY

The general objective of this research study was to investigate the impact of HIV/AIDS on education. The study also sought to find out how education can be used in the prevention and control of HIV/AIDS.

The specific objectives of the study were to:

- determine the impact of HIV/AIDS on children's learning experiences;
- determine the impact of HIV/AIDS on communities participation in education;
- find out how education can be used in the prevention and control of HIV/AIDS;
- build local capacity in child focused research.

The methodology for the study was qualitative and child focused. The study used a set of methods, which included written methods such as listings and essays, visual methods such as visual stimuli and drawings. Role-plays leading to focus group discussions were also conducted with children. Focus group discussions and key informant interviews were used to collect background information. Data from written records available in the research sites and communities were obtained to cross check information given by informants as well as to help determine some of the impacts. Observation was also done throughout the study to capture the general context of the research sites. Data analysis was done qualitatively and descriptively, mainly using content analysis.

The study was national in scope, however, the criteria used to select study sites was designed to capture prevalences, variety of population characteristics, availability of information and resources as well as taking into account the existing HIV/AIDS interventions. Consequently, the study was done in depth in Mombasa, Thika Garissa and as supplementary in Busia, Kisumu, Kisii, Machakos, Nakuru, Turkana and Kilifi. In the process, at least one district was covered in each of the eight provinces.

The findings of this study show that HIV/AIDS has had wide spread effects on children's learning experiences. Children living in a world of AIDS experience many challenges. As parents, guardians and members of communities increasingly become infected by HIV/AIDS and eventually succumb to diseases, children are increasingly lacking basic needs such as food, clothing, shelter, health and even education. Children are now becoming subject to many psycho-socio impacts of HIV/AIDS such as stigma, fear, worry, depression and hopelessness. All these impact negatively on their learning and development.

The study further revealed that children's learning has been affected by HIV/AIDS in many ways. Children's participation was reported to have been affected in that pupils themselves are getting infected and some of them infect others; attendance and performance in schools is affected; pupils are dropping out of school while some were reported to have died due to suspected HIV/AIDS related causes. All these are compounded by pupils' lack of love and guidance as well as material support as parents and guardians also get infected by HIV/AIDS.

The study also found perceptions, which indicated that the teaching force has also been affected by HIV/AIDS. Teachers' participation and performance in the learning process was reported to have been affected as some of the teachers have been infected and therefore are increasingly unavailable to the pupils. Pupils reported that they feared being taught by infected teachers.

Teachers' participation in school is also being compromised by HIV/AIDS related commitments in the community. Teachers were also reported to be dying from HIV/AIDS related causes and they are not being replaced hence are lost to the educational system. The results of the study also indicate that the resources available to support education have increasingly been diverted to meet HIV/AIDS related needs.

The study also established that education is an important tool, which may be used to stop the spread of HIV/AIDS. Pupils and community leaders called for the integration of HIV/AIDS education into the curriculum at all levels. This is more so, when it is noted that children reported that as a result of education, children are able to take initiatives and look for more information about HIV/AIDS. The study however, found out that while there is a lot of information and messages, the children felt that these were not relevant to them, as they seemed targeted at adults. There seemed to be knowledge gaps and misconceptions about HIV/AIDS as pupils and students asked the researchers many basic and fundamental questions about HIV/AIDS.

The study found out several things which children said they could do to stop the spread of HIV/AIDS. These included, abstinence and having safe relationships. Children in most of the research study areas reported that there existed such social-cultural practices which expose children to HIV/AIDS infection as circumcision, early marriages, incisions on the body, wife inheritance, extended burial ceremonies among others.

The study also found out that some pupils were of the opinion that their learning had not been affected by HIV/AIDS. This was especially in Garissa, which may be indicative that there are areas where AIDS is still seen as not a reality.

The study came across some perspectives, which indicated that HIV/AIDS had also led to some positive impacts amongst children. These included the fact that, as children increasingly become aware of the dangers of HIV/AIDS, they are now becoming more responsible and strict to themselves and uphold moral values.

The study recommends that listening to Children's voices is important in project design, implementation and evaluation. Since children are suffering psycho-social impacts as a result of HIV/AIDS, communities and institutions working with children should be sensitized on the needs of these children.

Communities should be encouraged to integrate safe procedures in those social-cultural practices. There should be immediate interventions in schools through guidance and counseling for infected and affected children. Mechanisms should be put in place for follow up in the implementation of HIV/AIDS in schools. School children should be educated in life skills, peer education and counselling. There is need for information and messages that are targeted at and are appropriate for children.

1.0 INTRODUCTION

The research described in this Report was carried out for the Government of Kenya (GOK) and UNICEF Kenya Country Office (KCO) in response to concern that the HIV/AIDS epidemic is affecting:

- The quality of education, due to reductions in the teaching force;
- The demand for education;
- The supply of education;
- The planning and management of the educational system;
- The content, process and role of education in national development;
- Rates of retention, performance and completion within the formal education system.

The Study also sought information about the impact of educational interventions on reducing the progress of the HIV/AIDS pandemic in Kenya.

The Government of Kenya and UNICEF KCO base their research and programming on a rights perspective, which implies that children's views and opinions must be taken into account, using appropriate ways for them to express their ideas and experiences. This also means that child research should be multi-disciplinary and inter-sectoral. Building on UNICEF experiences elsewhere, particularly Tanzania (Ahmed et al, 1999), the research process was used as an opportunity to strengthen capacity in child research in Kenya. The research instruments were specifically designed for the Study by the researchers themselves, in the light of research questions proposed by a group representing major stakeholders. The underlying philosophy was that:

- Effective learning is based on practical, meaningful experience. Thus, capacity-strengthening in children-centred research has little basis in the classroom and theory. Understanding is developed through carrying out action research, based on the knowledge requirements of stakeholders;
- Rights based programming for children can only take place if children's perspectives are meaningfully involved in the collection and analysis of information.

The scope was national and the topics included:

- Children and childhood in Kenya, with particular focus on HIV/AIDS – children infected by HIV, children affected by HIV/AIDS, and children living in a world affected by AIDS;

- Education in Kenya: the impact of HIV on informal (socialisation/initiation), formal (schooling) and non formal systems; the methods and curricula, teachers and resources in all three;
- HIV-related health and education services for children in Kenya, with particular reference to children's understanding of the messages conveyed, and the potential for changing behaviour;
- Changing dynamics of child and adult interactions and coping mechanisms in families and communities with respect to duties, expectations and responsibilities, as well as any gender differences, focusing on the effects on children's experiences of education and socialisation, including a consideration of changing traditional practices;

The outcomes of the process are:

- Better understanding of the ways in which HIV/AIDS is affecting the interface between children and the education system;
- Improved research and analysis skills amongst a core group of researchers and a reference group of stakeholders, which can be used for improving the impact of programming and advocacy work with and for children in the area of HIV/AIDS and education.

Within this framework the aims were:

- To provide information on the impact of HIV/AIDS on children's experiences of and access to education in Kenya, and the implications for future policies and programmes.
- To develop this information through a process of building, strengthening and maintaining capacity in systematic gathering, analysing, storing and using information about the lives and rights of Kenyan children, within a rights based framework, among:

Government of Kenya and its collaborating NGOs and professionals to improve planning, evaluation and technical support;

Academic institutions and researchers, to develop skills in children centred data collection and analysis; knowledge and understanding of children and childhoods in Kenya; and regional child research links.

Thus the intention was that, by the end of the process, there would be:

- Improved research and analytical skills amongst staff and partners of GOK/UNICEF KCO (whether producers or users of information), in order to improve the impact of

programming and advocacy work with and for children;

- A sustainable, national institutional basis of research and analytical skills for future capacity building and strengthening in child research in Kenya at all levels, bridging the gaps between 'academic' and 'practical' research, as well as between national and international networks of child researchers;
- Nationally appropriate materials for training, research and capacity building in children-centred, participatory research, at a variety of levels and for different purposes;
- An adequately supported, national institutional base for leading the development of children focused research in Kenya, driving a national research agenda that links applied and pure research and is situated within regional and international networks of child research institutes and processes.

This process took place through an integrated programme of capacity strengthening research that focused on the impact of HIV/AIDS on the education system. A multidisciplinary research team, together with a co-ordinator, was recruited through a workshop that was also practical, capacity-building experience. The research team was further supported by a Reference Group, an international technical advisor, a local facilitator and liaison focal points within UNICEF and the Children's Department. The process took place from March to November 2000, with a total of eight weeks in the field, during which a total of 6,145 items of data were collected. This report represents the first exploitation of these data, which is also a rich resource for other researchers.

2.0 BACKGROUND

Kenya

Kenya covers an area of 582,311 square kilometers. It borders Ethiopia in the North, Sudan in the Northwest, Uganda in the West, Tanzania in the South and Somalia in the East. Kenya lies in the East Coast of Africa, with the Equator nearly dividing it in half. It has 400 kilometers of Indian Ocean shoreline, and lies between 3 degrees north and 5 degrees south and between 34 and 41 degrees East.

The country has an unusually diverse physical environment, including savanna grasslands and woodlands, tropical rain forests, and semi-desert environments. About 80% of the country lies in the so-called arid and semi-arid lands in the northern and eastern regions. These regions suffer from frequent droughts, which invariably create economic and social problems that impact on education. The populations (mainly nomadic pastoralists) which inhabit the ASAL pose special problems for government in terms of educational provision. A large proportion of the ASAL has been set aside for wildlife conservation. The main climatic feature in the whole country is the long rainy season from March to May, followed by a long dry spell from May to October. Short rains come between October and December. However, in the area around Lake Victoria in the west, rains are well distributed throughout the year

The majority of Kenya's population live in the rural areas where they depend on agriculture for a livelihood. While agriculture is the mainstay of the domestic economy, tea, tourism, coffee and horticulture are the main foreign exchange earners. Kenya's economy has been adversely affected in recent years by declining world market prices and drought conditions in the country. In the recent past, drought has led to low water levels in the hydro-electric dam reservoirs thus affecting the power supply adversely and thereby, impacting negatively in the economy. The other factors which have impacted negatively on the socio-economic life of the nation include, the world wide economic recession, refugee influx, ethnic clashes, unemployment and the external debt burden.

Kenya was a British colony over the period of 1895-1963 and gained independence in 1963, after a bloody liberation struggle. Between 1960 and 1969, Kenya operated as a multi - party democracy, but reverted into a 'one' party state from 1969 to 1982. In November 1991, following strong local agitation and International pressure, the country again reverted to multi-party politics. Against this background, there is considerable debate over the nature of democracy and attendant issues of representation with accountability and transparency. Presently, human rights and responsibilities are a major concern to all as is the equitable distribution of social goods and services.

According to the provisional results of the Housing and Population Census of 1999, Kenya's population is currently estimated at 28.7 million people. This is a population growth rate of 2.9% as compared to the 1989 growth rate of 3.4%. Almost half of the population is aged below 15 years. The total fertility rate

between 1995 and 1998 is estimated at 4.7 children per woman. The Kenya Demographic Health Survey (1999) attributes the decline in the growth rate to the widespread use and accessibility of family planning services and facilities. The fertility rate is higher in rural areas than in urban areas (5.2 and 3.1, respectively), a pattern that is evident at every age (KDHS, 1999).

Kenya is divided into eight provinces. The country is multi-ethnic, with 43 ethno-linguistic groups, although Christianity and Islam are the major religions. Kenya has diverse cultural and religious communities, and each of these communities has certain rules and norms, which are their regulating mechanisms. Each ethnic community has its own traditions and customs. Some have common cultural practices, while others are so diverse. These religious and cultural practices have relevance to social behaviour, which are related to transmission and spread of HIV/AIDS and also the way children relate to the rest of the community. It is therefore pertinent to look at the various stages, roles and responsibilities within the various childhood ages, when doing research on the impact of HIV/AIDS on Education.

2.1 HIV/AIDS in Kenya

The joint United Nations Programme on HIV/AIDS (UNAIDS, 1999) estimates the number of people infected with HIV to be 33.3million, out of these 23.3million live in sub- Sahara Africa representing three quarters of the total population infected.

From a single reported AIDS case in Kenya in 1984, the Kenyan National AIDS Control Programme (1999) report estimates the reported AIDS cases to be close to 90,000, while over 2 million people are reportedly living with HIV. The report estimates the number of HIV/AIDS orphans to be 850,000. NASCOP collects its data from public hospitals or clinics using two methods of sampling. These are sentinel surveillance for ante- natal mothers and random blood testing for those who have sought treatment of sexually transmitted infections from selected sites. It is also possible that there are many unreported cases in the two groups who seek for the same services in private clinics/hospitals. Indeed, a study in Kisumu by Kahindo et. al. (1997) showed that many of those seeking treatment of STI's do it discreetly for fear information leaking and hence prefer private medical services.

Currently the surveillance is conducted in 13 urban and 11 peri - urban/rural sites around the country. It is from these sites that NASCOP gets the estimates of the prevalence, with that of the adults standing at 13.5%. The areas with high prevalence according to the strategic plan on HIV/AIDS prevention (NACC 2000) are Thika and Busia with 33 and 34 percent respectively.

The prevalence is generally higher in urban areas with an average of 11- 12%. Available data (NACC 2000) shows that 80-90% of infections are in the 15- 49 years age group, and 5 -10% occur in children less than 5 years of age .

Most AIDS deaths occur between ages 25 and 35 for men and between 20 and 30 for women, assuming an average of incubation period of 9 to 10 years, these deaths suggest that most infection occur in the teens and early twenties . This also suggests that young women are more vulnerable to infections than men of their age group. It is important to note that data quoted has largely been collected from AIDS surveillance units which are not well distributed geographically hence the need to corroborate and confirm their reliability.

AIDS mortality affects population projections. Kenya population is often projected to pass the 60 million mark by 2025. It may see its potential future population size reduced by nearly half, this however is under the assumption of a moderate spread of HIV/AIDS (Population Reference Bureau, World Population Data Sheet 1996).

Kenya National Aids and STDs Control Program (NASCOP) estimates adult HIV/AIDS prevalence in Kenya by conducting a systematic sentinel surveillance, which became operational 1990 and has been conducted annually since then.

NASCOP's 1999 report on AIDS in Kenya estimates adult prevalence at 13.5%, which means that Kenya has one of the most serious HIV/AIDS epidemic in the world when compared with figures available from other countries. However the percentage quoted by NASCOP is simply a percentage of some of the 15 to 45 year olds. This measuring system is also used by UNAIDS and omits a large number of those infected below the age of 15 and above 45years of age. In some cases in urban and rural areas some of the women do not attend antenatal clinics and therefore the results will not give a true picture of the realities within the selected sites.

Results from the report indicate that of all the pregnant women tested in the high prevalence districts of Busia, Kisumu and Thika, 20-35% of them were HIV/AIDS infected. Kakamega, Nairobi, Meru, Nyeri, and Mombasa had a rating of 10-25%, while Garissa, Kitui, Mosoriot, Kaplong, Njabini showed a rating of 3-10%.

Using the data available to them from the sentinel surveillance sites and adjusting it to represent the whole country NASCOP estimates that 1.9million Kenyans are HIV positive, with the projection that this number will increase to 3.3 million in the year 2010

Infected adults occasionally will break away from the family upon learning their diagnosis. This will cause a restructuring in households, with increasing numbers of children left to take care of themselves, or to be cared for by aging grandparents or other relatives. The illness and death of females will have particularly drastic effect on the family. Family food security is threatened particularly where families, depend primarily on women's labour for food production, animals tending, or planting and harvesting, and especially given that women provide the majority of labour and managerial services for small holdings in rural areas.

AIDS will also impact on the economic development of this country in a number of ways. The loss of young adults in their most productive years of life will certainly affect overall economic output. These impacts are likely to be larger in some sectors than others. For instance, a loss of agricultural labour is likely to cause farmers to switch to less labour-intensive crops. In many cases, this mean switching from export crop to food crops. This could affect the production of cash crops as well as food crops.

2.2. HIV and education in Kenya

2.2.1 The Kenyan education system

The Kenyan formal education system is structured in a four-tier framework, pre-primary, primary, secondary and tertiary.

Pre-primary education

Pre-primary or early childhood care and development saw a steady rise in of enrolment from 15.3% in 1989, to 37% in 1994. The gains were influenced by the management structure and training programmes instituted by GOK in support of this sub-sector. Growth in access has been most pronounced in the districts where District Centres for Early Childhood Education (DICECE) have been established. The demand for this level of education has been influenced by the head-start advantage that those who have been through pre-primary school benefit from on entry in primary school. The age of entry to this level of education is 3-5 years. In connection with the 1990 Jomtien Declaration of Education for All (EFA) Kenya had a target of 50% participation rate in year 2000. This goal has not been met, however, and as a follow-up of the recommendations of the World Forum on Education in Dakar in 2000, which evaluated progress since Jomtien, Kenya now aims to achieve the 50% enrolment in pre-schools by 2005.

Primary education

Primary Education in Kenya has an eight-year structure. Participation rates increased by 1.1% in the period 1980 to 1989 but then declined by 6.6%, during the period 1989 to 1993. This meant that gross enrolment declined from 90.6% in 1989 to 84.6% in 1993. As enrollment is recognised to continue to be on the decline, the overall goal of the Jomtien Declaration of universal primary education for all is unachievable in Kenya at this stage.

The commonly cited factors by guardians and parents underlying declining participation in primary education is poverty, combined with the increased burden arising from cost-sharing measures introduced by GOK. The youthful structure of Kenya's population and a population growth rate of 2.95 also exerts pressure on available resources.

Communities are losing the race to build, furnish and maintain schools at a rate that will cater for Kenya's expanding school-age population. At the same time, parents and

households face very difficult choices about investing in primary education or concentrating on short-term survival goals such as food, security and income generation.

Secondary education

Secondary education in Kenya is a four-year cycle. Like primary education it has recorded declines in enrolment as well as fluctuations. In 1990, the gross enrolment in secondary schools was 30.2% but in 1998, it had fallen to 24%, which indicates that well over 70% of eligible children in Kenya do not have access to secondary education. The 15-18 years old population bracket can therefore be categorized as largely comprised of those who never went to school, those who dropped out of primary school and those who completed primary, but failed to enter secondary school. The critical issue then is what happens to those categories of vital human resources in Kenya? How many of them gain access to alternative forms of education and training, such as technical and vocational institutions? How many succeed in getting jobs or becoming self-employed? How many are condemned to marginalised life in the subsistence sector, or to turn to petty crime in urban areas?

Tertiary education

This is a vital sub-sector for skilled manpower development to meet the needs of Kenya's economy. Technical and Vocational (TEC-VOC) institutions provide parallel opportunities to general primary-secondary-higher forms of education, and students can opt for this alternative during or after primary/secondary education. Despite the GOK's efforts to boost this sub-sector in the interest of national development and individual choice, enrolment levels are disappointingly low. Factors underlying low enrolment include a negative perception which views TEC-VOC as being for drop-outs and those who cannot cope with academic education. Also, existing capacity is not fully used due to lack of equipment and materials.

There are however some positive signs that TEC-VOC is becoming a genuinely attractive alternative to a wide range of school leavers. This is due in part to progressive strategies adopted in the development of TEC-VOC programmes and institutions. It is also due to an element of reality brought on by the unemployment crisis, which has awakened young people to the merits of TEC-VOC for employment prospects.

University education in Kenya has seen a rise in the number of institutions offering under graduate degree courses from one, in early 1980 to six public universities. This expansion has been due to demand for university education. The expansion has also seen seven private universities established. Unfortunately, admission to public universities has been pegged at 10,000 with a provision for a 3% annual increase since 1991; hence those who miss entry into public university may be admitted to private ones, though they are very expensive.

Public universities operate on independent charters, and rules and regulations governing them are enacted in Acts of Parliament. However, their curriculum packages have to be approved by the Commission of Higher Education (CHE).

HIV and the education system in Kenya

The magnitude of HIV/AIDS impact on education is not well documented. A World Bank (1999) report on Impact of HIV/AIDS on Education in Kenya indicates the impact as likely to be felt more in terms of reduced supply and demand of educational service, changing clientele for educational services, processes and content of education and planning for the sector. For example, the report shows that the annual attrition of teachers stands at 1800 and has attributed deaths to what is suspected by the Teachers' service commission as HIV/AIDS related deaths. There is a need to explore this.

The HIV/AIDS epidemic will also reduce the demand for education in Kenya. First and foremost, there will be fewer children of school age because of the impact on the population size of the country. Families affected will have fewer resources available for schooling.

Consequently, fewer children will be able to afford or to complete schooling. In particular, girls are taken out of school more often than boys to help care for sick family members, or to help make up for lost family income.

The demand for educational services also declines, because of reduced family resources available for schooling in AIDS affected households. HIV/AIDS also changes the character of the school age population. Most importantly, it is causing a considerable rise in the number of orphans in the country who may not afford education.

Many orphans also live in child-headed households without basic needs. In Uganda, a study of four sub-counties or locations (out of a total of 15 in the district) found 160 child-headed households, (Carm et. al. 1999). The sample was drawn from randomly selected households within the location with a history of parental deaths within the three preceding years. Figures from Zambia estimated that 7% of Zambia's 1.9 Million households are headed by children aged 14 or less (M.J Kelly 1999). For these households, schooling may seem a far-fetched demand.

In addition to stigma, orphans have to overcome many barriers if they are to continue schooling. Stigma and prejudice lead to social isolation. About two thirds of children born to HIV positive mothers do not contract the virus and hence have the potential to grow up as any other child. Evidence suggest that AIDS orphans are more likely to die from preventable disease because of the mistaken belief that their illness must be due to AIDS, and that medial help is thus pointless (UNAIDS 1997).

HIV/AIDS will also affect the process and content of education in Kenya. The seriousness of HIV/AIDS means that it needs to be integrated into curriculum for students throughout the country.

Illness and deaths among the administrative staff at national, regional and local level will negatively affect the systems ability to plan, manage and implement policies and

programs, and will further distract the planning and managing of educational resources e.g. the projection and planning of future teacher deployment, management and planning of future teacher deployment, management and recruitment will be extremely difficult.

The loss of trained and experienced teachers and interruption of teaching programmes due to illness will reduce the quality of education. A study by Armour-Thomas et al (1989), found that teacher qualification accounted for more than 90 of the variation in student achievement in mathematics and reading across the grade levels. The loss of the most qualified and experienced teacher have hence represents a serious threat to the quality of education.

An important challenge for HIV/AIDS awareness is how to reach as many people as possible, as soon as possible with relevant and correct information so as to help curb the menace, through positive behaviour change.

Knowledge attitudes and practices on HIV/AIDS in Kenya

The Kenya Demographic and Health survey (KDHS) 1998, after interviewing 7,881 women aged 15-49 years and 3,407 men aged 15-54 years found out that the most common single source of knowledge about HIV/AIDS is the radio. This study found out that 73% of the women and 87% of the men interviewed said they got HIV/AIDS's messages from the radio. The next most commonly cited source of HIV/AIDS messages were newspaper for men 42%, and friends and relatives for women 56%. The study generally found out that men obtain their HIV/AIDS messages through the mass media and work place, while women on the other hand are likely to receive these messages from community level networks, for example churches, friends, schools and health facilities.

This survey only used one instrument, a questionnaire, targeted households and not the youth and children. It also did not look at the impact of HIV/AIDS on education and how education can be used to prevent and control the disease.

A baseline survey conducted by Kenya Institute of Education (KIE) in 1994 to identify appropriate sources and channels of communicating HIV/AIDS education so as to facilitate the AIDS education project for the youth in and out of school, where the sample interviewed consisted of teachers, students, sponsors and community leaders from 8 districts found that the sources and channels for communicating HIV/AIDS education were as follows: radio, television, teachers, friends, siblings and newspapers. This survey further pointed out that most of youth express confidence and openness among their peers and this was also considered an important avenue for conveying the messages to the youth.

The KIE's AIDS Education Project for youth has been providing and publishing HIV/AIDS educational materials for primary and secondary schools. They also publish facilitators' handbooks, good health magazines and curriculum for the same. However, these materials have not yet been disseminated at national level to all education institutions. Furthermore, the project although also intended for youth out of school does

not address how similar HIV/AIDS education messages can be communicated to this group.

2.3 Children and childhood in Kenya

2.3.1 Child demography

The 1999 Census results have not been released yet, but a statement from the Ministry of Planning (March 2000), indicates that, Kenya's population is 28.679 million. This is a growth rate of 2.9% since 1989 when the population was 21.449 million. Table 1 is based on the analytical report of the 1989 Census, which gave projections to the year 2003 based on the 1989 census.

The figures from the 1989 projection can be compared with the figure for total child population (less than 18 years of age) in 1998 provided by UNICEF in The state of the world's children 2000, which puts the child population in Kenya at 15,025,000. The population of children who were HIV positive was 106,621 in 1998 (NAS COP 1999). This can be compared with a total population of 1,944,623 people who were HIV positive in the same year. According to the projections, children aged 5-14 years numbered 8,225,000 in 1997. They are at risk of contracting HIV/AIDS in the near future but, because their HIV sero-prevalance is believed to be low, they have been referred to as 'a window of hope' by UNAIDS (1999). The majority of this population is in primary school, and requires to be safeguarded from HIV/AIDS.

Overall prevalence of HIV/AIDS in Kenya is 13.9% with the majority of infections in the age group 15-49 (NAS COP 1999). This greatly influences the child population, changing dependency ratios and meaning that many of the children left orphaned may not be able to enrol in school, and/or to complete their education. As the trend of HIV/AIDS continues, the number of orphans will increase with resultant drop-out from schools, poor care and support systems and general reductions on gains already made in access to education.

Table 1: Population projections 1989 - 2003

POPULATION	Population ('000s)							
	1989		1992		1997		2003	
	N	%	N	%	N	%	N	%
TOTAL	23,150	100	25,240	100	29,011	100	33,264	100
CHILDREN 0 - 4 YEARS	4,190	18.1	4,421	17.5	4,741	16.3	4,907	14.8
CHILDREN 0 - 4 YEARS	11,316	48.9	11,999	47.5	12,966	44.7	13,829	41.6
CHILDREN 0 - 17 YEARS	12,761	55.1	13,686	54.2	15,096	52.0	16,210	48.7
PERSONS 15 - 64 YEARS	11,315	48.9	12,645	50.1	15,273	52.6	18,418	55.5
PERSONS 65 + YEARS	519	2.2	596	2.4	772	2.7	1,017	3.1
FEMALES 15 - 49 YEARS	4,999	22.5	5,585	22.1	6,733	23.2	8,075	24.3
PRIMARY SCHOOL AGE 6 - 13 YEARS	5,701	24.6	6,077	24.1	6,576	22.7	7,141	21.5
SECONDAR Y SCHOOL AGE 14 - 17 YEARS	2,106	9.1	2,442	9.7	2,966	10.2	3,260	9.8

Source: Kenya Population Census 1989 - Analytical report volume VII

Children and childhood in Kenya

Various communities in Kenya perceive childhood depending on the roles, duties and responsibilities associated with each particular stage of development. It is in light of this that this research team looked at the various stages of development, roles, responsibilities and duties of their various ethnic groups. The childhoods were categorized into age groups of 0-1 year, 1-6 years, 6- 15 years and 15 - 20. The roles, duties and responsibilities of each age group were identified:

- 0-1 age group: In some communities, the life of a child starts with an expectant mother. For example, an expectant mother among the Abagusii (called *Ebwateranitie*) has some certain duties and roles, such as being cared for, appreciated and feeding well. After birth the child at this stage is expected to cry, play and breastfeed.
- Between 1 and 6 years different communities have different expectations of roles and responsibilities of the child. This is a stage of a small boy or girl (known as *nyathi* among the Luo, *kaiji* for a boy and *kaari* for a girl, among the Ameru, *ahasioni* (boy), *ahahana* (girl), among the Luhya. More serious responsibilities and training starts at this stage, for example taking care of siblings, little errands in the house, fetching water and schooling.
- From 6 to 15 years, the child is a big boy or a girl. A child is known by various names in different communities, for example, *rawera* (boy), *nyandundo/nyanduse* (girl) among the Luo; *kahii* (boy), *kairitu* (girl), among the Kikuyu; *egesagane* (girl), *omoisia* (boy) among the Abagusii; *kavisi* (boy), *mwiitu* (girl) among the Akamba; *raja-dulhara* (boy) and *rahi-duhari* (girl) among Asians. At this stage, a child has slightly more complex duties, such as taking care of siblings, cooking, participating in the family's income generating activities and also undergoes initiation and continues with schooling.
- Between 12 and 20 years, the child is a young adult boy or girl, known by different names, for example *omomura* (boy) and *enyaroka* (girl) among the Abagusii; *nyako mopong* (girl) and *wuoyi motegno* (boy) among Luo; *muthaka* (boy) and *mwari* (girl) among the Ameru. The child at this stage may continue with similar duties and responsibilities as in age 6-12 years stage. However, in all communities, initiation, rites of passage coupled with instructions for preparation of adulthood and marriage are carried. These instructions also include training on sexuality. At this stage children may also be involved in community service and continues with schooling. Marriage and employment may also occur at this stage.

Sexual abuse and sexual exploitation

Sexual abuse and exploitation is a phenomenon found in Kenya. According to the Ministry of Home Affairs (1998), both boys and girls in Kenya are vulnerable to sexual abuse and exploitation. Girls of less than 10 years are more prone to sexual abuse than boys. The Ministry of Home Affairs (1998), reports that the main offenders are guardians, parents, relatives and house helps. The main predisposing factors of sexual

abuse include poverty, overcrowding and lack of proper childcare. Reported cases of sexual abuse and exploitation are but highlights of the problem hence there is need systematic data to determine the extend of the problem.

Child labour

The framework and guideline to national and international programs to child labour is provided by ILO instruments and their accompanying recommendations, the chief which are, the minimum age convention 1973(N0.138) and the Convention 1999 (N0.182) which defines the worst forms of labour as:

- a) All forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labour, including forced or compulsory recruitment of children for use in armed conflict;
- b) The use procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances;
- c) The use procuring or offering of a child for illicit activities in particular for the production and trafficking of drugs as defined in the relevant international treaties;
- d) Work which, by it's nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children.

According to the African Charter on the Rights and Welfare of the Child (African Charter) Child labour is defined as 'any form of economic exploitation or work that is likely to be hazardous or to interfere with a child's physical, mental, spiritual or social development. In the Convention on the Rights of the Child (CRC) states are called upon to protect children from work that is a threat to health, education or development (Article 32).

In Kenya , the analytical report of labour force in the population censurs (1989) gave some data on child labour . It stated that 596,569 children aged between 10 and 14 years old were in the labour force These figures were not inclusive of the children below 10 years old and those between 15 - 18 years old. This indicates that there could be more children in the labour force. The exclusion of child labour from the national statistical surveys makes it impossible to quantify or provide accurate data on its existence in Kenya. This, sometimes could be due to traditional practices and the roles that families play. For example, children used to work in preparation for their future, boys were taught the trade or occupation of their father's and girls were taught to do tasks they would be expected to do when they became mother and wives. This obviously involved work in which the training went together with economic production. This had the positive impact of 'on the job training' as well as supplementing family labour force in the subsistence economy as such , it becomes extremely difficult to pinpoint and differentiate child labour and child work situations . Child labour often involves many forms of work which have no bearing on their up bringing and are in many cases exploitative as defined in the Worst Forms of Child Labour Convention 1999(182).

According to a report on child labour by Central Organisation of Trade Union (COTU,1996) in Kenya, child labour is prevalent in the following economic sectors of the country; agricultural , domestic services , fisheries, quarrying and mining , informal sectors (food kiosks, small workshops, street trade and market places) formal industries and construction.

Street children

Street children is a term generally used to refer to a general group of children who live and work in the streets. The National Poverty Eradication Plan (1999), lists street children as among poor children in Kenya who have a socially psychologically and economically deprived childhood due to neglect, abuse, exploitation, poverty and lack of parental care (Ministry of Planning 1999: 182). These children are vulnerable to drugs, delinquency and HIV/AIDS.

2.4 Children and social policy

2.4.1 Children's rights

It is impossible in the late 1990s for research, policy-making or programming concerning children to proceed without using the 1989 United Nations Convention on the Rights of the Child (CRC) as the guiding framework. This Convention has been ratified by almost all nations, which now have the obligation to report regularly to the Committee set up under Article 43 of the CRC to monitor the implementation of this international human rights instrument. Now that the CRC has been almost universally ratified, the task is to ensure implementation of its provisions. This is particularly challenging because the CRC covers all possible areas of children's lives, from provision of services to protection from abuse and exploitation, from juvenile justice to the right to participate in decisions made on their behalf, from family life to childhood in state care. The CRC is the first international human rights instrument to cover not only civil and political rights but also economic, social and cultural rights. The implication of this for implementation is that policy and practice with respect to children's rights has to take into account a wide range of academic disciplines, expanding the field beyond the traditional fields of education, social welfare and psychology.

Perhaps the most exciting development to come out of the almost universal ratification of the CRC is that it has been taken as the framework for programming by major international child welfare agencies and their partners, as well as by indigenous NGOs. In the international sphere, UNICEF's Mission Statement (January 1996) makes it explicit that the lead agency for child welfare within the United Nations system now considers that all its work must begin from a child rights perspective.

In addition, the Convention on the Rights of the Child has stimulated considerable debate on appropriate definitions of childhood. Many of the crucial themes in these discussions are particularly pertinent in Africa. It has been argued, for example, that it is not possible to apply the principle of the 'best interests of the child' in the same way in different cultural and legal settings (Armstrong, 1994). Moreover, it is clear that even to discuss children's rights in isolation may be inappropriate. It may be that children's rights cannot be separated from adult duties. Indeed, as the complementary regional instrument of the Organisation of African Unity, the African Charter on the Rights and Welfare of the African Child (African Charter) makes clear, children themselves are often regarded as having duties to their families and societies (African Charter Article 31). The African Charter is a complementary instrument, designed to ensure the implementation of the CRC in African countries, in the face of 'certain local conditions' such as:

severely depressed economic situations, shortage of basic social amenities, widespread occurrence of armed conflict, and resultant displacement of populations (OAU, 1990).

The African Charter, drafted by the OAU and the African Network on Prevention and Protection Against Child Abuse and Neglect (ANPPCAN) with the assistance of UNICEF, as a result of the First Regional Meeting to examine one of the final drafts of the Convention in 1988, is designed to 'retain the spirit as well as the substance of [the] letter' of the CRC while making 'special provisions guided by the ground situation in Africa' (ibid). In Kenya as in many other developing countries, over 50% of the population is under the age of 18 and cannot vote, which has implications for the development of democracy.

2.4.2 GOK policies for children

Several instruments, both national and international spell out the legal position as well as inform national policies on the rights of children. The international documents include the Universal Declaration of Human Rights and the Convention on the Rights of the Child (CRC) which entered force in September 1990 after ratification by twenty countries. Kenya ratified this convention on the 30th of July 1990. The African Charter on the Rights and Welfare of the African Child, adopted in July 1979 by the General Assembly of the Organization of African Unity is not yet in force but has been ratified by the Kenya government.

For international conventions to attain the force of law in Kenya, Parliament has to pass an enabling act. The Childrens Bill (1998) which has just been discussed by parliament domesticates the international conventions as well as offer a comprehensive legal framework that will safe guard the rights of children in Kenya (Childrens Bill 1998). These instruments bind states to guarantee the well being of all children. There is therefore need to find out how comprehensively and adequately they address issues pertaining to HIV/AIDS and children, and in particular, how they are operationalised and implemented.

Kenya is also party to the World Declaration for All and a framework for action to meet basic needs, adopted in Jomtien, Thailand in MARCH 1990. The import of this declaration was the affirmation of all human beings right to education. Kenya has geared her education policies to be in tandem with this declaration (Abagi, 1995;Gok 1989; 1992).

The right of children in Kenya has hitherto been taken care of under diverse legislation. Foremost, the Constitution of Kenya, which is the supreme law of the land, guarantees the fundamental rights and freedoms of citizens under Chapter 5 sections 70 to 86. This chapter is otherwise referred to as the Bill of Rights. It guarantees among others things the right of life (section 71), right to personal liberty (section 72) and protection from discrimination on the grounds of race, tribe, place and origin or residence or other local connection, political opinions, colour, creed or sex (section 82).

Several pieces of legislation touch on children. These include Children and Young Persons Act (Cap 141), the Age of Majority Act (Cap 33), Penal Code (Cap 63) and the Employment Act (Cap 211). The problem with this legislation and the inherent gap in them with regard to children is that foremost, the child is prominently absent. The child is not explicitly defined. The Children's Bill 1998 now defines a child as any person boy or girl who is below 18years.

The Kenya government policy on HIV/AIDS is contained in the Sessional Paper No. 4 of 1997, which was approved on September 24th 1997. The policy framework was seen as a pre-requisite to effective leadership in efforts to combat the HIV/AIDS epidemic. The goal of the Sessional paper is to provide a policy framework within which AIDS prevention and control efforts will be undertaken for the next 15 years and beyond. This policy is operationalised through the establishment of a National Aids Control Council (NACC). While the policy paper addresses the plight of children in the face of threat of HIV/AIDS there is no mention of what the youth and children will do in this effort.

2.4.3 Children and HIV/AIDS in Kenya

HIV/AIDS has numerous ramifications for children. Our understanding of the effects of HIV/AIDS on children are predominantly based on adults' observations and perceptions of how children are or might be affected (for example, Saoko & Mutemi, 1994; UNICEF, 2000). Article 12 of the CRC states that children have a 'right to express an opinion in matters affecting the child and to have an opinion and to be heard.' There is need to take into consideration children's observations, experiences, and perceptions of the impact of HIV/AIDS.

In the context of HIV/AIDS, the impacts on children can be investigated by focusing on three categories of children:

- Children infected with HIV/AIDS;
- Children affected by HIV/AIDS;

•Children living in a world with HIV/AIDS.

This research study focussed on the third category which includes all children.

The proceedings of the Second National HIV/AIDS Conference in 1998 identified interventions that provide for the basic needs and protection of orphans as one of the gaps that exist in HIV/AIDS programs (MOH, 1999). Although a variety of formal and informal support systems for HIV/AIDS orphans exist, the extended family network is singled out as the most ideal care structure (MOH, 1997; Saoke & Mutemi, 1994). The government policy is that communities should be persuaded to care for orphans to avoid stigmatization, exploitation and alienation (MOH, 1997). However, the extended family network faces constraints that have largely rendered it incapable of adequately caring for orphans (ACTION-AID, 1995; Barnett & Blaike, 1992; Nyambedha, 1999). Consequently, some orphans are forced to take care of their younger siblings. Estimates by the Ministry of Home Affairs (1998) indicate that child-headed families represent 5% of all other family types. The extent to which orphans' needs are met in these families and the impact of increased responsibilities on children are issues that need to be addressed.

2.4.4 Children's awareness and understanding of their rights

Article 42 of the CRC seeks to make the principles and the provisions of the Convention widely known by appropriate and active means to both adults and children. Organizations such as Kenya Alliance for the Advocacy of Children's Rights (KAACR), Christian Children's Fund (CCF), ACTION-AID Kenya, and PLAN International have launched awareness projects that target children and adults. However, the tendency for NGOs to focus more on privileged groups of children such as those in schools excludes disadvantaged and vulnerable children. In this research study, school children were asked to list their rights and the rights they are denied. Children's perceptions of their rights were examined in relation to predisposition to HIV/AIDS and children affected by HIV/AIDS.

2.4.5 HIV/AIDS and children's rights

HIV/AIDS has several implications for children's rights. Affected children lack basic needs such as food, clothing, shelter, health, and education (ACTION-AID- Kenya, 1995; Johnstone, Ferguson, & Akoth, 1999; Nyambedha, 1999; Saoke & Mutemi, 1994). The lack of parental protection and poverty associated with parental loss increases orphans' vulnerability to sexual abuse and exploitation.

Despite the prevalence of HIV/AIDS in Kenya, the social stigma associated with it has forced communities to remain silent. Consequently, HIV/AIDS orphans are denied the right to information and knowledge of the cause of parental death. Explanations provided to children attribute parental death to a curse or witchcraft (Johnstone et al. 1999; Saoke & Mutemi, 1994). A similar pattern of silence is observed among health workers who often give the last opportunistic infection as the cause of HIV/AIDS related deaths. The

issue of the age at which children should be informed and how this information should be communicated in order to protect them from further was investigated in this study.

2.4.6 Children's knowledge, attitudes, and practices pertaining to HIV/AIDS

The government recognizes that reaching young people with information on HIV/AIDS is an important step in dealing with the problem (MOH, 1997; 1999). Although studies have assessed children's awareness of HIV/AIDS (KIE, 1994; Kiiti, Portzback, Gaturu, Wangai, 1995; Mukarebe & Morgan, 1995, KDHS, 1999), their main focus has been on adolescents, a factor that may explain the tendency for HIV/AIDS awareness campaigns to target adolescents.

In most traditional African societies, parents played a minimal role in educating children on sexuality. This task was left to selected elderly women and men, grandparents, and persons who acted as guardians to initiates (Njau, undated). Parents continue to play a minimal role in contemporary Kenyan society has not changed. Previous studies (AMREF, 1998; KDHS, 1999) found that children and youth are exposed to information about sexuality mainly through their peers, teachers, mass media, and other social networks. In a survey of 1,827 girls and 805 boys aged between 15 and 19, 24.9% of the girls and 15.8 of the boys did not know any way of avoiding HIV/AIDS. In the same survey, 10.2% and 9.7% of girls and boys, respectively held misconceptions about how HIV/AIDS can be avoided. Specifically, 24.1% of the girls and 15.5% of the boys thought that a healthy looking person cannot have the HIV/AIDS virus.

Studies also show that young people in Kenya are sexually active at an early age. According to the KDHS, only 56% of young women aged between 15 and 19 and 45.8% of young men in the same age bracket reported they had never had sex. The survey also showed that 17% of the young women sampled were already mothers while another 4% were pregnant at the time of the survey.

2.5 Research methods

2.5.1 Methodology

The methodology, or philosophical basis, of any social science research determines the type of method that is used. Methodology defines, for example, how researchers view the people in the population that is being studied as well as their views of their world. As already pointed out, the Convention on the Rights of the Child establishes children as subjects of rights and as active participants in their own lives, with views and information that must be listened to and respected (Article 12). This means that, although adults' perceptions are not devalued, they are not taken to be the sole authority on children's lives. It also means recognising that children cannot always express themselves verbally

as efficiently as adults. Thus researchers are obliged to find research methods that help children to express themselves. Direct verbal approaches used with adults, such as interviews and questionnaires, are not always appropriate for use with children (Article 13). Other methods that can produce better, more verifiable data include role plays, drawings and group discussions (Boyden & Ennew, 1997). Sometimes methods such as these are called participatory, but this is incorrect. No method is inherently participatory. All methods of social research can become participatory if they are used within a participatory approach, in which the population under study is encouraged to define the questions and set the agenda.

As Roger Hart has pointed out with respect to children's participation in general, participation is a process in which the skills of self-determination are gradually acquired (Hart, 1992). This applies equally to participatory research, whatever social group or groups are involved. Although it is theoretically possible that a community might spontaneously begin to research the conditions of its own existence, the origin of a perceived need for a study tends, like the one under consideration here, to be in an agency of governance, civil society or academic research. Thus, in the current study, while children and adults may be facilitated to express their own ideas and perceptions, rather than being subjected to a pre-determined interview schedule, they had not been involved in deciding the topic of study and what overall research questions were to be explored. Nevertheless, the responses they made to the research instruments in Phase One of the research provided the major input to the design of questionnaires and additional research instruments for Phase Two (see below for research design details). It is also important to note that the researchers in this Study were responsible for designing all the research instruments themselves, so that their participation in the study was greater than is usual for a research team. If there had been sufficient time available within the time frame of the study, the researchers would have liked to have had the opportunity to return to the field to share their preliminary analyses with the children and adults who had provided the data and obtain their feedback. This could be regarded as the next stage in a participatory process that would include community-level planning and programming, including children as partners alongside adult community members.

2.5.2 Research ethics

In all research with human subjects certain ethical principles must be observed and informed consent must be negotiated. This is particularly important in research with vulnerable and powerless groups, such as children. Adult researchers have a responsibility to children in research. These include: -

- Do no harm
- Protect children;
- Agree on any appropriate intervention with the child/children;
- Do not expose children to risk or harmful information;
- Do not exploit adult power.

Because of the special position of children in society it is necessary to seek the permission of a parent, or guardian as well as the individual consent of a child. The consent of an adult alone is not sufficient, and researchers must ask a child themselves and not rely on a parent or teacher telling them that consent has been granted. Informed consent means that a respondent has been informed of and understands:

- Research aims;
- Research methods and processes;
- Research topics;
- What the data will be used for;
- The full implications of what they are being asked to do;
- That it is possible to withdraw from the research at any time.

In this last respect ‘informed consent’ might be better termed ‘informed dissent’. No respondent should be cajoled, persuaded or intimidated into giving informed consent or withdrawing dissent. Researchers were required to follow the checklist of ethical rules provided at all times, and also discuss and decide upon ethical issues that arise during fieldwork on a daily basis. In difficult situations when a team decision could be reached the Research Coordinator’s advice was sought immediately and her decision was final.

2.5.3 Methods used in the study

Integrated methods were used to obtain information from children and adults in all the research sites. More than one method was used to collect data on a specific issue for purposes of triangulation. Full details about these methods can be found in the protocol document (Akunga et al, 2000).

Children-focussed methods

The methods used in collecting data were child-focussed in that they enabled children to effectively articulate their views on various issues. A variety of methods were used:

Written methods: Children were asked to write their own views about various issues. This method was used to obtain large quantities of data from many children within a short time. Two specific methods were used:

Listing: Children were provided with a topic and asked to list the things that pertained to the topic. Instruments 11, 12, 13, 14, and 27 required children to list.

Essays: Children were provided with a topic and requested to write an essay on the topic. Instruments 3, 6, 15, 16, 17, 18, and 19 were essays.

- Focussed group discussions were conducted with between 8 and 12 children. A standard set of questions were asked by one researcher to guide the discussion, while a second researcher recorded the discussion verbatim. Instruments 2 and 3B were focussed group discussions. This method was also used with community leaders and key informants in Instrument 5 and 20.

- Role play combined with focussed group discussion: Role plays were used to set the stage for focussed group discussions with children. Children were requested to prepare a five-minute play on the topic for discussion. The role plays were entertaining for children and helped to establish rapport between the children and between the researchers and the children. Role plays were also used to enable children to communicate to the researchers on sensitive topics such as rites of passage. The role plays were then followed by a focus group discussion on the same topic. Focus group discussions with children were used to provide children an opportunity to elaborate on key issues emerged from the pilot study. Instruments 2, 3B, 9, 10, 22, and 23 used role plays leading to focus group discussion.
- Visual method and focussed group discussion: Children were shown a set of pictures followed by a focussed group discussion on issues pertaining to the pictures. Researchers used pictures of basic needs to ask children questions that pertain to access to basic needs. Instrument 7 used pictures of various forms of education to stimulate discussion on children's perceptions of education.

Ethical checklist for researchers

- Children and adults should be informed about the research, what information is being sought, what methods will be used, how the research results will be used and its possible consequences;
- Based on this information the adult or child can consent or dissent at any point in the research process;
- Ensure that no child, or adult or community suffers harm as result of research;
- Protecting anonymity and confidentiality;
- Protecting safety and security (including of researchers);
- Not causing distress;
- Dealing with distress if it occurs;
- Ensure the best interest of the child is the cardinal principle in all cases;
- Do not encroach on privacy:
- Asking intrusive questions;
- Probing for information when it appears that a child or adult would rather not give an answer;
- Recognize the moral obligation of an adult to protect a child that is placing itself at risk by taking team decisions on when and how to intervene;
- Do not act as a teacher or instructor, do not tell children they are wrong or contradict the information they give;
- Minimize the power imbalance inherent in relations between children and adults;
- Acknowledge authorship and ownership of products of research;
- Respect cultural traditions:
 - Codes of dress and behaviour;
 - Politeness, ways of asking questions;
 - Social hierarchies;
 - Customs;
 - Food and ways of eating;
 - Do not criticize;
- Always keep promises made to children, adults and communities;
- Do not give children information about things they do not yet know and are not yet ready to know.

Methods used with adults (and children)

Key informant interviews: Structured interviews were used to obtain data from key informants on various issues. One researcher asked the questions while the second

- one recorded the responses on the interview schedule. Instruments 24, 25, and 26 were interviews.
- Written records: Records kept by key informants on specific issues that were of interest were obtained from all the research sites. These were used in conjunction with key informant interviews (Instruments 24, 25, and 26).
- Observation: In each research site, researchers were required to make general observations. A detailed record of the elements in the setting in which all the instruments were administered was made in a standard observation sheet. This was done to provide a context for the responses obtained and to record occurrences that may have interfered with data collection. Observation was also used to collect data on substance abuse in the community (Instrument 8) and HIV/AIDS messages found in each research site (Instrument 21). A standard observation sheet was used to guide the researchers' observations.
- Still Photography: Pictures of interesting scenes were taken to provide a context for data collected using other methods and provide information that could be best captured on film.
- Personal Communication and Observation: Informal discussions with key informants and community leaders provided useful information on issues that had not been anticipated. Information obtained was recorded in diaries. Each researcher kept a comprehensive diary of their experiences and observations in the field.

2.5.4 Research sites and the criteria used to select them

The selection of the research study sites was based on various factors and considerations. to enable the collection of varied data and also to be as representative as possible of the whole country. The criteria were:

- Prevalence: Current information on HIV in Kenya categorises prevalence into either low or high in the various parts of the country and it was necessary to carry out research in both kinds of area.
- Population Characteristics: The country's population is characterized by a variety of ecological zones, ethnic groups, and socio-economic groups. The research sought to capture all these varieties.
- Information: The study took into consideration the availability of information on education, previous and on-going research and existence of UNICEF Programmes within the locality.

- Existing HIV/AIDS interventions: Existing HIV/AIDS interventions by the GOK, UNICEF and others needed to be taken into consideration.
- Resources: The research study has to take into consideration the available human, financial and material resources available. The time span within which the study has to be done was also taken into consideration.

Research sites

The research sites originally identified by these criteria were divided into the following groups:

Indepth areas, where all the study instruments would be used:

- Mombasa – Kilifi
- Thika (urban and rural)
- Garissa

Supplementary areas, where only some of the study instruments will be used:

- Busia – border
- Kisumu (urban and rural)
- Kisii (urban)

Focal points where secondary data would mainly be used:

- Nairobi
- Kisumu

In the course of the research Turkana, Machakos, and Nakuru were added supplementary sites in which not all instruments were used. The reasons for adding these sites were:

- National outlook. In the initial sites selected, two provinces; Rift Valley and Eastern, were left out. For the research to have truly national scope, Machakos in Eastern Province and Nakuru and Turkana in the Rift Valley Province were added.
- Turkana District was also added because of the pastoral-nomadic lifestyles of the inhabitants of the district. The research had to capture this socio-economic group.

The following descriptions give the main characteristics of the final field work districts:

- Busia district is one of the six districts that form western province. It borders Kakamega to the east, Teso to the north, Siaya to the south- east and The Republic of Uganda to the west. It falls within the lake Victoria basin with altitudes varying from 1130 m. on the shores of Lake Victoria, to 1375m.

The central parts of Butula and Nambale occupy a plain characterised by low flat divides of almost uniform in height, which are often capped by laterites and shallow incised swampy drainage systems. The southern parts are covered by a range of hills comprising the Samia and Funyula hills which run from northeast to south west culminating in Port Victoria. This region is covered by Yala swamp.

The lower parts of the district covers parts of Funyula and Budalangi divisions, which is a fairly flat terrain. There are two main rivers in the district, Nzoia and Sio-Port rivers, both of which drain into Lake Victoria. The numerous streams and undulating topography support agriculture but constrain the development of roads due to the large number of bridges and culverts required.

There are two rainy seasons, the long rains (March to May) and short rains (August to October). During the long rains, crops such as maize, sorghum, sweet potatoes, soya, beans, cowpeas, green grams, beans and onions are grown in most parts of the district. The climate also supports crops that grow all the year round or have long gestation period such as sugarcane, robusta coffee, cassava, avocados, sisals and bananas.

The total population of Busia was 275,074 in 1989 and this was expected to rise to 348,292 in 1997 and 369,459 in 1999 and 391,913 in 2001. The total population of Busia is expected to rise further with the revival of the East African Cooperation and the setting up of the Busia sugar factory.

Currently Busia and Thika are ranked by NASCOP as leading in HIV prevalence in Kenya, (NASCOP 1999) with the percentages for Busia standing at 34 %-36%. This active border town greatly contributes to predisposition. There is also the fishing activity at the busy Sio-port and Port Victoria towns. Like other fishing ports, the fishmongers engage in sexual activity with the many ladies who flock the ports and are ready to offer sexual favours in exchange for fish. During our research a priest at Port Victoria told us he was tired of burying HIV/AIDS victims, sometimes up to four in a day.

Culture is also a predisposing factor in the district, in Butula, the research team came across 50 year old women infected after being inherited. Polygamy and circumcision were also mentioned by community leaders as other HIV/AIDS predisposing factors. A new practice has also hit the area known as 'sweetie parties'. These parties are really opportunities for people to meet and engage in casual sexual activities.

- Garissa is one of the three districts of the northern province of Kenya. It borders Wajir district to the north, Lamu district to the south and Tana River and Isiolo district to the west and Somalia to the East. It covers an area of 43,931 square kilometres, with an estimated population of 241,000 people (District Development plan 1997 – 2001). The district is arid and low-lying with altitudes ranging between 70 and 400 meters above sea level.

The district is normally hot and dry throughout the year. Frequent drought and unreliable rain do not favour agricultural activities. However, the predominant human activity is pastoralism. The river Tana that runs along the western border of the district is the only permanent water source. The Somali ethnic group predominantly inhabits the district. Garissa town is a cosmopolitan town. It also has a large presence of security personnel both in the urban and Liboi. There is a large refugee population in Daadab.

The indigenous people are largely Muslim with a culture that is based on Islam. Some of the socio-cultural practices, which could predispose the indigenous people to HIV/AIDS infection, include early marriages, polygamy, female circumcision, incisions of the body, and traditional birthing practices. Garissa town is a transit town to the North Eastern Province. Large trucks and crews that stop over in town could expose the local people to infection. Livestock trade also makes some of the traders to traverse the district, a practice that could lead to infection.

- Kilifi is one of the districts in the Coast province. It is situated approximately 60 kilometers to the north of Mombasa town. It borders Mombasa and Kwale districts to the south, Taita Taveta to the northwest and the Indian Ocean to the east. The land is low lying. The Mijikenda people, who are mainly Muslims, largely settle the district. The main socio-economic activities in the district include tourism, agriculture, fishing and trade. There are a few manufacturing industries such as salt works and cashew nuts processing.

Some of the socio-cultural practices which may predispose people to HIV/AIDS are wife inheritance, elaborate dances during funerals, and traditional birthing practices.

- Kisii is one of the nine districts in Nyanza province. It borders Nyamira to the east, Transmara to the south, Migori to the southwest, Homabay to the west and Rachuonyo to the north. It occupies an area of about 1,302.1sq kms. The terrain is mostly hilly. With its favourable altitudes the district is able to grow tea and pyrethrum in areas lying above 1000m, while at the lower altitude coffee, sugarcane and bananas are grown. The high and reliable rainfall coupled with moderate temperatures is suitable for growing crops such as maize, beans, potatoes and groundnuts. These make it possible to practice dairy farming in the district.

The district is highly populated hence forcing natural forest and vegetation to be cleared for cultivation. The population of the district was 387,549 females and 359,493 males in 1989 census; this was projected to rise to 534,794 females and 496,079 males in 2001.

The existence of both male and female circumcision, which are cultural rites of passage, are viewed as one of the predisposing elements. Though female circumcision is being outlawed by the government the practice is almost universal in the district standing at 99%(KDHS 1998).

The large population in the district has put pressure on the available resources like land. This has resulted in a higher level of idleness among the youth, who have ended up using drugs and engaging in irresponsible sexual practices. Children's' responses and key informants indicated that the most abused substances/ drugs are Busaa, Kangara, Changaa, Kuber and Bhangi. Of all the above Kuber is the most abused as it is readily available in shops. The movement of men with prostitutes is another predisposing factor. Most men once they have received their earnings from their agricultural products engage in extra-marital relationships. Earnings especially from the tea bonus attract twilight girls from as far as Nairobi and Kisumu.

- Kisumu is one of the nine districts of Nyanza Province, bordering Nyando, Siaya, Vihiga and Lake Victoria. Kisumu is the major town in western Kenya and is therefore a major trading Centre. The soils are black cotton soil, which is ideal for the cultivation of cotton, sugar cane and millet. These crops are grown in abundance. Other crops grown here include maize, sweet potatoes, cassava and green vegetables. Fishing is an activity that is predominant in Kisumu and is responsible for the livelihood of the majority of the people here. This area has two rainfall seasons, from March to May and from August to October.

Workers in the sugar industry are mainly men who leave their homes for long periods of time to go and work on the sugar plantations. When they are away from home, they find the local women with whom they engage in sexual activities. Culture greatly contributes to predisposition. In particular, wife inheritance, where even young unmarried men take up widows who may have been exposed to HIV/AIDS. Poverty in this area is also rampant forcing widows and young girls to engage in sexual activities in order to get money to buy their necessities. Funerals also predispose people as they attract large crowds. These funeral ceremonies take many days forcing many of the mourners to stay away from their families for long periods.

- Machakos is in Eastern Province. It borders Nairobi and Kajiado to the west, Mbeere and Thika to the North, Kitui to the east and Makueni to the south. Most part of the district is semi-arid with unreliable rainfall. People from the Kamba ethnic group predominantly inhabit the district. Machakos town, the district headquarters is a cosmopolitan town and is the district headquarters. The main commercial activities are trade and some manufacturing. The major socio-economic activities in the district are small-scale agriculture, sand harvesting, handicrafts and small scale trade.

The Trans-African highway runs through the western border of the district. The numerous long distance trucks and their crew stop at the small towns along the towns. Close proximity to Nairobi means there is a lot of interaction between the people of Machakos and those from Nairobi. All this predisposes the people of Machakos to HIV/AIDS infection.

- Mombasa district has an area of 282 square kilometres and is the smallest of all the six districts in Coast Province. It borders Kilifi district to the north, Kwale district to the south and west and then Indian Ocean to the east. The population in Mombasa is

projected to rise to 661,085 by 2001 with a predominately Muslim centre with extensive flat areas rising from 8 m above sea level in the east, to about 100m above sea level in the west.

The district has a climate different from that experienced by inland districts. The long rains occur between the months of March and June with a 60% reliability with the months of May and June recording the heaviest rains. The short rains start towards the end of October and last until December or January. Agricultural activity has suffered to a large extent from the unreliable rainfall. However, while farming activity has been affected by the weather, the tourist industry has benefited greatly from the sunny and dry weather that prevails in this region. The hottest months are December to February while the coolest months are from June to August. This kind of climate is favourable for growing tropical fruits such as oranges, coconuts and mangoes. Other crops that can be grown include cashew nuts and cassava. However, with the growth of urban settlements, agriculture is being marginalised by industrial development. Land available for agriculture is limited. Housing is also a problem. There is a large population of landless and squatters in the district. The main activity of Mombasa is its port activities where goods for the hinterland to Kenya and its landlocked neighbours such as Uganda, Zaire, Burundi, and Rwanda pass.

Mombasa district has several historic sites. These combined with the beautiful sand beaches, attract tourism, which is also a major industry in Mombasa. The attendant lifestyle of the urban population and tourism may create situations, which may predispose people to HIV infection.

- Nakuru district is located in the central part of the Rift Valley. Nakuru is on the highway and railway line connection eastern Kenya with the west. The principle economic activity of the district is commercial agriculture, mainly producing foods. Nakuru town is the headquarters of the district. There are a few industries. These economic activities and the fact that the town is the Rift Valley Provincial headquarters attracts people from all parts of the country. The main activities that predispose inhabitants of Nakuru to HIV/AIDS are:
 - (a) Nakuru is traversed by the busy Trans - African highway with numerous transit truck drivers, with stopovers on shopping centers that dot the district along the road.
 - (b) Migrant workers working in the Rift Valley Provincial and district headquarters, agricultural processing plants and the agricultural service Industries in the town.
 - (c) Child labour in the large and small scale farm as well as the town and other trading centres.
 - (d) Nightlife in the various nightclubs that dot the town and on the shopping centres along the trans-african highway where truck drivers stop.
- Thika is a cosmopolitan town located approximately 34 km from the city of Nairobi. It is largely an industrial town with commercial agriculture being the major socio-economic activity in the outlying rural areas. The key cash crop areas are coffee and

pineapples. Some of the people who work in the industries and plantations in the area are migrant workers from all parts of the country. Consequently, they are usually unaccompanied by their spouses, a situation that could lead to risky sexual behaviour. In addition child labour in the coffee plantations is common and could put children in situations that could expose them to infection.

Thika town also has a vibrant nightlife in entertainment spots. These could encourage promiscuity and expose young people to infection.

- Turkana is located in the Rift Valley Province bordering Sudan and Ethiopia to the north, Uganda to the west, Marasabit and Samburu to the east and West Pokot and Baringo to the north. The indigenous population is largely Turkanas who are nomadic pastoralists. There also exists a large presence of refugee population in Kakuma consisting of Ethiopians, Ugandans, Sudanese, Zairians, Somalis and Congolese. Within the urban centers there exists a small proportion of other national tribes.

Turkanas are culturally polygamous where the man has a minimum of six wives. The man's duties consists primarily of providing security to his family and animals while the boys herd. The woman duty is to give birth, nurture, and look for food collect firewood and water, and construct the *manyattas*. Their daughters assist the women. There are certain prevailing issues that affect their social life:

- (a) SECURITY: This is of great concern to the Turkana's daily life as they are frequently exposed to bandit attacks from the bordering tribes; Ugandans (Karamojong) and Somalis, for their animals.
- (b) WATER: Due to the drought, which has lasted since 1998, many rivers have dried up leaving no water for them and their animals.
- (c) FOOD: The Turkanas have lost a lot of animals due to the drought and this has greatly predisposed them to hunger and poverty. In turn they have been forced to move to peri-urban areas camp near the urban centers for survival.

The urban population in Lokichogio consists predominately of individuals who have moved there from other parts of Kenya in search of employment. Some have been fortunate in acquiring employment with the numerable NGOs and bilateral agencies that are providing humanitarian assistance to southern Sudan. The local Turkanas are mostly employed as security personnel, cleaners and restaurant staff with very few of them holding professional positions which are generally given to the Sudanese.

The drought emergency situation has predisposed the community to contracting HIV/AIDS due to the increase in poverty. The Turkana men come to sell their goats in the town, half of the money goes to the family and the balance in spends in town drinking alcohol and engaging in sexual activity with the young girls who have come from the neighboring divisions looking for employment with the NGOs. These same girls also engage in commercial sex with the men working

with the NGOs who are living in Lokochoggio and Kakuma without their families. The Turkana man then goes back to his many wives unaware of whether he has contracted any STI and thus passes it on.

Child labour is very common, where you get young boys who run away from school during the day to ferry water for pay and girls who work as domestic help for payment in the form of money or food. Mothers out of desperation walk door to door looking for work for their daughters. Most of these girls work for single men who live in these urban areas without their families. There are times when these girls are sexually abused by the same men, and even they do not get the payment due to them until their mothers get the chief intervene.

The local Turkanas do not take much interest in sending their daughters to school, and those girls who go to school and stay in school is due to their own individual initiative of seeking for financial assistance from well-wishers and NGOs. Turkana girls are considered more valuable by staying at home and assisting in domestic work till marriage. She is then married off and the father gets dowry, which is their wealth.

The Turkana youth have a local dance called 'Edonga', which all the youths participate in. And it is during this dance that the young men pick their girlfriends and after this activity they engage in sexual activity. And during the next such dance one picks a different partner.

The local Turkana girls have learned from those 'upcountry' girls that one can get money through sex so they have also started engaging in similar activities to support their families. There is a street in Lokichoggio called 'Mapenzi Street' where women brew local alcohol and rent out rooms for sex.

2.5.5 Study Timetable

9th March – 11th April: Secondary data collection according to work plan based on research questions developed by reference group

9th July - 30th July: Capacity building workshop- participatory research with children within a rights based framework. Piloting and refining research instruments. Analysis of secondary data and refinement of research questions. Development of research protocol with customized research instruments. Fieldwork research work plan (including precise field sites).

1st August – 11th Sept: First Field work period

12th September – 15th Sept: Capacity building workshop- Analysis of data from the first fieldwork. Development of additional research questions. Development of second – level research instruments (including questionnaires)

16th September – 31st September: Second field work period collection/questioners

1st November – 10th November: Capacity building workshop – Analysis of data and Report writing

11th November – 30th Nov: Finalizing report writing and report delivery.

DEFINITIONS OF KEY TERMS

Child: A person under the age of 18 years

Orphan: A person under the age of 18 who has lost his/her mother or father or both.

Child Labour: As defined as any form of economic exploitation or any work that is likely to be hazardous or interfere with a child's physical mental, spiritual or social development.

Child work. Light work after school or legitimate apprenticeship opportunities for young people in the family or communities

HIV: (Human Immune Deficiency Virus). A virus that leads to AIDS

AIDS : Acquired Immune Deficiency Syndrome, caused by a virus (HIV), which attacks the body's defense mechanisms, weakening it thus exposing one to various infections such as TB, persistent diarrhoea and vomiting, skin infections and pneumonia. The progression of these infections leads to death.

Sexual Abuse: A term that refers to the following :

- i. Rape or forced sex, involving children whether with peers or adults.
- ii. Sodomy, that is, forced anal sex.

Sexual harassment: To include touching a child's body in a sexual manner; using language with sexual connotations with children, and exposing children to pornographic materials.

2.5.6 Some of the factors which influenced the research process and outcome.

In the course of fieldwork, three more research sites were added to enhance the study's national coverage. These were Nakuru, Machakos, and Turkana. All the same, the research team was to submit the draft report on the earlier agreed set date. These changes increased the workload and pressure on the research team.

Due to logistical delays, some data collection had to be done during August (school holidays) and in October and November, when Kenya National Examinations, and schools end of year examinations were in progress. Again, due to limitation of time, psychological entry into some of the research sites was problematic.

While the team appreciates the support they received from UNICEF (KCO) in the course of the research, they experienced delays in accessing computer/printer facilities, and this slowed down the data analysis and report writing processes.

Except for transportation, all other fieldwork expenses for the researchers were not catered for and this was a constraint to the researchers.

The researchers were selected with an objective of building a core group of child focused researchers in Kenya. The team was composed of relatively young professionals, some of whom had limited research experience. This research hence, was also a training and a learning process.

3.0 DATA AND DISCUSSION

3.1 Key ideas

Children need appropriate HIV/AIDS education, at home, at school and in the community. Their rights are being violated. Other pressing needs, such as food, water and security, push HIV/AIDS into the background. If these needs are not addressed the messages about HIV/AIDS will be viewed as inappropriate.

3.1.1 Children

Children have a sense of hopelessness in the face of HIV/AIDS: They need support

Various children's rights are denied by HIV/AIDS, including survival and development, protection and participation). Children are adversely affected by AIDS in a number of ways, including their education. HIV/AIDS has made access to education an unrealisable dream for many affected children. Those who are in school have fewer chances of accomplishing their goals. They are at risk of infection at home through parental sexual abuse, in school through teacher abuse and within the community. Children assume adult roles prematurely.

Children need peer education and counseling to address hopelessness and life skills education in order to be able to protect themselves against predisposing activities, such as promiscuity and drug use.

Youth-friendly centres should be established to take care of children's and youth's needs for socialisation, recreation and counseling as well as sports centres.

Parental role in guidance and information is central to children

Children want their parents to take a guiding role (as often stressed in the text of the Convention on the Rights of the Child), yet parents barely talk to them about HIV/AIDS. Children need their parents to communicate openly with them on their sexuality as well as on HIV/AIDS. Parents thus need HIV/AIDS education, peer education and counseling.

Children of infected parents are afraid their parents may infect them, and they are angry that their parents have let them down by being 'bad role models'.

Children-appropriate messages about HIV/AIDS are needed

Children are curious about, more accepting of and know more about condoms than we tend to think. They are keen to know some very fine details about HIV/AIDS, asking about research, testing, history and drug use for example.

Children need to be listened to, heard and included in planning HIV/AIDS interventions

Children are well aware of, and understand the impacts of AIDS. Yet research focuses on adults. When communities grapple with HIV/AIDS children are forgotten actors, despite the fact that they are affected in many ways.

The media influence is important – for example the association between ‘Trust’ and condoms. This could be exploited in messages for children.

Children are asking for the inclusion/integration of HIV/AIDS in the curriculum. Teachers need training in HIV/AIDS to be open to discussion with children and to be supportive of affected and infected children.

In some areas (GSA, KSM, TH) street children are at risk of HIV infection

3.1.2 Schools/formal education

Even though they are affected, schools are inactive

- Schools lack HIV/AIDS education resources;
- Teachers hardly talk about HIV/AIDS to children;
- Teachers lack the knowledge and skills for HIV/AIDS education;
- Teachers should be (but often are not) good role models and abide by professional codes of ethics, particularly with respect to sexual abuse of students.
- Parent education and community education should be integral to the education system (life-long education as in CRC Article 29, Jomtien Declaration (1990) and Dakar Agreement (2000)).

3.1.3 Society/informal and non-formal education

Communities are ill-equipped to communicate with children.

Culturally-appropriate messages are required

Underlying predisposing factors, such as loss of livelihood, circumcision, wife inheritance, incision and polygamy, should be addressed.

HIV/AIDS messages should be available to all community members, especially at grass roots level. Communities should be involved on the design and dissemination of messages. They should be supported in caring for individuals living with AIDS, those infected/affected by AIDS, AIDS orphans and community education.

International organisations should be sensitized to the need for their messages to be culturally appropriate, and youth sensitive.

Some attempt should be made to censor pornographic materials.

There is widespread awareness of HIV/AIDS among adults and children, combined with widespread misconceptions

Need to 'open up'. Females have previously been viewed as victims of HIV/AIDS, yet they are instrumental in spreading it.

Opinion leaders and others who should be helping to spread messages about HIV/AIDS are in fact acting as blockages.

Culture makes behaviour change difficult. The educated cling to cultural practices (polygamy, promiscuity) that predispose to HIV/AIDS. Health personnel are involved in a conspiracy of silence. HIV/AIDS programmes are viewed as money-making ventures. People are skeptical about government information on HIV, there is a widespread misconception that the government is holding back money that could be used for AIDS cures.

3.2 KNOWLEDGE GAPS: WHAT CHILDREN WOULD LIKE TO KNOW ABOUT HIV/AIDS

The study established that children have knowledge gaps in many areas relating to HIV/AIDS. Both primary school pupils and secondary school students asked basic as well as fundamental questions relating to origins, causes, transmission and control of HIV/AIDS. These gaps become significant when viewed against a backdrop of the many years of HIV/AIDS education and messages that have been passed on to communities, including children. The existence of knowledge gaps amongst children may be seen as hinging or even bordering on the violation of childrens rights to information and education. Thus a violation of articles 13, 17 and 29 of the United Nations convention on the rights of the child and the African charter of the Rights and Welfare of the Child article xi. The basic concern is the right to information and education for all children.

3.2.1 Meaning of HIV/AIDS

Primary and secondary school children in Thika, Machakos, Kisumu and Mombasa sought to know the meaning of AIDS and HIV and the difference between the two terms. A 17 year old secondary school boy from Thika sought to know the difference between “HIV positive and HIV negative.” In some of the areas visited, children have coined their own idiosyncratic definitions of the terms ‘HIV’ and ‘AIDS.’ A boy in Turkana defined AIDS as “American Idea of Denying Sex.” Other definitions given were “American Insect Disease.” These definitions could lead to misconceptions about the disease among children.

3.2.2 Origin of HIV/AIDS

Children in Kisii, Thika, Machakos, Kisumu, Busia, Kilifi, and Mombasa were curious to know the origin of HIV/AIDS. Specifically, the children would like to know when HIV/AIDS was discovered, who discovered it, and how it came to Kenya. Children are also aware of the controversy that surrounds the debate on the geographical origin of HIV/AIDS:

Was the virus, brought to Africans by Europeans?

(15 years old boy, Mombasa, Inst. 27)

Which people started to transmit the disease?

Africans, or Europeans?

(15 years old boy, Mombasa, Inst. 27)

3.2.3 Nature of Virus

Some of the questions asked were: -

- Why is it that the AIDS virus is more actively destroying white cells?
- Why is the virus concentrated in blood only?
- How long does the virus take to die after exposure to the environment
- Can the virus continue living outside the body?
- Is it true that the virus can stay in the body for 5 years if one is not stressed?
- Is the rumor that the AIDS virus can only last for 30 minutes outside the body true?
- For how long does the virus live in the body before the person becomes sick?
- Is the virus found in the faeces and urine of an infected person?

- From questions asked by children both in primary and secondary schools visited, concerning the nature of the virus, it is apparent that much more information is lacking, which may leave them with misconceptions about the disease.

3.2.4 Causes of HIV/AIDS

Children from all the study sites were interested in finding out about what causes HIV/AIDS. The commonly asked question was, 'What causes HIV/AIDS?' However, a 17-year-old secondary school boy from Kisii asked, 'whether one can develop AIDS on his or her own,'.

3.2.5 Symptoms

The issue of signs and symptoms is one that many children sought clarification on.

Questions raised included: -

- I would like to know the symptoms of HIV/AIDS.
- How can you differentiate someone who has AIDS and one who doesn't?
- Are there any complications related to it after you have been infected?
- Does an infected person have boils and elephantiasis?
- How long do symptoms take to appear?
- Can you identify an AIDS patient by looking?
- Why is it that HIV positive people suffer from pneumonia, anemia and malaria?
- Why do AIDS symptoms take too long to appear on the body?

These questions were noted mainly in Kisii and Mombasa from both girls and boys aged 15-17, in the urban areas. The lack of information from children in rural areas may be attributed to lack of knowledge of the disease, or inaccessibility to information which is correct using many conceptions.

3.2.6 Effects

Children from primary and secondary schools, in all the research areas were concerned about the effects of HIV/AIDS on various aspects. These include effects on the individual, family, the economy and on education.

The questions asked on effects were: -

- How does HIV/AIDS reduce the body immunity?
- What are the effects of HIV on humans?
- What will happen to schools' populations if many students are infected with HIV?
- What threat is AIDS giving our economy?
- How does the disease affect learning of students?
- We want to know how HIV kills people?
- Are there any other diseases accompanied by AIDS/
- Apart from death, what can AIDS cause to an individual?
- The problem / consequences of this HIV?
- Is it true that it leads to death?
- Do you grow old quickly?
- Why does it cause a lot of impacts on Africans and not Europeans?
- How does it attack kids in the womb?
- What makes one a carrier and not infected?
- What problems are faced by HIV victims?
- Do you feel any pain or not?
- How can it affect people who stay alone?
- Is it a must to die if you have AIDS?

These questions reflect a high level of information which is assumed and resulting in interventions which are not translating to behaviour change.

The above questions cut across all the research regions, but notably from girls and boys in Kisii and Mombasa.

There were also a few misconceptions, which were reflected in questions such as: -

- 'Do you grow old quickly?'
- 'Is it true it leads to death?'
- 'Why does it attack interior parts?'

These questions suggest that there is still a lot to be done in terms of giving children correct information about HIV/AIDS. The lack of information could be attributed to the fact that teachers and parents do not willingly talk to their children about HIV/AIDS forcing children to find other channels and sources of information, which may not necessarily have adequate information.

3.2.7 Treatment

On treatment, children from both primary and secondary sought to know issues that pertains to treatment if there were any.

The questions asked were: -

- 'Can all the blood of an infected person be removed and changed to good blood?'
- 'Are there plans of finding some medical help?'
- 'Are the medicines developed by the universities reliable?'
- 'Can T.B be treated from an HIV/AIDS infected person?'
- 'Do they have to use medicines when they start to fall sick?'
- 'Can it be treated?'

The questions children asked on treatment reflected knowledge gaps, suggesting that any information the children receive on HIV/AIDS is inadequate.

3.2.8 Curative Measures

Children from all areas asked questions on whether or not there exists a cure for AIDS. They also questioned why there has not been support for initiatives such as 'Pearl Omega, Traditional Herbs and Witchcraft.

Some of the questions asked were: -

- Is there any true cure of AIDS?
- Can multiplication of the virus be stopped when it is in the body?
- Why did they refuse the tablets, which Dr. Stone discovered to cure AIDS?
- What happened to Pearl Omega? Is it still in function?
- Is it true that Americans have the cure for AIDS but are withholding it to make money?
- Is it true that there is a vaccine made from herbs, which can be given to children?
- Is there a way to get a vaccine to combat the virus?
- Is there a drug that freezes the attack of the virus?

The children's questions suggest there is still lack of clear information on AIDS and curative measures, and that the level of learners understanding is high.

3.2.9 Coping with HIV/AIDS

Children in Kisii, Machakos, Kisumu, Busia, Kilifi, Mombasa, and Thika asked questions on how infected persons and their families can cope with the illness.

Children were curious to know how one can cope with information that they are infected and avoid stress:

If you have AIDS how can you avoid a lot of thoughts in your mind?

If you have AIDS, can you kill yourself because of shame?"

Children also wanted to know how children can cope with parental infection and how parents can cope when their children are infected:

What can one do when both parents are infected?

How do you react on learning a family member is HIV positive?

What can parents whose children in school have HIV/AIDS do?

3.2.10 Care and support

Children in Kisii, Mombasa, Busia, Kilifi, Machakos, Kisumu, and Thika sought to know how one could take care of infected persons and their families. Some of the questions children asked are shown in Table

Table

Questions on the Care and Support of Infected Persons
If a person has Aids what can you do for him or her? How can victims be treated so that he/she cannot be frustrated? • What advice can you give to an infected person? • If my parent or friend is infected, can I help him to clean a wound? • How can I support an orphan who has a virus? Can an HIV victim join his friends in going for outings or having fun? What kinds of food can you give to them to stay longer?

3.2.11 Government Role

Boys in Kisii, Mombasa, and Kisumu, and girls in Busia raised several questions about the role of Government and specific government departments in relation to various issues pertaining to HIV/AIDS. Some of the commonly asked questions appear in Table

Children's Questions on the Role of Government.

<ul style="list-style-type: none">• What has the government done to alleviate spread of HIV/AIDS?• Why does the government discourage Arthur Obel to manufacture his drugs?• Why can't the government screen every person coming into the country?• Does the government want to control population by leaving the disease to eradicate people?• Why doesn't the government control dirty pictures, which stimulates one's mood?• Why does the government insist on condom use and still people are getting

infected?

- Why can't the government castrate people with the disease?
- What is the government stand on those affected for example orphans and widows?

3.2.12 Myths and misconceptions

Children in Busia, Kilifi, Thika, Machakos, Kisumu, Mombasa and Kisii, asked questions about commonly held myths and misconceptions about HIV/AIDS:

'Is Aids a curse from God?

Is it true that the disease came from man having sex with a monkey?'

'Do praying or if you have AIDS and pray you get cured?'

3.2.13 Ethics and morality

Children in Thika, Kisumu, and Mombasa would like to know if infected person should get married and whether people should marry before going for a blood test. A 15yr old girl in Mombasa sought to know if '...people who are HIV positive enter the kingdom of God?'

3.2.14 Diagnosis

Children, both boys and girls sought to know how HIV/AIDS is diagnosed.

Children's main concerns were: -

- How can you know one is HIV positive?
- Apart from thinness, how else can you detect an HIV positive person?
- Is it possible to notice a newborn baby with AIDS?
- How do people discover that they have HIV - virus?

From the above questions, apparently, Children would want to have a simple and easier way of detecting an HIV P- positive person.

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3.2.15 Prevalence of HIV/AIDS

In all the study sites both girls and boys from both primary and secondary schools were interested in finding out the prevalence rates of HIV/AIDS. The questions asked included;

How many people die of AIDS per day?
How many people in Kenya have got AIDS?
Which age group has the highest percentage of HIV infection?
Can everybody have HIV/AIDS?
Why is it that HIV/AIDS spreads highly in African countries?
Do Europeans die of AIDS fast like Africans?
Why do so many people die of AIDS?
Which part of our country is most affected?
Why is the rate so high in Thika?

From the above set of questions, it seems that both primary and secondary school boys and girls were curious about the extent of the prevalence of HIV/AIDS locally and also internationally. However, they were wondering why it is a common disease in Kenya nowadays. The following questions raised by boys and girls focussed on pupils concern about prevalence rates amongst the youth, and equally wondered why the most affected are the youths.

Which is the highest gender affected in Kenya, men or women?
Who are the leading carriers of AIDS, youths or adults?

A primary school girl from rural parts of Busia asked a question regarding ages at which youth may become affected, She asked,
Why does HIV affect young girls about 12-16
and not 1-10 years of age?

3.2.16 Protection, prevention and control of HIV/AIDS

Children from all the study sites visited were concerned about methods of prevention and control of HIV/AIDS. The children seemed interested in knowing how they could prevent themselves and while it seemed difficult to control themselves from engaging in sexual activities. Primary and secondary school girls from Busia were curious and wondered,

How can I avoid being infected with HIV/AIDS yet sex is natural?

There were also many questions regarding use of condoms in the prevention and control of HIV/AIDS. The questions below were some of the mostly asked questions,

Will use of condoms stop it?
Is it safe to use condoms?
Does use of many condoms prevent AIDS?
How many condoms can you use when having sex?
How does a condom protect people from spreading sex?
Why are condoms not preferred as the best measure of prevention?

Children however went on to ask about any other methods available other than condoms for the protection against HIV/AIDS infection. The recurring concern amongst the pupils seemed to be 'how you can prevent HIV/AIDS'. Several questions were raised with regard to control of HIV/AIDS. These included, 'How to control the virus at an early stage'.

A 16-year-old secondary school boy from Kisii wondered,
why didn't they kill the first person with the disease?

Specific questions relating to protection of students against HIV/AIDS included;

Questions related to pupils protection from HIV/AIDS :

What other methods can students use in the prevention of HIV/AIDS?

Is there any drug that can be used to prevent the spread of HIV/AIDS/

How can we avoid some tricks played by those who have AIDS/

If your friend or partner has it, how can you escape from him or her?

What precautions can we take if somebody has AIDS?

What can unmarried couples do to prevent sexual intercourse?

3.2.17 Other general questions

The questions of children born positive and later on turning to negative were asked by children from Mombasa, Thika and Kisumu.

Other general questions asked included: -

- Why isn't it taken seriously like Ebola?
- How much does the vaccine cost?
- Who survives a longer period between a man and a woman?
- Is it true that there are some prostitutes who do not get AIDS?
- How is the pill connected to HIV/AIDS?
- How come people do not like involving children to know more about the disease?
- Why doesn't it attack wild and domestic animals and plants?
- Is it good for a person who is positive to declare it?
- Why are the teachers not telling the truth about AIDS?
- Why are scientists telling lies that there is medicine?

3.3 GENERAL IMPACTS OF HIV/AIDS ON CHILDREN

Children living with parents suffering from HIV/AIDS face numerous challenges long before parents succumb to the illness. This information was obtained by asking children in all the research sites to write an essay on ‘Some of problems faced by children living with parents who have HIV/AIDS’ (essay 19). Community leaders and key informants in FGD 5 and 20 were also asked to discuss problems faced by children affected by HIV/AIDS. Table * shows the percentage of boys and girls who mentioned various problems faced by children living with parents who have HIV/AIDS. The problems that children and adults wrote and talked about in all the districts fall in four broad categories.

- Lack of basic needs;
- Psycho-social impact;
- Predisposition to HIV/AIDS;
- Increased responsibilities for children.

3.3.1 Lack of basic needs

Parental infection leads to impoverishment at the household level. Children in all ten districts mentioned the lack of basic needs as one of the problems children experience. Out of the * children who mentioned lack of basic needs, *and * were girls and boys, respectively. The basic needs that children identified included food, shelter, education, clothes and health. Children in Garissa, Kisumu, Nakuru, Busia, Turkana, Machakos, and Kisii attributed the loss of material support to inability to earn a livelihood and the huge medical bills incurred in the treatment of HIV/AIDS related illnesses. In Thika, children felt that grandparents who often take up the responsibility of caring for affected children lack adequate resources to cater for children’s needs.

‘Their parents will no longer work hence there be lack of basic needs.’
(17 year old secondary school student, Kisumu, essay 19).

‘First of all father cannot do any job to provide for the family with the basic needs’ (15 year old Form I girl, Turkana, essay 19).

‘Medical and hospital bills in turn force many families to evicted from the lands/homes as they sold to meet the bills which are always hefty indeed’ (17 year old secondary school boy, Kisumu, essay 19).

Besides impoverishment, children may lack basic needs due to parental infirmity. A 15 year old secondary school boy from Kilifi reported that infected parents lack the energy to work and cook for children, a situation that leads to hunger, malnourishment, and death. According to a 17 year old secondary school boy from Kisumu, lack of food could lead to girls getting married early as a means of obtaining their basic needs.

Boys and girls aged between 13 and 17 years old in Kisumu, Thika, and Mombasa reported that children lack shelter and may become homeless because either their parents use all the money to pay for medical expenses or they are too weak to work and cannot therefore pay for rent. In some instances, children suggested that lack of shelter may force to children being involved in certain malpractices such as prostitution.

Parental neglect was also identified as a factor that could deprive children of their basic needs. In response to essay 19, a 10 year old boy from Kilifi wrote that infected parents lavishly spend their money and fail to educate their children because they know they will leave their children after succumbing to illness. Owing to reduced family resources and parental illness, children's medical and educational needs are likely to be ignored. Children and community leaders in all the ten districts observed that affected children generally lack care and a good life. Extravagant traditional bereavement practices could also contribute to the loss of family property. Amongst the Luo and Luhya, tribute to the dead entails the slaughter of a cow and all living things in the homestead, respectively (Saoke & Mutemi, 1994).

3.3.2 Psycho-social impacts

The tendency for researchers, communities and organizations to focus on the more overwhelming material needs of AIDS orphans often masks the psychosocial impacts of HIV/AIDS on children. Children whose parents are infected with the HIV/AIDS face numerous psycho-social challenges (Table *)

3.3.2.1 Loss of parental love and guidance

Children whose parents are infected with HIV/AIDS experience loss of love and parental guidance. Some of the causative factors that children mentioned included parental preoccupation with their illness, impending death, and frequent hospitalization. Loss of love leads to a feeling of abandonment in children who respond by losing love for their parents. Children in Kisii and Busia felt that infected parents only care about themselves and not their children:

‘Parents do not care their children because they have already lost hope that they are about to die’ (16 year old Form II boy, Kisii, essay 19).

‘If a parent knows that he/she is HIV/AIDS they don’t tell their children and abandon them then they leave the community because of shame’ (15 year old Standard 8 boy, Busia, essay 19).

Parental illness could also reduce parents' capacity to offer advice and guidance. Secondary school children in Mombasa and Kilifi cited indiscipline and engagement in high risk behaviours such as stealing, running away from home, and prostitution as direct consequences of parental/guardian inability to guide children in the right direction. In situations where infected parents provide guidance, children lack respect for their parents because they view them as poor role models. Specifically, children in Thika and Kilifi suggested that infected parents can not guide children on issues pertaining to STDs and HIV/AIDS since they were poor role models:

‘There is no moral values the parents can teach or transmit to the children. Even if they do, the children would not regard them, in consideration to what made

the parents to be victims. How did they get the disease?' (Form III boy, Kilifi, essay 19).

When parents succumb to illness, children have no one to guide and control their movement and tend to engage in high risk behaviours. Saoke and Mutemi (1994) found that female orphans resorted to truancy and sought consolation in sexual relationships. Children may also lose parental guidance when they run away from home for fear that parents can infect them with HIV/AIDS.

3.3.2.2 Sadness and loneliness

Children in all ten districts said that children experience sadness and loneliness when parents are ill. Affected children feel lonely because they know their parents are sick and are going to die and leave them as orphans.

'A child would feel alone all the time' (16year old Standard 8 girl, Turkana, essay 19).

Isolation by the community, friends and relatives aggravates their loneliness. They are treated suspiciously and isolated by other children and they thus suffer from psychological torture and often do not fit in. Children also suggested that stress and depression could lead to mental illness, use of drugs, and alcohol to forget their problems. Children also attributed loneliness to the frequent hospitalization which physically separates children from their parents. Children may also feel lonely due to the knowledge that parents will eventually succumb to their illness.

'The children are depressed so much that some of them may become insane. They always think that they are soon dying. At school such pupils won't even concentrate in learning' (15 year old Standard 8 boy, Busia, essay 19).

3.3.2.3 Shame/embarrassment

Primary and secondary school boys and girls in Kisii, Kilifi, Turkana, Mombasa, Machakos and Kisumu, reported that affected children feel embarrassed and let down more so if their friends know about their parents' situations. Children are also embarrassed because they are despised and teased by friends, relatives and community members.

'Sometimes children do run away from home and stay away due to embarrassment by parents and people of the neighbourhood talking ill about the family and their laughter' (15 year old secondary school boy, Kisumu, essay 19).

Shame could make the children to develop negative perceptions of themselves and to find it difficult to associate with others. As a result, they lack confidence to face the future.

3.3.2.4 Rejection and Mistreatment

Although Sessional Paper No. 4 of 1997 on AIDS in Kenya states that 'The government will ensure that children are protected because they are not able to articulate their own needs' (pg. 17). Children whose parents are infected with HIV/AIDS and those who have lost parents through the disease continue to experience rejection and to face mistreatment in the home, school, and community.

Children in Busia and Nakuru reported that parents blame their children for their sickness and mistreat them. In Busia, a 15-year-old Standard 8 girl said 'Some of the parents go to an extent of forcing their children to sleep with them infecting them.' Except for Garissa, children in all other districts reported mistreatment by relatives. Mistreatment takes many forms such as beatings, overwork, among others.

'There are many people died because of HIV/AIDS especially our parents and they live their children with uncles who make you like slave if you want to eat you must do a lot of work' (14-year-old Standard 8 student, Thika, essay 19).

In Garissa, AIDS orphans are rejected even in death. A community leader noted that 'nobody takes care of them, When they die they are buried very fast.' (FGD 5).

3.3.2.5 Negative Self Perceptions

Parental infection could lead to children developing negative perceptions of themselves. Children in Busia and Kisii reported that children with infected parents tend to develop negative perceptions about themselves. This was attributed by the fact that they are not free with the surrounding environment as the people do not want to associate with them. A 15-year-old girl in Busia observed that children feel unwanted sometimes while a 15-year-old boy from Busia said that affected children feel unwanted in the community. This could make children feel worthless, and with no confidence to face the future.

'...the children are suffering from the lacking of their parents and now they may not have that confidence to tell you their problems' (15-year-old Form II boy, Kisii, essay 19)

'The child feels that he wasn't blessed by God to live in this world so they end up taking drugs, e.g. cocaine, heroine and to end in their they take suicide as the solution' (16-year-old girl, Thika, essay. 19).

In Busia, a 15-year-old Standard 8 boy suggested that affected children may 'indulge themselves in practicing bad behaviour because they also want die like their parents' (essay 19).

3.3.2.6 Fear/Worry/Uncertainty

The enormity of the challenges that affected children face make uncertainty and worry a common problem (Figure []). Johnstone et al. (1999) found that nearly all the adolescent orphans in their sample were apprehensive about the future. To most orphans, parental loss represented a loss of reference point and security blanket. Parental infection instills uncertainty, fears, and worries in children when their parents are infected

Fears that children have when parents are infected with HIV/AIDS (essay 19).

Children fear

- Parents will infect them with HIV/AIDS
- That they are also infected
- Loosing the parent or the other parent
- Parents may die any time
- That they too will die
- A future without parents
- Others will gossip about their family
- Friends will laugh at them
- Getting into relationships
- To tell others what they think of their parents

Children with infected parents think a lot and are afraid of their parent's illness. They are also scared of what will happen after their parents have died. In all ten districts, children reported children fear that their parents will infect them and are also worried of their own death. Children felt that this fear may force children to run away from home while others will use drugs to escape their predicament. A 16 year old Form II student in Thika said,

"The children may fear their parents because they think they may spread the disease to them and they fear even to tell others how they feel about their parents." (16 year old, Form II student in Thika, essay 19).

A survey of 1827 girls and 805 boys aged between 15-19 found that 10.2% of the girls and 9.7% of the boys held misconceptions about how they could avoid HIV/AIDS infection (KDHS, 1999). Although the survey did not include children aged below 15, this research study found that children may have similar misconceptions that could lead to unnecessary fear. In Kilifi, children reported that affected children refuse to shake their parents' hands and do not eat well due to worry over their parents. These fears indicate that children hold misconceptions about how HIV/AIDS is transmitted.

Children may also fear what other people will think about them. In the Ameru community, a family with an infected family member is viewed as a "bad" family and its members are the subject of gossip and are excluded from village and school life (Mukarabe & Morgan, 1995). In this research, children in Kilifi and Mombasa reported that affected children fear that their friends will gossip about them.

3.3.2.7 Changed relationships

Parent-child relationships

Parental illness has adverse effects on children's social relationships within and outside the family. The close bond between parents and their children is threatened by several factors. Children in all areas singled out children's fear of getting infected by their own parents as a factor that creates a physical, social, and emotional barrier between children and their parents. Specifically, fear of infection leads children to run away from home, refuse to talk to, sit near their parents, and eat their food. In Busia, Kilifi, Kisii, and Turkana, children's fear of infection may force children to abandon their ailing parents:

' Children neglect their parents because they think that if they reach near his/her parent he or she will transmit HIV/AIDS to her' (16 yr old Form II, Kisii, essay 19)

'Many children believe that if they share food with their parents they may get the malady and so they end up starving or stealing food' (14 year old girl, Kisii, essay 19)

Parental infection negatively alters children's perceptions of their parents. In Nakuru, Garissa, and Thika, secondary school students reported that affected children do not identify with their parents. Children from Kilifi reported that affected children blame their parents for their predicament and could resort to killing them. On the other hand, parents may directly break relationships with their children. In Thika, Kilifi and Garissa, high school students mentioned that infected parents isolate themselves from their children to avoid infecting them. In Thika, infected parents abdicate their parental responsibilities and expect children to fend for themselves.

"The parent might chase their older child and tell them to go and find his own livelihood needs." (13 year old boy, Thika, essay 19).

Parents may also break families by abandoning their children. Except for Machakos and Kisumu, children in all other areas recognized that strained relationships between parents can lead to the disintegration of the family unit:

'Many families are breaking due to father and mother dying' (girl, 19 years old, Thika, Four IV, essay 19)

'If one parent has the virus the other parent tends to take the children away from that suffering parent and this shows no good to the children for they are not acquiring the correct parental love.' (18year old form 4 girl, Kisii, essay 19)

Peer relationships

The intense stigma associated with HIV/AIDS puts a strain on children's relationships with their friends. In Kilifi, affected children do not socialize with their friends for fear that other children will gossip about their family.

Strained peer relationships can also be attributed to children's negative perceptions of themselves. Children in Nakuru suggested that affected children may feel guilty and fear to socialize with their friends.

3.3.3 Predisposition to HIV/AIDS infection

The impoverishment associated with parental illness may put children at risk of HIV/AIDS infection. Children in Thika, Turkana, Mombasa, and Kisumu reported that affected children could resort to prostitution due to the loss of parental guidance or to earn a living.

"Children may become disobedient since there is nobody to take care of them so they may develop bad behaviours such as being prostitutes".(Girl, 18, Form IV, Thika, essay 19)

"When children saw that their mother or their father have HIV virus also then they will start walking with their boyfriend and get the HIV virus".(Girl, 15 year old girl, Mombasa, Std. 8, essay 19)

Children in all areas identified living with parents who are infected and sharing a variety of household items as factors that may expose children to HIV/AIDS.

"If the children are living with parents who have HIV/AIDS, it's easily those children to catch the HIV/AIDS because if a mother she has an injury and the blood followed down and one of his or her child step that blood without having a sandal and that blood have virus, virus passing through to that child and that child also she/he having an HIV/AIDS". (16 year old, Std. 8 boy, Mombasa, essay 19)

Risk of infection was also perceived in situations where children have to take care of their ailing parents.

"If for example the children are not infected, they are in danger of being infected may be during washing their parents clothes if they have wounds etc". (18 year old, Form III boy, Nakuru, essay 19)

"Some parents they don't take care for themselves thus spreading the virus to the children without knowing." (18 year old, Form III boy, Nakuru, essay 19).

Children in Turkana, Thika, Busia and Garissa cited that parents may deliberately infect their children through incestuous relationships. Some of the motives cited included despair, malice and a desire to eliminate children's suffering after parental death.

"Some parents e.g. father some times they practise incest with their daughter and for bad luck the father has HIV/AIDS i.e. will transmit his daughter. Other parents say that because they have HIV/AIDS their days are numbered and so they don't want their children to suffer hence they also make sure that they transmit the disease to the all family and this will make the children to suffer." (14 year old Form I girl, Turkana, essay 19)

"Some parents say that they cannot die alone so they decide to transmit the disease to the whole of the family." (16 year old, Form II boy, Busia, essay 19)

"Other fathers can rape their daughters so that they can be infected too". (15 year old, Class 8 girl, Thika)

Primary and secondary schools students in Thika observed that children do not have the necessary skills to handle parents suffering from HIV/AIDS.

"Children may be affected by their parents because they don't know how to handle people who are suffering from Aids" (14 year old, Class 8 girl, Thika)

3.3.4 Increased responsibilities for children

Parental illness and preoccupation with their illness and impending death leaves parents unable to carry out their daily responsibilities. Consequently, children whose parents are infected with HIV/AIDS are forced to assume new and challenging responsibilities inside and outside the home. Increased responsibilities inside and outside the home may overwhelm children and lead to children leaving their homes. Except for Turkana, children in all other districts cited fatigue as common problem that affected children experience. In Busia children reported that affected girls may opt for marriage to escape their new roles.

3.3.4.1 Increased responsibilities in the home

In some cases, children must manage entire households. Some of the duties that children mentioned were taking care of siblings, cleaning, and caring for sick parents.

"...It is going to be their work to feed their parents. The children will cook, fetch water, bath their parents, give them food like small babies, clean the house." (13 year old Std 7 boy, Garissa, essay 19)

Children suggested that affected children may find the task of caring for infected parents overwhelming. In Nakuru, children reported that affected children may lack adequate skills to comfort their parents. Increased responsibilities in the home could leave children with inadequate time to engage in leisure activities such as play.

3.3.4.2 Increased responsibilities outside the home

Outside the home, children reported that they are forced to engage in paid work to provide for their families and to meet the medical bills incurred by their parents:

“Parents who are self-employed will not always find it easy to fetch for their families when they are sick. Due to this reason their children will lack food and they are forced to do odd jobs for their survival and their parents.” (18yr old secondary school student, Kisumu, essay 19)

In Thika, children go out to work in the coffee plantations or seek employment as house girls and house boys in towns. Children also reported that securing employment is difficult since the children affected drop out of school early. Faced without any prospects of earning a decent living, children may also engage in high-risk behaviours to support their families. In Turkana and Thika, children suggested that some of the girls resort to prostitution, which may predispose them to HIV/AIDS infection.

3.3.5 HIV/AIDS orphans

3.3.5.1 Definition of orphan

Different organizations and authors have adopted different definitions of an AIDS orphan. NASCOP (1999) defines an AIDS orphan as a child under the age of 15 who has lost the mother to AIDS. Based on its definition of an AIDS orphan, NASCOP (1999) estimates that the number of orphans will be 860,000 by 2000 and 1.5 million by the year 2005. This definition and estimate is limited in that it excludes orphaned children aged between 15 and 18 and children who have lost their father. The Children’s Bill defines children as persons under the age of 18 (Ministry of Home Affairs, 1998). In Kenya, young people aged between 15 and 18 years are still in secondary schools and dependent on their parents. Consequently, estimates of the current population of orphans that are based on this definitions are likely to underestimate the number of children orphaned.

AIDS orphans can be classified depending on whether they have lost their mother (maternal orphans), father (paternal orphans) or both parents (double orphans) (Hunter & Williamson, undated; Saoke & Mutemi, 1994). In this study, community leaders came up with two definitions of an orphan. In Garissa and Kilifi, an orphan was defined as a child who has lost a father while in Kisii, Thika, Nakuru, Machakos, and Busia, an orphan is a child who has lost both parents. The first definition could be due to the fact that in these communities, are predominantly Muslim and fathers are the sole breadwinners.

Studies that have investigated issues pertaining to orphanhood have often relied on indirect methods of identifying HIV/AIDS orphans. These include the combined use of several indicators such as morbidity information provided by orphans, family background and behavioural variables and clinical reports where available (Johnstone, Ferguson, & Akoth, 1999). Other researchers (for example, Saoke & Mutemi, 1994; Odhiambo, 1999) have relied on the use of facilities that offer medical and psycho social support to infected person to identify HIV/AIDS orphans. While the use of indirect methods of identifying orphans is

necessitated by the stigma and silence associated with HIV/AIDS, there is a risk that children may be wrongly labeled as AIDS orphans.

When asked how they know whether a child is an AIDS orphan, community leaders in some of the districts cited indicators that could be flawed and potentially stigmatize affected children:

“We know its AIDS because *wanalemewa kabisa!* (they are completely incapacitated) They ask for many things, They become very small, *small* (emphasis) you can put twenty people on the bed.” (Primary school (community elder, Kamwangi Thika, FGD 5).

Reliance on inaccurate methods of identifying infected persons may be attributed to the failure of medical personnel to disclose the HIV status to infected individuals and their relatives. Health personnel often give the last opportunistic infection as the cause of AIDS related deaths (Johnstone et al. 1999). According to the Provincial Medical Officer of Health in Garissa, doctors conduct HIV/AIDS tests occasionally to confirm their curiosity and do not disclose to infected persons and their relatives. Similar views were expressed in Thika:

“ When you go to hospital and you are diagnosed with AIDS they say TB. Those who are left think dad has died from TB or other diseases. The preacher or religious leaders need to say the truth so every one knows. Hiding does not help the community.” (Chief, Kamwangi, Thika, FGD 5).

3.3.5.2 Informing orphans about the cause of parental death

Article 13 of the CRC states that children have a right to seek, receive, and impart information through the medium of their choice. Despite the high prevalence of HIV/AIDS in Kenya, the social stigma associated with the disease has forced communities to remain silent about the epidemic. Consequently, AIDS Orphans are denied the right to information on the cause of parental death. Explanations provided to children and adolescents largely attribute parental death to a curse or witchcraft (Johnstone et al. 1999; Saoke & Mutemi, 1994). Except for Garissa, community elders in all the other districts reported that adults do not inform children that their parents have died of HIV/AIDS.

“There is a problem there. If the father dies and the children are very young. Unless the ones who are left explain to the children, most children do not know because the relatives feel shy to tell the children-when I attend funerals, I say the cause. I have said hate me or not I will talk about it.” (Chief, Kamwangi, Thika, FGD 5).

Besides shyness, community elders in Thika reported that relatives resist public disclosure of HIV/AIDS related deaths during funerals:

“When I buried a woman, I said she had AIDS. People attacked me a lot. Doctors should issue a letter that says AIDS to protect us preachers. The preacher should read

this. This will open the way for the preacher to talk about it.” (Akorino church leader, Kamwangi, Thika, FGD 5).

In Kisii, community leaders in FGD 5 said it was difficult for one to communicate the cause of parental death to children when the cause is HIV/AIDS. The findings could suggest that communities are ill equipped to communicate with children. This is supported by the recommendations made by community leaders in Machakos, Garissa, and Nakuru that children should be informed by trained counsellors and health workers. Community leaders in Nakuru proposed that children should be counseled first and then informed by family members.

While children are denied the right to information about the cause of parental death, studies indicate that children sometimes engage in denial. Nearly all the orphans in Saoko & Mutemi’s (1994) study denied HIV/AIDS had claimed their parent’s lives. Similarly, only 18.3% of adolescent orphans in the Johnstone et al. (1999) study accepted that HIV/AIDS had afflicted members of their extended families.

Johnstone et al. (1999) have argued that neither genuine ignorance nor denial contributes to the promotion of adolescent behaviours that could protect them from HIV/AIDS. The issue of the age at which children should be informed becomes pertinent. According to a chief in Kamwangi location in Thika, the “very young ones” should not be told.

3.3.5.3 Care structures for orphans

The Proceedings of the Second National HIV/AIDS conference in 1998 identified interventions that provide for the basic needs and protection of orphans as one of the gaps in the area of programmes (MOH, 1999). A variety of both formal and informal support systems for AIDS orphans exist in Kenya (Table 2)

Table 2. Care structures and form of assistance given to HIV/AIDS orphans by region

	Food	Shelter	Health	Clothing	Education	Guidance Counseling	Moral Support	Employment
Extended family	TKA, KS MKS, MSA, BS KIS, KI NKU, TU	TKA, KS KIS, MK NKU, TU KLF, BSA	KSM	TKA, KSM, K MKS, KLF, NKU, TUR, MSA, BS	TKA, KS MKS, KI NKU, MS KIS		KSM	TKA
Friends neighbours	KLF, MS MKS	MSA		MSA, MKS	MKS			
Community CBOs	MKS, KI KIS, NK TUR, MS	KLF, KIS		MKS, KLF, NKU, TUR, MSA, KI	TKA, MK NKU, TU MSA, KIS	KSM		GSA

Community leaders					TKA, BS KIS			
NGOs/Multinational Agencies	TKA, KS TUR, MS	TUR	TKA, TUR, GSA	TKA, KSM, TUR, MSA	KSM, KI NKU, TU MSA			
G.O.K.					TKA, KS KLF, BS KIS			
Religious Institutions	GSA, KS MSA, KI TUR, BS NKU			BSA, TKA, KSM, MSA,	KSM, MK KLF, TU BSA, KI NKU	MKS		
Orphanages	TKA, KS KIS, GSA	GSA, KI KSM, KL	KIS, GSA	KIS, GSA	KSM, KI GSA, KLF			
Schools	TKA, MK NKU			TKA, KSM, NKU, MSA	TKA, KS MKS, NK TUR, MS BSA, KIS	TKA, KS KLF, NK KIS	TKA, NKU, KIS	

KEY

BUSIA: BSA Source: orphans, headteachers, community leaders key informants
GARISSA: GSA (FGD10, Inst. 26, FGD5, & FGD20, respectively)
KILIFI: KLF
KISII: KIS
KISUMU: KSM
MACHAKOS: MKS
MOMBASA: MSA
NAKURU: NKU
THIKA: TKA
TURKANA: TUR

Extended family

The extended family network is singled out as the most ideal informal care structure for orphans (MOH, 1997; Saoke & Mutemi, 1994). The government's policy is that communities should be persuaded to care for AIDS orphans to avoid their stigmatization, exploitation and alienation (MOH, 1997). The extended family provides orphans with opportunities for social and cultural continuity as they adjust to the challenges of orphanhood. From Table 1.4, it is evident that the extended family continues to play a key role in supporting orphans in all the districts except for Garissa. Children and adults in these areas mentioned that grandparents, uncle, aunts, cousins, and other relatives mainly provide

food, clothing, shelter, and education. In Thika, relatives provide employment to orphans so that they can support themselves.

Despite the significant contribution of the extended family in supporting orphans, several constraints limit the quantity and quality of care that orphans receive from relatives. Sessional Paper No. 4 on Aids in Kenya (1997) describes orphans as “social burden,” a perception that reflects the general feeling of the wider community. Johnstone et al. (1999) found that 18.9% of adolescent AIDS orphans in Rusinga had lost land and fishing boats following parental death. In patrilineal cultures, orphaned children and particularly boys whose mothers are single are sometimes denied their property rights (MOH, 1997). This research study showed that orphans are sometimes rejected and subjected to mistreatment by their relatives. Key informants in Garissa recommended that the government provides protection to affected and infected persons:

"There should be state policy or regulation to safeguard the interests of a widow and property left for children orphaned through AIDS not to be grabbed by the relatives. The regulations should be clear especially in relation to orphans (Male District Health Education Officer – Garissa, FGD 20).

Due to the strong stigma associated with HIV/AIDS in Thika, community leaders who participated in a FGD openly and strongly declared their unwillingness to take in orphans:

“I am scared if the child also has AIDS. Even if it is my brother’s children, I’m scared!”(Akorino Church leader, Kamwangi Division, Thika)
“Traditionally children were adopted and rescued into a home but today people think by adopting AIDS orphans they may be importing problems.” (Community leader, Mombasa, FGD 5)

According to the District HIV/AIDS coordinator in Garissa, the community perceives HIV/AIDS as a curse from God, a perception that could explain the limited role of the extended family in supporting orphans. Extended families would be in a better position to take care of orphans if the stigma surrounding HIV/AIDS was addressed:

"AIDS should not be taken as curse. People will be more willing to take care of orphans if they don't see this as a curse...people fear the subject of AIDS. An AIDS orphan has been chased away because of fear it is infected".(Male District HIV/AIDS Coordinator – Garissa, FGD 20)

As the pressure on the extended family mounts, orphans are increasingly forced to take care of their younger siblings. The Ministry of Home Affairs estimates that child headed families constitute 5% of all family types in Kenya (Ministry of Home Affairs, 1998). The extent to which orphans’ needs are met in these households and the impact of increased household responsibilities on children are issues that need to be addressed in programs designed to benefit orphans.

Community support

Besides the extended family, communities play an important role in caring for AIDS orphans. In Kilifi, Mombasa, and Machakos, friends and neighbours assist orphans with food, clothing, shelter, and educational needs. This finding could be attributed to the strong neighbourhood bonds that exist in these communities.

Children and adults in all the nine districts cited the mistreatment and exploitation of orphans by relatives, friends, and neighbours as a problem that orphans face. In Mombasa, a manager of a school narrated the case of a Standard 8 girl who was sexually molested by a neighbour who had taken her in. Yet, except for Garissa, children and adults in all other districts reported communities had mobilised resources to assist orphans. In these areas, orphans receive food, clothing and educational assistance. In Kilifi and Kisumu, communities provide orphans with shelter. In Kisumu communities provide orphans with counselling services while in Garissa, communities employ orphans so they can support themselves.

"The local community does not know how AIDS is contracted. People cannot shake on AIDS victims hand. The neighbour isolate AIDS victims. Orphanages will put a lot of stress on orphans".(Male KNUT Executive Member – Garissa, FGD 20)

The geographic concentration of HIV/AIDS implies that orphans are likely to be cared for by impoverished families and communities (Hunter & Williamson, undated). In Bondo, the growing population of orphans has led the community to be indifferent to the plight of orphans. People in Bondo perceive orphanhood as a “normal situation and therefore (show) no sympathy or serious thought for them.” (Nyambedha, 1999, p.5).

Although communities are willing to assist orphans, sustaining the assistance is difficult. A female social worker in Machakos observed that communities help initially but they get tired on the way. Interventions that empower communities to start self-sustaining orphan support programs are required to boost the morale of communities that are actively involved in assisting orphans.

Schools

In all the ten districts, schools and communities associated with schools provide orphans with various forms of assistance. Schools provide bursaries or waive tuition and other fees, books, school uniforms, and food to orphans. Similar assistance is extended to orphans by school committees, school board of governors (BOGs), parents teachers associations (PTAs), old students’ associations, and teachers.

Teachers are also instrumental in providing moral support and counseling to affected children. In one secondary school in Thika, teachers are assigned to orphans to guide and counsel, and to provide moral support.

Religious organizations

In all the areas visited, religious institutions and organizations provide support to orphans. Assistance is provided in the form of food, clothing, education, and counselling.

“A father died then later on a child died, the mother died. They left a Form II boy. The boy left school, was selling *miraa* (Khat). He was chased away by the landlord. The boy is a drug addict, he is past rehabilitation. The Islamic foundation helped him, counseled him. The boy is on his own.” (Religious leader, Machakos, FGD 5)

The assistance provided to orphans by religious organizations is likely to be limited by the views about HIV/AIDS held by specific religious groups. In Garissa, Muslim leaders perceived HIV/AIDS as a curse from God. Similar views were held by some Christian religious leaders in Thika. There is need to address these views and misconceptions so that orphans from these religious groups can be accepted and cared for.

National and international NGOs

Several local and international organizations have responded to the HIV/AIDS problem by starting programs to assist orphans (KANCO, 1998). In the Districts visited, organizations mainly provide assistance in the form of food, clothing, education, and health. In Turkana, NGOs provide orphans with shelter.

Key informants in Garissa cited the lack of resources as a problem that hindered HIV/AIDS activities in the area. According to the District Health Education Officer, lack of resources is linked to the insecurity in Garissa “NGOs feel North Eastern Province is insecure, so they don’t come here.” (FGD 20).

Community leaders and Key Informants who participated in FGD 5 and 20 in Thika, Mombasa, Garissa, Kisumu, Kilifi, Busia, Kisii, Turkana, and Nakuru expressed concern over the manner in which NGOs operating in their areas utilized their resources.

“ Assistance from NGOs and other individuals should be used in the right way so that orphans can benefit” (community leader, Chaani, Mombasa, FGD 5).

“Misuse of funds intended for HIV/AIDS programs by individuals and NGOs has led to suspicion.” (NGO representative, Nakuru, FGD 5)

Institutionalized care

Despite consensus that institutionalized care is not the best support for orphans (MOH, 1997: WHO/UNICEF, 1994), the increasing number of orphans who are abandoned by their extended families have no choice but to turn for institutions for support. Infected orphans have difficulties gaining acceptance in existing children’s homes and are often neglected. The abandonment of babies for fear that they are infected has led to the establishment of homes such as Nyumbani and New Life Homes which care for a limited number of abandoned orphans.

Key informants in Thika and Garissa emphasized the need for communities to take care of children infected and affected by HIV/AIDS. In Garissa, each community has its own system of guidance and counselling which is based on religion. Participants felt there is need to build upon the existing care structures:

"We have extended families. For a Somali, even if it is a far distant relative, let the relative take care of the orphans. If there are no resources, community should be encouraged to contribute so orphans are taken care of in the community". (FGD 20*, Garissa)

" Removing (from the community) children who are infected will demotivate them, that will kill them!" (Ex Assistant Chief, Karuri sub-location, Thika, FGD 5).

Key informants also suggested that communities should mobilize resources and establish homes for orphans. However, they expressed concern that orphanages were not a viable care structure for orphans.

"If there are no resources, communities should be encouraged to contribute so orphans are taken care of in the community. Orphanage bring stigmatization, misuse of resources, people cannot take more care of children than the relatives".(Male District Health Education Officer, Garissa, FGD 20)

The establishment of institutions that offer care for orphans is constrained by individuals and NGOs who use these as money making ventures. A social worker from the Children's Department in Nakuru observed that "children's homes get certificates of registration which enables them to get money from donors- they no longer accept children." (FGD 5). In the absence of clear policy guidelines in the establishment and running of the institutions, orphans who are institutionalized are vulnerable to abuses such as unethical clinical research and premature death as a result of negligence (Saoke & Mutemi, 1994).

In light of the growing population of orphans, institutional care is not an economically viable option in handling the orphan crisis, Given that the extended family is the predominant care structure for orphans, supporting communities through economic empowerment remains the most cost effective and appropriate option of caring for orphans. Interventions geared towards helping orphans must recognize and enhance the potential of communities to care for orphans.

GOK support for orphans

Government support for orphans was reported by key informants and community leaders in Turkana, Kisumu, Kilifi, Busia, Kisii, and Kisumu. Assistance comes mainly in the form of bursaries for orphans.

In Thika, community leaders in FGD 5 expected the government to do more to assist the orphans. It is important to note that some of the elders in this community openly expressed that they were too scared to care for AIDS orphans. On asking how orphans should be taken care of, elders in Kamwangi, Thika felt that the government should assist:

“It is for the government to help us.” (Akorino church leader, Kamwangi, Thika, FGD 5)

“We have asked you the same question. How can our children be helped? Their mother died of AIDS, I’m jobless, my parents are old. What can I do? You tell me!” (Male Community leader, Kamwangi, Thika, FGD 5)

“ The government should help us because we are unable. We have many problems. Our work is only to take orphans to them.” Male community leader, Kamwangi, Thika, FGD 5)

Although communities are constrained economically, the negative attitudes of some of the community leaders in Thika towards orphans do not augur well for the establishment of community initiatives to assist orphans in the area.

From Table 1.4, it is evident that AIDS orphans have limited access to health services. This finding is consistent with Saoke and Mutemi (1994) who found that all carers of HIV/AIDS orphans identified access to medicines as an urgent need.

3.3.6 Rights of children affected by HIV/AIDS

Although Sessional Paper No. 4 emphasizes the need to ensure that orphans are cared for and protected from all forms of violations, there are no clear and specific structures to address the rights of children affected by HIV/AIDS (Table 1. 3) Legislation is needed to ensure that all children are provided with basic needs and protected from individuals, relatives, and institutions.

Rights denied to children affected by HIV/AIDS

- Basic Needs
- Protection from Abuse & Neglect
- Protection from Discrimination
- Freedom of Association
- Leisure
- Information
- Protection from economic exploitation and work
- Cultural rights.

Source: children, listing 11

3.3.6.1 Factors that children say could predispose children to HIV/AIDS

Early marriages

Children in Kisumu suggested that the lack of parental guidance could force children to resort to early marriages, a practice that could predispose children to HIV/AIDS.

“Some of these children especially get married at an early age even to someone who has HIV/AIDS, causing more problems.” (18 yr old, Form 4, Kisumu, essay. 19).

“Girls are lured by their parents to marry older men who are the same age as their father/mother.” (13 yr old Std 8 girl, Thika, essay 19)

“ Girls should not be forced to marry old people so that parents can received dowry and may be to educate their son.” (14 yr old Std 8 girl, Thika, listing. 12)

“We should not be forced to get married if our age has not reached for marriage.” (14yr old Std 8 girl, Thika, listing 12).

Substance abuse

In all the areas, street children, community leaders, and headteachers reported that children abuse substances (Table []). Alcohol, *cannabis sativa*, and cigarettes are abused in all the research sites.

Table 3. Substances that are commonly abused by school children by region

SUBSTANCE	Kisi	Machak	Thika	Busia	Kisum	Gariss	Momba	Kilifi	Turka	Nakur
1. Alcohol	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. <i>Cannabis sativa</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Cigarettes		✓								✓
4. Glue	✓	✓				✓	✓			
5. <i>Kuper</i> *	✓				✓					
6. Herbal tea*						✓				
7. Cocaine							✓		✓	
8. Heroine							✓		✓	
9. <i>Miraa</i>						✓				
10. Petrol										✓
11. Valium		✓								

*Kuper: a brown pellet that acts as a depressant.

* Herbal tea: Herbal tea laced with drugs that act as stimulants.

Source: FGD 5 (community leaders), FGD2 (street children) Observation 8 (substance abuse) and interview 26 (headteachers)

In all the areas, community leaders and head teachers reported that substance abuse by children could encourage promiscuity. Street children in Garissa reported that young girls offered them herbal tea and later lured them into sex.

Parenting

The style and norms of parenting that parents adopt may predispose children to HIV/AIDS infection. In Garissa and Thika, parents will punish disobedient children by chasing them out of the home, a practice that may lead to children living in the streets where they are exposed to infection.

"they make you to sleep outside in the store or goat shelter. You are also beat up by mother using a stick or rope. They beat you slightly. They can punish you to fetch water - 10 *mitungis*, (20 litre water containers) digging the *shamba*, you go without food for one day." Class 7 & 8 primary school children from Kamwangi, Thika).

Parents who are infected with HIV/AIDS may face resistance from their children when they guide them. A 14 year old girl from Mombasa said that children become argumentative when parents counsel them:

'When a child is told by the parent to lead his life right and the child answers back that why didn't she be that way' (14 year old girl, Form 1, Mombasa, essay 19).

This resentment seems to be based on the assumption that parents have been infected through promiscuous behaviour which may not always be the case.

3.3.7 Children's perceptions of their rights and predisposition to HIV/AIDS

Primary and secondary school children in Thika, Mombasa, Busia, Garissa, and Kisumu were asked to list the rights that they should have and rights that children are denied (listing 11). Children's perceptions of their rights and the rights that they are denied may suggest direct predisposition to HIV/AIDS infection (Tables 3.1.4 & 3.1.5). Primary and secondary school boys in Thika and Garissa suggested that they have a right to have sex or a sex partner. This perception may lead children to engage in premarital sex and directly expose them to the HIV virus. Urban primary school girls in Thika felt that they are denied the right to circumcision, a practice that children identified as a possible cause of HIV/AIDS infection in the area.

Children also expressed perceptions about their rights that could indirectly put them at risk of infection. In Garissa, Thika, and Mombasa, girls and boys in urban areas felt that they are denied the right to "walk" at night, go out alone, and to visit discos and nightclubs. It is important to note that children in Thika identified "walking at night and frequenting night clubs and discos as activities that contribute to the spread of HIV/AIDS in the area.

Table 4 Children's perceptions of their rights

Rights children say they Should have	Thika	Kisumu	Garissa	Mombasa
1. Have sex or sex partner	✓		✓	
2. go out at night	✓		✓	✓
3. visit discos and night clubs	✓			
4. watch pornographic movies	✓			
5. go out alone	✓			
6. get circumcised (boys)				✓
7. get circumcised (girls)	✓		✓	✓
8. marry early		✓	✓	
9. marry early as long as there is family planning			✓	

Source: children (listing 11)

In Kisumu, Mombasa, and Garissa, children especially boys suggested that they have a right to early marriage. In Garissa, secondary school boys felt they have a right to marry early as long as they practice family planning. These views may be attributed to the fact that the Islamic religion encourages early marriage as a way of discouraging promiscuity. Early marriages in Garissa pose a risk of infection for children. Community leaders in the area identified the high rate of divorce associated with early marriage forces young divorced girls to resort to prostitution.

Table 5 Children's perceptions of the rights that they are denied

Rights children say they are denied	Thika	Busia	Kisumu	Garissa	Mombasa
1. Forced sex to feed family Article 34, CRC,	✓				
2. Forced to work to support family Article 32, CRC; ILO, 182; Article 10, ACRW	✓				✓
3. Forced to marry early Article 21, ACRW	✓		✓		
4. Forced to marry old people Article 21, ACRW	✓				
5. Girls are forced to be circumcised	✓				✓
6. Forced to beg in town Article 19, CRC	✓				
7. Girls are denied education Jomtien Declaration, 1990; Article 11, ACRWC; Article 28, CRC	✓	✓	✓	✓	✓

Source: children (listing 11)

Denying children education may indirectly predispose children to HIV/AIDS. Children in all the areas sampled (Mombasa, Busia, Garissa, and Thika) recognized that children are denied their right to education. Children perceive education as having the potential of preventing the spread of HIV/AIDS among young people:

'By educating the masses especially youths on how they can take their in creative work like games, clubs, and societies, this will minimize the idleness in the youths which makes them have time to involve in immoral activities.' (18 year old Form 4 boy, Kisumu essay 18)

'As one is in school, one gets preoccupied as there is a lot of work to be done in school hence discourages students from being idle as the saying goes idle minds is the devil's workshop. Students are kept busy as they do various activities hence they are able to prevent and control the disease.' (16 year old Form 3 student, Kisumu, essay 18).

In Thika, urban primary school boys and girls felt that girls are denied education, a factor that may suggest increased risks of infection for girls in the area:

'For example girls are denied education and forced to stay at home and work in the fields.' (13 year old Std 8 girl, Thika, listing 11)

'Girls should not be forced to marry old people so that the parents can received dowry and may be educate they son' (14 year old Std 8 girl, Thika, listing 11)

Owing to the difficult economic conditions that prevail in most parts of the country, infected parents may violate children's rights by forcing them to engage in high risk activities to earn their livelihood. In Thika, children viewed being forced to work and beg for money in town to support their families as infringement of their rights. These practices, directly and indirectly expose children to environments and situations that could encourage early sexual behaviour and exploitation, thus increasing the risk of HIV/AIDS infection.

3.3.7.2 Children in need of special protection (CNSP) and predisposition to HIV/AIDS

Child work and labour

Child labour refers to children who work to earn a living for themselves or their families (GOK/UNICEF, 1998). In Thika and Turkana children reported that they are involved in child labour.

' Houseboys are sexually abused by their employers, they are raped by employers. We know cases of house workers who have been raped or made sexually active by their employers.' (Standard 7 pupil, Lokichogio, Turkana, FGD 3B)

Children could also be predisposed to HIV/AIDS when carrying out their day to day duties. In Thika, rural primary school girls reported that watchmen in nearby plantations sexually harass them when they are sent to collect cattle feed:

'Girls can be raped when they go to cut *ithanji* (napier grass). The watchman can also say you have to pay. The watchman can tell you to follow him for your *panga* and then he rapes you.' (Std 8 primary school girl, Thika, FGD 3B)

Street Children

Street children are grouped into "children who live and work in the streets with few or no ties with their families; children born and bred in the streets; part-time street children and those who work on streets during the day but return to their homes at night and those who come to the streets occasionally, such as during weekends and school holidays." (GOK/UNICEF, 1998, pg. 53).

Children living in the streets of major towns and cities are exposed to many situations that could put them at risk of HIV/AIDS infection. Sexual activity amongst street children could directly predispose them to infection. In Thika and Kisumu, boys living in the streets reported that they are sexually molested by older street children.

"We are bothered by the big street children. They sodomise us when we are asleep *Simba* does that (Referring to an older street boy)." (9yr old male street child, Thika, FGD 2).

"A boy has sex with another boy. One boy sleeps and he has anal sex with another boy. He is given money." (15year old boy, Kisumu, FGD2)

Children in Kisumu and Thika also reported sexual activity between boys and girls:

"I sleep with Wambui. She is my dame, I have married her. If somebody steals her from me, I take his girlfriend." (street boy, Thika, FGD 2).

"Our girlfriends are young, they cannot get AIDS." (12year old street boy, Kisumu, FGD2)

The misconception that young girls are not infected with HIV/AIDS could expose street children to infection. Based on children's accounts, it is possible that street children do not take any precautions when having sex. On asking the children how they protect themselves from HIV/AIDS, one street boy in Thika said, "I have never used a condom. I don't eat those things a lot. I only eat once." A 15year old boy in Kisumu said, "When you are having sex you are happy, you forget she might have AIDS."

The dangers faced by children living in the streets are brought alive by the radical protective measures adopted by street boys in Kisumu to keep off unwanted sexual advances.

"When he comes near you, you can cheat him and lure him and when he is about to have sex you cut his thing *chwiii....!*" (10 year old street boy, Kisumu, FGD 2).

Street children who collect waste paper to earn a livelihood in Kisumu also reported that they are exposed to used syringes that could expose them to infected blood. Girls living in the streets engage in prostitution for survival, exposing themselves to infection:

“I have a girlfriend. I got scared because she is proud. She is given money and she has an affair. I decided she can go.” (15yr old street boy, Kisumu, FGD 2).

Street children in Kisumu complained of sexual molestation by adults in the community:

“He can cheat you to carry luggage for him, he says its firewood and he closes the door and removes a knife and tells you to undress. He got me but I ran away.” (15yr old street boy, Kisumu, FGD 2)

“Sometimes wealthy people come to us with cars, you go into their car and they want anal sex. One boy was caught, he screamed and was let to go. They take you far like to Dunga”. (18yr old street boy, Kisumu, FGD 2)

Socio-cultural practices

Wife Inheritance

Wife inheritance is a cultural practice in which a brother or cousin to the late husband inherits his widow. Wife inheritance is practiced in Busia, Kisumu, and Kilifi. A male social worker in Kisumu observed that wife inheritance has changed over the years: “wife inheritance is now sharing the bed. In the old days, it was symbolic inheritance.”

The practice poses a risk of infecting children since widows whose husbands die of HIV/AIDS are not exempted from the practice. All community leaders in a focus group discussion held in Kisumu were unanimous that wife inheritance was here to stay because “customarily we support (it) because everybody is for it.” (An elder & aide to the area Chief, Kondele, Kisumu). In Kisumu wife inheritance is entrenched even among the highly educated people. A social worker in Kisumu said that stopping the educated from the practice meets with the response that *Unatuharibia boma* (meaning- you are ruining my household). This could mean that sensitizing people on the impact of wife inheritance in Kisumu would be a difficult task.

Wife inheritance could predispose children to HIV/AIDS in two ways. First, children born out of the unions may be infected in utero or after birth through breastfeeding. In Busia, boys who are out of school are forced to inherit widows while those in Kisumu are paid money by women who wish to be inherited. These practices could lead to infections among boys in the districts. The practice of wife inheritance is also common among young people:

“ Young men are dying leaving young widows who are inherited immediately. The young are cheeky, nobody want to inherit but the lady uses her power/money etc to be inherited.” (Male church leader, Kisumu, FGD 5)

Practices that involve incisions of the body

Children in all the areas reported that there are socio-cultural practices that may predispose children to HIV/AIDS infection. In Garissa, Kisii Mombasa, and Thika, children reported that circumcision may expose children to HIV/AIDS infection. When one knife or razor blade is used to circumcise more than one child. Further, children reported that night dances that are part of circumcision ceremonies tend to promote promiscuity among the youth, thus increasing the children at risk of infection.

In Garissa, traditional birthing, cutting the 'tongue' (epiglottomy) removing teeth, incisions and scarring may expose children to HIV/AIDS. The Muslim community in Garissa does not allow expectant mothers to be attended to by males during the birth process. Home deliveries managed by traditional birth attendants (TBA) are therefore common due to the fact that health facilities in Garissa are predominantly staffed by males.

Burial ceremonies

In Busia, Kisumu, and Kilifi burial ceremonies and accompanying prolonged feasting and night dances may predispose young people to HIV/AIDS infection. Sexual intercourse is culturally accepted as an integral part of these ceremonies.

'Sweetie parties'

A sweetie party is a social function that is popular in Busia. According to a primary school teacher who was a key informant (personal communication-letter), the parties started as “merry-go-round” ventures that were meant to boost the financial status of the participants. When one hosts a party, the invited guests “sweeties” contribute money and luxurious gifts such as household goods and farm animals. According to the teacher, “This has led to many cases of women and girls looking for sexual partners outside marriage or boyfriends who sponsor them in exchange for sexual gratification. This has resulted into broken marriages, pregnancies among school-going girls and even spread of STIs.

During the party, there is feasting, music, and alcohol. Some of the parties may extend late into the night indirectly exposing girls to HIV/AIDS:

“Sweetie Parties among girls are organized in such a way that the boys invited are either boyfriends to the girls present or are meant to start relationships with the guest or visiting girls. This is sometimes the case with adult parties. Parents allow and support their children to organize or attend these parties because of the gifts involved. But most of them regret later when things turn sour.”

“Free socialization, a lot of beer and dark spots in the compound at night promote immorality during the party. All these happen behind the gift-exchanging mask.”
(Male primary school teacher, Nambale, Busia, personal communication).

According to the teacher “The good intention for which the Sweetie Parties were started have been outweighed by the negative moral impact it has on the community. They have turned into bitter parties especially in this era of HIV/AIDS.”

3.4 IMPACT OF HIV/AIDS ON EDUCATION

Education involves a large number of actors who may be affected by HIV/AIDS in various ways. These actors include pupils, teachers, educational administrators and managers, families and communities. As such, the impact of HIV/AIDS on education may be identified at the levels of these various actors in education. To facilitate the identification of the impact of HIV/AIDS on education in all the research sites, pupils were requested to write an essay on, "How HIV/AIDS has affected our learning" (instrument 18). Focus group discussions (FGD) were also held with community leaders (FGD 5) and with key informants (FGD 20). They included government officials, municipal leaders, religious leaders, chiefs, NGO/CBO leaders, youth leaders, community elders, teachers, parents and women group leaders. The results of this study show that pupils' and community leaders' perception was that HIV/AIDS has had effects on participation in education by pupils and teachers and on the community's capacity to participate in education. The results also indicated that children have experienced psycho-social impacts such as, stigma, fear, depression and shame, which have affected their learning.

3.4.1 Impact of HIV/AIDS on pupils' participation in education.

Pupils and community leaders in all the research areas reported that pupils' participation in education is affected in terms of their attendance and performance. Pupils were also reported to be infected and others were reported as having died after being infected.

3.4.1.1 Impact of HIV/AIDS on pupils school attendance

According to Carr-Hill, Kataboro and Katahoire (2000), in a draft report on HIV/AIDS and education which was based on a review of a number of case studies in Sub-Saharan Africa, report that children in households with an AIDS patient were likely to remain absent from school because of the need for care of a sick member of the family. They also found that as a result of HIV/AIDS related deaths, children are also likely to be absent from school to attend funerals. The report further indicated that in an in-depth study conducted in Uganda on 20 students in a district hardest hit by AIDS, nineteen of the students reported having been out of school for periods ranging from five weeks to one and half terms during the past one year. The most common reasons given for absenteeism were lack of school fees and helping with the care of AIDS patients at home.

The results of this study show that pupils and community leaders from all the study sites were of the view that affected and or infected pupils poorly attend school. This is because when parents are sick and die from HIV/AIDS, pupils temporarily absent themselves from school to take care of their sick parents as well as their siblings. Both Kilifi primary and secondary school boys and girls cited these as the most common reasons for poor attendance in school. The Head teacher of one of the primary schools visited in Busia confirmed this and reported that most children in his school are absent to attend burials, most of which are associated with HIV/AIDS. He said that there were about three such burials everyday within his community. A 16-year-old secondary school boy from Kisii also stated that,

'If you hear a schoolmate has died of AIDS or teacher, it will force you to leave learning and go to mourn and that is a wastage of time of learning.'

In Kisumu urban areas, the primary school boys cited temporary absenteeism as a frequent phenomena following parental death due to HIV/AIDS. The Head teacher of one of the primary schools in Kisumu confirmed that absenteeism is very high amongst pupils affected by HIV/AIDS. He also stated that, 'during market days, pupils go to the market to trade to raise money to meet their basic needs'. For example, during the day when the research team visited the school, 65 pupils were absent and the headteacher said that they had gone to the market. He also said that orphans were mostly absent because they live with grandparents, and most of them, due to lack of parental guidance, have had children out of marriage. They leave the children with them to attend school. They are also out of school to attend to their children, hence their irregular school attendance.

In Garissa and Mombasa, boys reported that, affected as well as infected pupils poorly attend school. It was also reported by another head teacher from another primary school in Kisumu, that orphans are also absent during peak agricultural seasons when they go to work as bird-minders (scare crow) and also do other activities such as sand harvesting to raise money for their necessities. He further added that other orphans are absent to attend market days. For example, during the day when the research team visited the school, 65 pupils were absent and the headteacher said they had gone for market day. He, for instance, reported to the researchers during their visit that,

'today is a market day and about 100 students are absent. They go to the market to sell items for their parents or for themselves to earn a livelihood. They also engage in "ngware" business (hire bicycles to ferry luggage or people to and from the market for pay'.

He also said that orphans were mostly absent 'because they live with grandparents and most of them due to lack of parental guidance, have had children out of marriage and leave the children with grandparents to attend school. They are also out of school to attend to their children hence their irregular school attendance'.

A cross section of community leaders and key informants from Mombasa had a perception that pupils miss school to attend to funerals of parents. Other reasons cited for pupils' absenteeism included lack of school fees, hunger, illness of parents and guardians, pupils sicknesses, domestic work, 'edong' dances (youth cultural dances in Turkana), raids, work to earn a living, migration of parents, indiscipline, death of parents or guardians and peer group influence. The key informants from all research sites were also of the view that most of these reasons for absenteeism could be tied to HIV/AIDS. Again due to absenteeism, many pupils perform poorly and or are forced to repeat classes. For example, the headteacher of a primary school in Thika, reported that in the current year, 2000, there were many repeaters in his school.

While the results of this study are similar to those of World Bank (1997) and Carr-Hill et. al (2000), it emerged from this study that pupils are also absent from school to engage in trade in the market to raise money for school and other basic necessities. They also engage in paid work such as bird minding, rice and sand harvesting, and bicycle transportation business.

3.4.1.2 Impact of HIV/AIDS on pupils' performance

Carr-Hill, Kataboro and Katahoire (2000) report that teachers are expected to attend to sick relatives in critical conditions and this can take their time from school activities. They further argue that teachers attend funerals in their community, and given that the frequency of death can be as high as two per week in some areas, this translates into many work hours lost over a period. This most likely impacts on pupils' performance. The results of this study show that pupils and community leaders in all the study sites had the perception that pupils' performance had been affected by HIV/AIDS. Data collected from 129 primary and secondary school pupils and students showed that 52% of the boys and 48% of the girls indicated that HIV/AIDS had affected pupils' performance in education. The majority of these, that is, 74%, were from Thika, Mombasa, Garissa, Kilifi and Nakuru while the rest (26%) were from the other areas (Busia, Kisii, Machakos, Kisumu and Turkana). It seems that a relatively large percentage of pupils from Thika, Kilifi and Nakuru, (that is 19% in each) were of the view that children's performance in school had been affected by HIV/AIDS (see Table 6 below).

Table 6 Pupils' perception of the impact of HIV/AIDS on performance by gender and region (percentage) N = 129

	Boys	Girls	Total
Garissa	6	3	9
Kilifi	9	10	19
Mombasa	6	2	8

Nakuru	12	7	19
Thika	4	15	19
Others	15	11	26
Total	52	48	100

Pupils reported that their participation and academic performance is affected by HIV/AIDS in several ways. Foremost, boys and girls from urban schools in Nakuru, Garissa and Mombasa reported that infected pupils have low concentration in their studies and therefore perform poorly in their work. Rural primary school pupils in Kilifi and Turkana said that pupils infected by HIV/AIDS fear coming to school and these may lead to poor results. Key informants from Nakuru were also of the same view that when parents die, children are not able to concentrate in their studies and this affects their performance.

The other reported impacts by primary and secondary children on their performance included that when parents are sick they lack time to study in the evening further affecting their performance. While in school, pupils also worry about the sick parents such that there is a drop in their classwork. This is a phenomenon noted by primary school children from rural Kisii, Turkana, and secondary school pupils from urban Garissa. Indeed this was also a view held by the chairman, Garissa county council.

Primary school boys from Turkana, secondary school boys from Mombasa and girls from secondary schools in rural parts of Busia reported that the fast spread of HIV/AIDS is further making students loose hope of the future. This has affected their participation and performance in education.

3.4.1.3 Impact of HIV/AIDS on pupils' drop out

HIV/AIDS has led to pupils' dropping out of school. Ferguson and Johnston (1999) in their study on 'AIDS, gender and school drop out in Rusinga Island, Kenya', found out that school drop out occurred for both gender because there is no money left to sustain them in school. This could be due to the fact that scarce economic resources may be spent on medical treatment and as such, children may be taken out of school in order to save money for treatment. Out of the total primary and secondary school pupils who wrote essays in response to instrument 18, on 'How HIV/AIDS has affected our learning', 56% of the boys and 44% of girls said that HIV/AIDS has resulted to school drop out. A relatively larger percentage of these, that is, 16% (10% of whom were girls) were from Thika, an area which, according to the National Aids Control Council (NACC) Strategic Plan 2000, has one of the highest HIV/AIDS prevalence rates in the country. Thika has a prevalence rate of 33% second to Busia at 34%, the highest in the country. This perception from Thika contrasts that from Busia where despite the high prevalence rates, only 2% of the children mentioned that HIV/AIDS had led to pupils drop out. This was possibly due to the fact that Busia has been among the districts with high prevalence rates over the 1990s (NACC 2000: 3). Table 7 summarises the children's perceptions on pupils' drop out.

Table 7 Pupils' perception on the impact of HIV/AIDS on pupils' drop out by gender and region by percentage. N = 451

	Boys	Girls	Total
Busia	-	2	2
Garissa	11	4	15
Kilifi	9	4	13
Kisii	7	6	13
Kisumu	2	3	5
Machakos	2	5	7
Mombasa	7	4	11
Nakuru	3	5	8
Thika	6	10	16
Turkana	9	1	10
Total	56	44	100

Pupils and community leaders in all research sites reported that HIV/AIDS has led to pupils dropping out of school. This is because of several reasons. First, there were cases of drop out due to pupils themselves being infected. This was a perception of primary school pupils in Turkana secondary and primary school boys, girls in Kisii, girls from urban and rural secondary schools in Busia, secondary school boys in Garissa, boys and girls from secondary and primary schools in Machakos, Kilifi, and Thika district. The pupils reported that infected children dropped out because they feel there is no hope. Boys and girls from Thika and boys from Garissa reported that some of their infected friends have dropped out. For instance, a 14 year old primary school girl from Kilifi said that, 'because I was infected I was afraid to come to school anymore'. This is in conformity with Kelly's (2000) finding that children who have experienced HIV/AIDS in their families may find school attendance hateful because of the Stigma related to AIDS.

Secondly, the pupils stated that they are dropping out of school because of parental death. Parental death leads to lack of money for school fees and material support for children while in school. This was a view expressed by mainly secondary and primary schoolboys and girls in Kisii and Thika.

Thirdly, pupils stated that following parental death; they are unable to concentrate in studies leading to drop out from school. Girls and boys from Thika and boys from urban secondary schools in Busia seemed to hold this view. The essay reproduced from an affected form three secondary school girl from Thika highlights the many problems students experience after parental death.

Testimony of an HIV/AIDS affected student

(A form three secondary school girl, Thika)

From the student's testimony, it seems apparent that pupils' participation and performance in school is affected by HIV/AIDS. The student indicates that following her parents' demise, she has to miss school severally to go to work to support herself and her siblings. Her performance has dropped from the top five to the few last ones.

The views of community leaders and key informants in Garissa, Thika, Kisii, and Mombasa supported those of pupils that parental death may mean that children cannot go on with school. Community leaders in Thika added that the problem is made worse by the fact that the community and relatives are not able to assist and the numbers of orphaned children is increasing.

The headteacher of one of the primary schools in Kolwa East, Kisumu told the research team that when adolescence catches up with the girls, they become sexually active and leave school to go and get married. This is also because they start school at ages as late as 11 or 12. This may expose the girls also to HIV infection and could lead to drop out. The Head teacher further indicated that drop out from his school is so high such that on average only 38% of the pupils complete. A headteacher from another primary School in Kisumu also confirmed that peer pressure on girls is also a cause of drop out for most of the mature girls. He told the research team that the girls loiter with men who buy them good things and become the envy of others.

A church leader from Busia confirmed that 'children engage in sexual activities when young. Some get married between 12 and 13 years. Early pregnancies are common in this area indicating that children start sex quite early'. He also added that 'Sweetie parties', where children with friends get together and have a party, drink and then get into some bad behaviour which may expose them to HIV infection.

Head teachers from other schools visited by the researchers in the various research sites mentioned several other reasons for pupils drop out from school. These included lack of school fees, pregnancies, early marriages and lack of means of livelihoods. These are situations, which may predispose children to HIV/AIDS infection. For example, a headteacher from a primary school in Kisii reported a case where a girl had eloped with a man. However, Headteachers from several schools in Turkana district added that besides the above stated reasons for pupils drop out from school, pupils from their schools, drop out because of the fact that some feel they are over age and hence cannot continue learning with children. In some of the schools visited there were boys as old as 14 years old in standard one and even 25 years of age in Standard 8. The other reasons given were that during relief food distribution days, children do not come to school and that some of the refugee children disappear from school and go to Sudan to fight and come back during examination time. The headteacher of a primary school in Kilifi reported that 'pupils dropped out of school and go to the beach to hook tourists'. These practices may predispose children to HIV/AIDS.

3.4.1.4 Perception that HIV/AIDS has led to pupils' infection/death

According to Kelly (2000) in a report on the impact of HIV/AIDS in the education sector in Africa, indicated that around half of the people who acquire HIV become infected before ages 15 to 24. It has become traditional to refer to those aged between 5 and 14 as constituting 'the window of hope'. The 1999 World Bank report on 'HIV/AIDS and the education sector in Kenya' holds that HIV/AIDS prevalence is low among this group. Programmes ought to be targeted at this group to provide a special opportunity to prevent infection and reduce the transmission of the disease. Majority of the children in this age range is in primary schools. However, reports from children and community leaders in the various research sites showed that pupils are probably infected with HIV/AIDS. This may have subsequently led to pupil deaths.

Researchers came across cases of suspected child deaths due to HIV infection. The team, for instance, was told of a pupil from a primary School in Busia who had died. The head teacher reported that,

'She had a history of absenteeism due to sickness. During the second term she was very sick. Then she recovered during the third term, however she was sick on and off. She finally died in December 1999. It was rumored it was due to HIV/AIDS'.

Primary and secondary school girls from Thika and Busia reported that pupils are infected with HIV/AIDS in schools and that some infected pupils infect others. A Kenya National Union of Teachers (KNUT) official and community leaders in Machakos, during a focus group discussion, stated the same. He reported that it had recently been discovered that students have the HIV/AIDS virus. The primary and secondary school girls from Thika and Busia further observed that some infected pupils infect others who are not infected, and thus pupils reported that they fear sitting near an infected person in school as they fear

infection from their colleagues. For example, the research team was informed by the headteacher of a primary school in Thika, of a case of an orphaned infected child. He said,

'There is one child in school who is an orphan. She joined the school in class eight on transfer from Nairobi. The parents had reportedly died of HIV/AIDS. Her attendance in school is very irregular, she can finish a month without coming to school. The nature of her illness is suspected to be HIV/AIDS'.

The research team found a similar case in a primary school in Machakos where the headteacher reported that, 'There is a student in class two who was born with AIDS and is in critical condition'.

Secondary school boys from Garissa and Turkana, primary school pupils from Machakos and secondary school girls from Busia and Kisii also observed that infections amongst pupils arise from the fact that pupils have sexual intercourse with each other especially in secondary schools. This was confirmed by the headteacher of a Primary school in Kisumu, who reported that there is a lot of sexual activity experienced in the school even amongst cousins. For example, he said that,

'There were some students who were suspended because of being involved in sexual activity within the school. With the presence of condom they (pupils) feel safe to practice sex and it is now very common'.

In Kisii, it was also reported by the headteacher of a primary school that he had about 14 cases of children playing sex in class 6, 7, and 8. Researchers were told of several HIV/AIDS predisposing factors. The headteacher of a primary school situated near a slum area in Thika town, also reported that,

'There is a lot of drug use in that area and high practices of sexual immorality. Some students do not sleep well at home because their parents are engaged in commercial sex work. Therefore, the children have to wait outside the house till midnight when the commercial sex work is over for them to go in the house and sleep. Worse still, they have not done their homework. In such situations they are also predisposed to HIV/AIDS as they wait outside for their parents to finish'.

She further stated that, there are a number of children in school who come from that slum area who have also engaged in commercial sex work due to the influence of what they are seeing in the community. Other pupils are engaged in drug abuse (sniffing glue) in school. They are undergoing counselling.

Pupils also mentioned early marriage as a predisposing factor to HIV/AIDS and infection. For instance, a 14 year old primary school girl from Kisii said, 'our parents drag us out of school and take us to old men who are having HIV and will affect our learning'.

The headteacher of a primary school in Kisumu added that drug abuse also predisposes pupils to HIV/AIDS infection. He said there were two boys who had been suspended from school a week ago because of taking bhang. In most schools visited, headteachers remarked that students take bhang, cigarettes and beer. They get money from stealing, cheating their parents or use their pocket money. The problem with drug abuse is the effect it has on children becoming reckless. An assistant chief of a location in Mombasa stated that, 'while on drugs, you become out of your senses and children become predisposed to HIV/AIDS'.

A key informant from the DEO's office Machakos also stated that,

'children in particularly Machakos, Tala and Kangundo area take bhang which predisposes them to HIV/AIDS because they do things which they would not do under normal circumstances'.

It was also reported that pupils engage in reckless sexual behaviour which predisposes them to HIV/AIDS infection. The pupils indicated that some pupils engage in sex without caring; they know it is bad and dangerous. They cannot control themselves and they do not care, while at the same time those infected want to spread the disease to the others who are not infected as they do not want to die alone. This was reported by boys and girls from primary schools in Thika, Kilifi and Kisii, primary school boys from

Garissa and Mombasa and secondary school boys from Turkana. Indeed, a 15 year old secondary school boy from Garissa stated that,

'Many pupils who are having this disease got it because of being careless. When somebody knows that he has HIV he always tries to spread the disease. I know that one day I saw girls who was having HIV. She went to eight different boys and have sex with them in only one night'.

Further, children from the various study sites indicated that pupil infection has led to school drop outs resulting to children running away from home after they find out that they are infected. Teachers were also reportedly infecting pupils with HIV/AIDS. A 14-year-old secondary school girl from Kisii reported, 'here we get that in our country many people who are affected with this disease are mostly young people... but the most ones are the small pupils...!'.

In a focus group discussion held in Kisumu with community leaders (FGD 5), it was indeed reported that in school, teachers have sex with learners who risk HIV infection. The learners cannot insist on teachers to use condoms.

Boys and girls from secondary schools in Thika, Machakos and Kisii further reported that some of their friends and schoolmates have died of HIV/AIDS. The same views were held by boys from secondary schools in Garissa, Turkana and Nakuru who, further indicated that some of their best students have died due to HIV/AIDS.

Table [] summarises children's perspective on pupils' deaths

Table 8 Pupils' perception that HIV/AIDS leads to pupils' death by gender and region by percentage N = 154

	Boys	Girls	Total
Busia	1	8	9
Garissa	10	4	14
Kilifi	10	5	15
Kisii	9	9	18
Kisumu	1	3	4
Machakos	3	7	10
Mombasa	8	7	15
Nakuru	3	1	4
Thika	5	3	8
Turkana	3	-	3
Total	53	47	100

The findings in Table 8 were as a result of pupils' response to instrument 18 where pupils indicated how they are affected by HIV/AIDS in their learning. These results show that 53% boys and 47% girls were of the view that HIV/AIDS leads to pupils' death. Relatively larger percentage of pupils in Kisii (18%), Mombasa (15%) and Kilifi (15%) were of the view that HIV/AIDS had led to pupils' death. Also, a larger percentage of boys than girls in Garissa and Kilifi were of the perception that pupils had died from HIV/AIDS.

The research team was told of several cases of pupils' death in Thika, and Kisumu. Most of these were suspected to be HIV/AIDS related. For example, from Thika, a primary school headteacher said, 'A girl was reported to have died due to sickness. She was sickly and weak throughout and during the time of her death. She complained of just a headache'. From Kisumu, a headteacher reported that students had died of unknown causes, which were suspected to be HIV/AIDS related. Community leaders from Nakuru, and a Kenya National Union of Teachers official also stated that children have died of HIV/AIDS. In Turkana, the same sentiments were reported and a Catholic Priest further stated that, 'HIV/AIDS is taking the intelligent in the society including teachers'.

3.4.1.5 Perception that HIV/AIDS has led to pupils' lack of concentration

The findings indicated that HIV/AIDS has led to lack of concentration amongst the school children in various ways. Firstly, pupils reported that when living with an infected person or parents, one could not be able to concentrate in school. This is because they are always thinking about the parents and infected persons, how they are coping, and the amount of work they will have to do at home since the infected persons may not be able to work. This affects their concentration and could lead to poor performance. The pupils also reported that when they are being taught by infected teachers they cannot concentrate and this could lead to poor performance in schools. This is because they fear the infected teachers. These views were held by primary and secondary school boys and girls from Thika, primary school boys from Machakos and secondary school boys from Mombasa.

Secondly, secondary school boys from Garissa and Nakuru urban areas, secondary school girls from Kisii urban, and Kilifi rural areas reported that lack of concentration amongst pupils is also due to fear of the HIV/AIDS and worry of their friends who have died of the virus and left them. The same views were expressed by primary and secondary school boys and girls from Mombasa, Machakos and Thika.

Further, urban secondary school boys from Kisumu and girls from Nakuru indicated that pupils go through a lot of trauma when they lose their parents and this affects their concentration and subsequently performance. For instance, a 13 year old primary school boy from Thika stated that, 'When my mother died because of HIV/AIDS, because of sadness, I cannot get anything at school. And when I am even coming last I might leave the school'.

Thirdly, children showed concern that infected pupils are not able to concentrate in learning. Orphaned children also lose concentration; they are particularly affected by lack of parental love, guidance, food, clothing and shelter among others. This was reported by secondary school girls from rural areas of Busia, Machakos, Thika and urban areas of Mombasa, Kisii and Nakuru. Urban schoolboys in Kisumu and Garissa observed the same.

Headteachers from all the schools visited invariably indicated that among the problems faced by orphans in schools were lack of school fees, school textbooks, uniforms and equipment. They also lacked parental love and guidance. A few other specific problems were mentioned by headteachers in various schools. For instance, the headteacher of a primary school in Thika stated that,

'the major problem is that the Ministry of Education, Science and Technology does not exempt them from paying examination fees. So even when they are exempted from school levies, they are not able to sit for their examination'.

Loneliness and inability to cope with the new reality of orphanhood were identified as a problem orphaned children suffered and these affected their learning. The Headteachers of a mixed secondary school in

Kisumu and a primary school in Garissa reported that once orphaned children are sent home for school levies and guardians do not come to school to explain why levies have not been paid, they feel abandoned and unwanted. They suffer psychologically. They added that some of the orphaned children are not able to cope with their new environment especially for those who had been used to good life and learning in urban areas. Once their parents die, they are brought home in the rural areas for learning. Their coping in the rural environment is difficult. The orphaned children find it difficult to concentrate in their learning. In a focus group discussion (FGD 5) with community leaders in Nakuru, it was reported that orphaned children are not able to concentrate when parents die.

3.4.2 Perception of school as a source of HIV/AIDS

The impact of HIV/AIDS has been such that pupils and some members of the community have also started perceiving schools as a source of HIV/AIDS. Kelly (2000) argued that many school children are in danger of sexual harassment from the teachers, their peers, and strangers. He further argued that poverty, long walking distances to and from school and travelling always the same route contribute to these dangers. Boys from Garissa and Thika informed researchers in this study that pupils fear infection from their school mates. A 15-year-old informed them primary school boy from Garissa stated that,

'Some parents refuse to take their children to school because they think that school is a place where children are taught bad thing like sexual intercourse and their children die easily. The real thing which make parents fear and refuse to educate their children is because of HIV/AIDS'.

Of the four pupils who wrote essays, on 'How HIV/AIDS has affected their learning', three were boys from Garissa and a girl from Thika. These were areas the researchers in the course of fieldwork formed an opinion that the some of the pupils and the community members were in denial about HIV/AIDS. In Garissa, HIV/AIDS was seen as a problem of 'down country people', that is people from outside the district. They were rather intolerant about infected people. The researchers were informed by both pupils and community leaders (FGD 5) in Garissa that because it was perceived that, foremost, in schools children are exposed to many things including some values alien to their religious doctrine. It was also felt that there is a lot of mixing and interaction amongst pupils in school, and on the way to and from school. These were situations that were felt may expose children to HIV/AIDS.

Below is a case study of a school where researchers were informed of the effects of HIV/AIDS on pupils' participation in education.

CASE I

Impact of HIV/AIDS on education: a case of a primary school, Kolwa east, Kisumu

This school is located at Kolwa East location of Kisumu District. It has an enrollment of 459 pupils (217 boys and 242 girls) It has a staff establishment of 9 teachers (3 male and 6 female). According to the Head teacher of the school, the school has been affected by the problem of HIV/AIDS in several different ways. The Head teacher informed the research team that absenteeism is very high in the school. The reasons for pupils' absenteeism included sickness, lack of fees, lack of school materials and children's involvement in market day activities. He indicated that absenteeism is high during market days (Tuesday and Fridays) because most pupils are asked to stay at home while their parents go to the market.

The problem of lack school of fees is mainly due to social problems. He said, 'most of the children are born out of wedlock, have lost parents cannot afford school fees so they drop out'. He indicated that since 1996, there have been many deaths (many of them probably due to HIV/AIDS). He estimated that there have been about 143 deaths in the community. This has brought an increase in the number orphans. He estimated that three-quarters of the school children are orphans. This guess was that there were about seven (7) deaths in a week in the area.

Pupils are also dropping out of school especially due to lack of school fees stability at home as grandparents cannot cope and general poverty. The rate is becoming high. The headmaster indicated that,

for example in standard seven in January 2000 there were 49 pupils by the time the researcher team were there in September 2000, there were 37 pupils. The student population has also dropped from 462 to 252. He said that some students disappear only to reappear in October just to do final examination.

Some of the school pupils are also involved in drug abuse, mainly bhang and local brew. These predispose children to HIV/Infection because of impairment of judgement. The Headmaster also reported that pupils in the school were increasingly predisposed to HIV/AIDS. This was because there was a lot of sexual activities experienced in the school even amongst cousins. He gave an example of term one and two where some pupils were suspended because of being involved in sexual activities. He said, 'With the presence of the condom, they feel very safe to practice sex and it is now very common'.

In the area, most of the girls get children out of wedlock and leave children behind with grandparents. He suspected that most of the parental deaths were due to HIV because most of them die when they are slim and their spouses follow.

Attendance of school by the orphans was reportedly irregular as they stay with grandparents and have to assist with household chores and market and so they miss school. He said, 'they lack school materials, they are often sick and physically appear malnourished'. The school allows them to come to school without uniforms and teachers offer some uniforms and books for them.

From this case it may be seen that HIV/AIDS may have affected pupils' participation in education. The headteacher reported that it may have resulted into pupils' absenteeism, drop out, lack of school fees, and that it has resulted into pupils involvement in practices that may predispose them to HIV/AIDS, for example, drug abuse and sexual activities within the school.

3.4.3 Impact of HIV/AIDS on teachers' participation in education

HIV/AIDS has affected teachers' participation in many ways. Carr-Hill et. al. (2000: 13) states that, teachers, like many others have not been spared by HIV/AIDS such that even if educational facilities are available, there may be lack of teachers to provide teaching services. While some have been infected and are sometimes absent from school, others have died following HIV infection.

3.4.3.1 Perception that HIV/AIDS has led to teachers' infection

Teachers have been infected as well as affected by HIV/AIDS. The 1999 World Bank report on HIV/AIDS and the education sector in Kenya, holds that 'as HIV infected teachers are more and more affected by the opportunistic infections, they will increasingly have to be absent from the classroom'. Carr-Hill, Kataboro and Katahoire (2000) reported that in Tanzania, teachers are affected by AIDS and their participation and performance deteriorates. The same may also be said of possibly be said of teachers in Kenya. They report that,

'the qualitative effects of HIV/AIDS are clear in that, teachers are concerned about their health, and become nervous and depressed; they are frequently absent; their attitudes to work deteriorates; they become unable to perform well; and that there is a negative psychological impact on children'

Similar views are reported by Kelly (2000:) where he argues that,

'teachers are also suffering from overwhelming stress and psychological trauma. They are deeply affected personally by the incidence of HIV/AIDS among their relatives, and colleagues and by their fear and uncertainty about their personal infection status'.

Pupils and community leaders from all research areas the study team visited were of the view that HIV/AIDS has affected teachers in various ways, to the extent that their participation and performance in

the education has also been affected. They said that teachers have been infected, are sick and are therefore often absent from their schools and that teachers have also died from HIV/AIDS.

Secondary school boys from Thika and Nakuru were of the view that where teachers are infected, learning does not take place effectively. Boys from Thika and Garissa also said that with infected teachers, pupils cannot concentrate and this leads to their (pupils') poor performance and failure. Boys from Garissa were of the view that infected teachers will be absent for many days due to illnesses

Finally, it was observed by girls from Thika rural and boys from Kisumu rural that classes run by infected teachers are often disrupted by illnesses. Indeed a 16 year old secondary school girl from Thika reported that,

'teachers infected with HIV cannot teach well because of regular diseases that can affect them and they become very weak even to stand in front of class. Pupils might also reject such a teacher and therefore cannot concentrate during lessons'.

Another student, an 18 year old secondary school boy from Kisumu noted that,

'teachers who are infected cannot no longer teach properly due to worry or psychological unrest. When no proper teaching takes place, education cannot be advanced and this leads to low standards of education'.

Below is an excerpt from an essay on how infected teachers conduct their classes and its impact on pupils psychologically and academically: -

How HIV/AIDS has affected our learning:

HIV/AIDS has affected our learning in various effects. Last year, we had a teacher who had just graduated from university. Our class was her first class to teach after graduation. She taught us for a period of one year. She then started to deteriorate in health and then went for a sick leave. She was teaching us English. At that time the school was running short of English teachers. As a result of this problem, we were taught English for two weeks. She reported back to work two weeks later. Immediately she stepped into the classroom, we started to clap. We were trying to show her that we were happy to see her back. Unfortunately, she was still ill. She taught while sitting on a chair and never wrote on the board. She walked slowly, being careful with her steps.

She could come to school on and off i.e. not frequently. It reached a time when she could not come to school at all. It happened that my desk mate was her close relative and he informed me how her health was deteriorating fast. He also informed me that she lived by the second husband and that the first husband died of AIDS. This desk mate of mine told me that he was sure she suffering from AIDS.

Two months later, we were informed in the assembly that the teacher is dead. It was really shocking to our class, furthermore the teacher was still young and energetic.

(An 18 year old secondary school boy, Kisumu).

The headteacher of one of the primary schools Kisumu stated that teacher infection leads to death and this affects performance. For example, he said that from January 1998, one male teacher had died. In 1999, two female teachers had died. They had been sick for a long time. He also gave a case of a teacher in her school, who is usually sick, 'last term she was sick for over a month. She is now given upper classes because she cannot cope with lower primary. She suffers herpes zoster on her body. She is in school but is very weak'. Worse still, boys from urban secondary schools in Kisumu, Machakos, and Garissa stated that infected teachers can not teach properly. A key informant of the Municipal staffing office Mombasa indicated that at the time of this study (mid September 2000), she already had 64 teachers in her records who were sick. She had seen them as they came to the office to seek for help in maintaining their

employment. 75% of them are suspected to be AIDS related sicknesses, two are bedridden and their husbands have already died.

A key informant from the Provincial Inspector of Schools office, Kisumu, reported that, 'returns show that teachers are there in school but on the ground they are bedridden and therefore there is somebody who is teaching on their behalf and they share the salary'.

Indeed the key informant cited cases of a school he is aware of where the headmaster and the deputy were both infected and ailing. The deputy headteacher's husband had reportedly died a year ago from HIV/AIDS. The researchers who visited the said school found the headteacher appearing sickly while the deputy headteacher was away on sick leave. On enquiry by the researchers, it was confirmed that she is often off-duty due to illness.

Below is a case study on the various impacts of HIV/AIDS on education

CASE II

Impact of HIV/AIDS on learning: a case of a primary school in Kisumu district

The school is situated a few kilometers from Kisumu town in Kolwa East location of Kisumu District. It has a population of 94 students. The classes run from Standard one to Standard Eight with one stream of each class. The buildings are mud walled with grass thatched roofs. The school was in a poor state. The mud walls had fallen off, the polls supporting the building were bent towards one side, almost breaking and the roof was also tilted towards one side (the side where the poles were bent) so as the teachers taught they could see and hear one another across the classrooms.

The researchers arrived in the school at around 11.30 a.m., this was during classtime and pupils were in classrooms. However, in the incomplete stone building, there were 3 pupils (girls) who were cooking some food. On enquiry, they reported that they were preparing lunch for their teachers, after which they would then go for lunch and come back after lunch to clear up the dishes.

The Headmaster was away but the researchers were attended to by the deputy headmaster. The school has a staff establishment of seven teachers, all male teachers. One was currently sick and had been admitted in hospital for some time. He had a history of sickness. It was reported that he could be out of school for some time, show up in school for one or two days then fall sick again and take sick-off. He was suspected to be suffering from HIV/AIDS. Two other teachers were also regularly sick. They were also reported to be off duty quite regularly. Every week, they would be off duty due to illness. They were suspected to be suffering from HIV/AIDS. This left only four active teachers including the headmaster to attend to all pupils from class 1 to 8. Asked how they cope, the headmaster remarked that they try and teach as much as they can (meet the demand) but he admitted that it is quite difficult, tiring and inefficient and this could be one of the major reasons why the performance of that school was not good.

The schools' performance in the last 4 years

Year	Mean Score
1999	221.83
1998	191.63
1997	212.76
1996	233.35

The school has very high numbers of drop out. Out of about 20 pupils who enrolled in standard 1, only 4 complete in standard 8, and most of those who complete were boys. For example, currently (2000) out of the 43 are boys with one girl. In 1999, only six (6) completed, while 8 completed (7 girls and one boy).

Some of the reasons given for drop out by the Deputy Headmaster were lack of fees, though the fees was only Kshs. 135.00, they still could not afford. After they drop out, boys are employed in agricultural activities e.g. rice harvesting, sand harvesting, and bird-minding (scaring away birds from farms etc) take up "ngware" business (transportation business) using bicycles mostly on market days and they don't see the need to come to school. Most girls drop out due to pregnancies, engage in market activities like selling tomatoes and finally get married early.

Most of the children in the school are orphans. Most of the parental deaths have been suspected to be due to HIV/AIDS related illnesses. The attendance to school by these children is not regular. They are absent from school most of the times due to lack of fees, hunger, lack of school material, text books. Also most of the time they are working to earn a livelihood.

An informant from the staffing office in the Provincial Director of Education's Office in Kisumu indicated that due to illnesses, their office receives complaints about teachers who cannot teach because of sickness. For example, he said that within a month there can be about five complaints from headteachers about sick teachers who are not able to teach. As a result of sickness, some of which are suspected to be HIV/AIDS related, some of the teachers seek transfers to go to stations/schools nearer their homes. These findings were similar to those of Carr-Hill, Kataboro and Katahoire (2000) in a draft report on HIV/AIDS and education where it was indicated that teachers who are infected may try to transfer to another area, or once visibly ill, abscond and disappear. Headteachers of some of the schools visited gave some figures (presented below) on teacher transfers out of their schools over the past one year. Some of the transfers according to some of the headteachers were suspected to be due to HIV/AIDS related sicknesses.

Table 9 TEACHER TRANSFERS IN THE PAST ONE YEAR AS REPORTED BY HEADTEACHERS IN SELECTED SCHOOLS.

SITE	NO. OF SCHOOLS VISITED	TRANSFERS		TOTAL
		MALE	FEMALE	
BUSIA	10	2	3	5
KILIFI	11	2	6	8
KISII	12	14	8	22
KISUMU	6	3	3	6
MACHAKOS	14	4	10	14
MOMBASA	8	10	6	16
NAKURU	17	17	19	36

THIKA	7	8	10	18
TURKANA	16	3	12	15
Total	101	63	77	140

Table 9 shows that head teachers from 101 out of a total of 129 schools visited in the various study sites, a total of 140 teachers had been transferred out of their schools in the past one year. These included 63 male and 77 female teachers. While most transfers were normal transfers, the researchers were informed of cases where some of the teachers had been transferred on medical ground, some of which may have been due to HIV/AIDS. An informant from the staffing office in the Provincial Director's office, Kisumu, confirmed that teacher transfers have been reported. He further indicated that some are due to medical reasons, though, it could not specifically be tied to HIV/AIDS. He reported that in 1999, there were 12 cases of teachers who sought transfers because of medical reasons, while in 1998 there were 13 such cases. During the research team's visit to one of the primary schools in Kisumu, the researchers were told of a case of one teacher from the school who was transferred to another station near his home where he died soon after.

3.4.3.2 Perception that HIV/AIDS has led to teacher deaths

The issue of teacher deaths due to AIDS continues to pre-occupy educational planners, managers and researchers. In a draft synthesis report by Kelly (2000:22) on 'the Impact of HIV/AIDS on the education sector in Africa', it is reported that, an estimated 860,000 children in Sub-Saharan Africa, two thirds of eight countries lost teachers. It is further noted that in Kenya, the Teachers service commission has reported that teacher deaths rose from 450 in 1995 to about 1,500 in 1999. The 1999 World Bank report on 'HIV/AIDS and the education sector in Kenya' argues that,

'while the Teachers Service Commission is not able to identify the cause of death, the annual number of teacher deaths is likely to continue to rise as the full impact of the epidemic is felt in coming years'.

Results of this study show that pupils' perception was that HIV/AIDS has resulted to teacher deaths. Their view was also that when infected teachers die, there is teacher shortage as they are not replaced. These were sentiments expressed by boys and girls from both primary and secondary schools in Nakuru, Mombasa, Kisii, Garissa, Machakos and Kisumu. The same views were expressed by key informants (FGD 20) from Kisii and Garissa. The pupils' perspective was that the remaining teachers were also overburdened and therefore may not perform well. An 18 year old secondary school boy from Kisumu indicated that,

'the disease is also consuming the lives of teachers in the province.... This leads to burdening of the remaining teachers as one teacher can even be allocated over twenty lessons a day to cover the shortage'.

A KNUT official from Kisii said that the teachers left behind have to share the burden. He said, 'their lessons are not attended to. Other teachers share the work of infected teachers. This means they have more workload'. He added that the problem is compounded by the fact that teachers who died are never replaced since the government is no longer employing teachers. The impact is quite heavy'. A leading politician in the Garissa County Council noted that the morale of the teachers left behind also goes down (FGD 5). Pupils were indeed concerned that HIV/AIDS has killed their subject teachers. This was a lament by primary and secondary school boys from Garissa, a secondary school boy from a rural secondary school in Busia and a girl from an urban primary school in Kisii. The excerpt below from an essay by a 14 year old primary school in the urban area of Kisumu demonstrates the effect of teacher death on pupils learning:

'AIDS has affected my teacher for English, per now nobody to teach me English and that was the teacher whom I was understanding how she was teaching'. (14 year old primary school girl, Kisumu)

Another girl, 13-years old from a primary school from Thika, also stated that,

'If my teacher is going to die of HIV/AIDS and maybe she is the one whom I loved very much and I was understanding that subject better now I am not going to pass that subject well'.

Teacher death not only affects pupils academically but also psychologically. A testimony by a 12 year old primary school girl from Busia attests to this: -

It has also kill my teacher whom I loved very much, I ran on the street to look for her but I didn't found anybody like her - at that time I was not understanding anything I was told I was shocked when I was told that my teacher have died because of the HIV virus, two weeks ago. I was still worrying about my teacher and that message affected my mind".

(Testimony of a 12 year old primary school girl, Busia)

Indeed, boys from Nakuru, Mombasa and Garissa secondary schools, girls from Thika, Machakos and Busia felt that "infected teachers die leaving students unattended. A 14 year old pupil from Garissa also stated that,

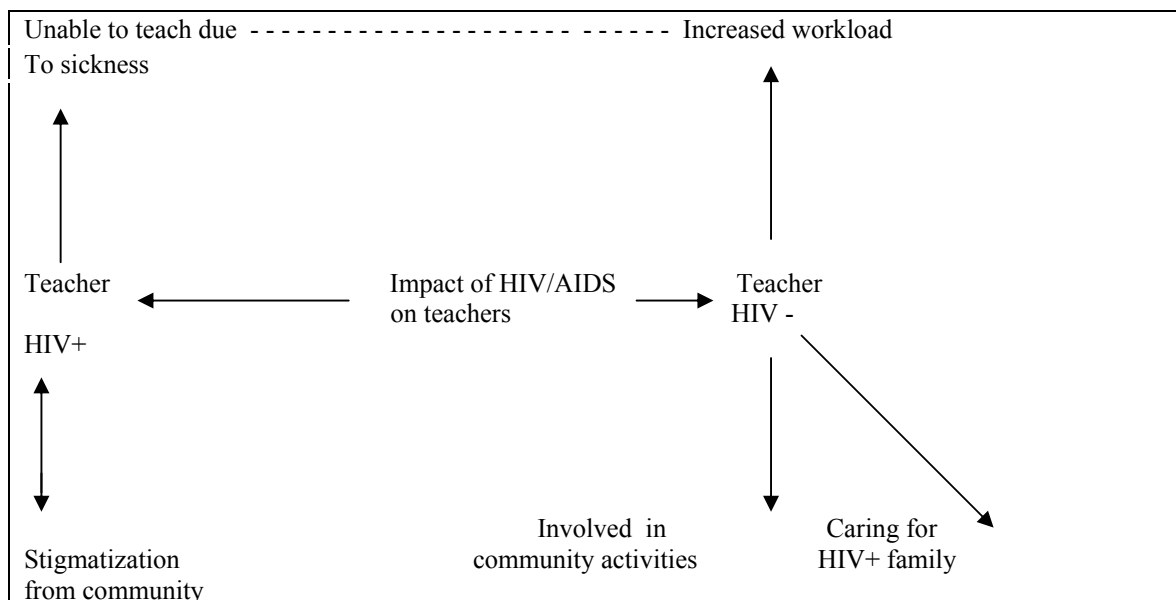
'Once I was learning in one of the schools in Tana River, one of our teachers died of HIV/AIDS and so it affected me in school because we do not have any class teacher for our class in lower primary'.

On the same issue, another student, a 15 year old primary school boy from Garissa reported that,

'Once I was learning in primary school in standard, our teacher died of HIV/AIDS and we were not able to go for school for one full week because of the burial and our teachers were involved in the burial ceremony'.

Key informants supported these views by also stating that teachers are dying and students are left without teachers (FGD 20). The Headteacher of a day secondary school in Kisumu reported that some subjects end up being dropped when the teachers die. He cited a case in his school where, 'one male teacher died in 1997 (four years ago due to HIV/AIDS) he was teaching drawing and design and has not been replaced since then. The subject had to be discontinued due to lack of a teacher'.

The impact of HIV/AIDS on teachers may be summarised as in the conceptual diagram below:



Reports from the sites visited during the study indicated that teachers have died. While it was not possible to attribute all the cases of death to HIV/AIDS, key informants in the various research sites indicated that there were cases of teachers dying due to HIV/AIDS. Informants from the Provincial Inspector of schools office (Kisumu) admitted that the Impact of HIV/AIDS on the teaching force is high and that teacher deaths are equally high in Nyanza province. Table (10) below shows the number of teachers deaths as reported by educational managers in the sites visited.

Table 10 Teachers' deaths over the past 3 years as reported by educational managers in selected sites up to August 2000.

Sites	1998			1999			2000			Source of Information
	M	F	Total	M	F	Total	M	F	Total	
Mombasa	6	5	11	2	6	8	2	8	10	KNUT office Mombasa (primary school) (Benevolent scheme records)
Mombasa PDE's office	-	-	6	-	-	8	-	-	4	PDE office -Coast Province (secondary school)
Kisumu	-	-	75	-	-	142	-	-	32	DEO's office - Kisumu (year 2000)

										fewer cases because they exclude Nyando which was hived from Kisumu district..
Kilifi	14	1	15	12	2	14	-	-	-	KNUT - Kilifi (suspected HIV/AIDS cases in 1999; 4 male 1998, 7 males) (Benevolent scheme records)
Busia	20	9	29	18	7	25	20	5	25	DEO's office
Kisii	38	9	29	28	5	33	20	6	26	KNUT office - Kisii (Benevolent Scheme records)
Machakos	22	10	32	9	11	20	25	13	38	District Personnel office (Base on claims for terminal dues)
Total			197			250			135	

Note: The records kept by KNUT offices only relate to those teachers who are KNUT members mainly primary school teachers. The P.D.E.'s office deals with records of secondary school teachers while the DEO's office deals with primary school teachers.

From the data reported in Table 10 educational managers from the various study sites reported that in the year 1998, 197 teachers had died, while 250 teachers had died in 1999. As at August 2000, 135 teachers had died in the areas the data was collected from. The figures refer to deaths from all causes. It was not easy to get conclusive and exhaustive data on deaths due to HIV/AIDS. Indeed a KNUT official from Kisii observed that,

'this is a sensitive issue as no one will tell you openly that teachers have died. We know the exact number of teachers who have died, but we do not know the exact number that has died of AIDS'.

The same was observed by an Assistant Chief in Mombasa, who stated that, "teachers are dying but we have no report about causes of death" (FGD 24).

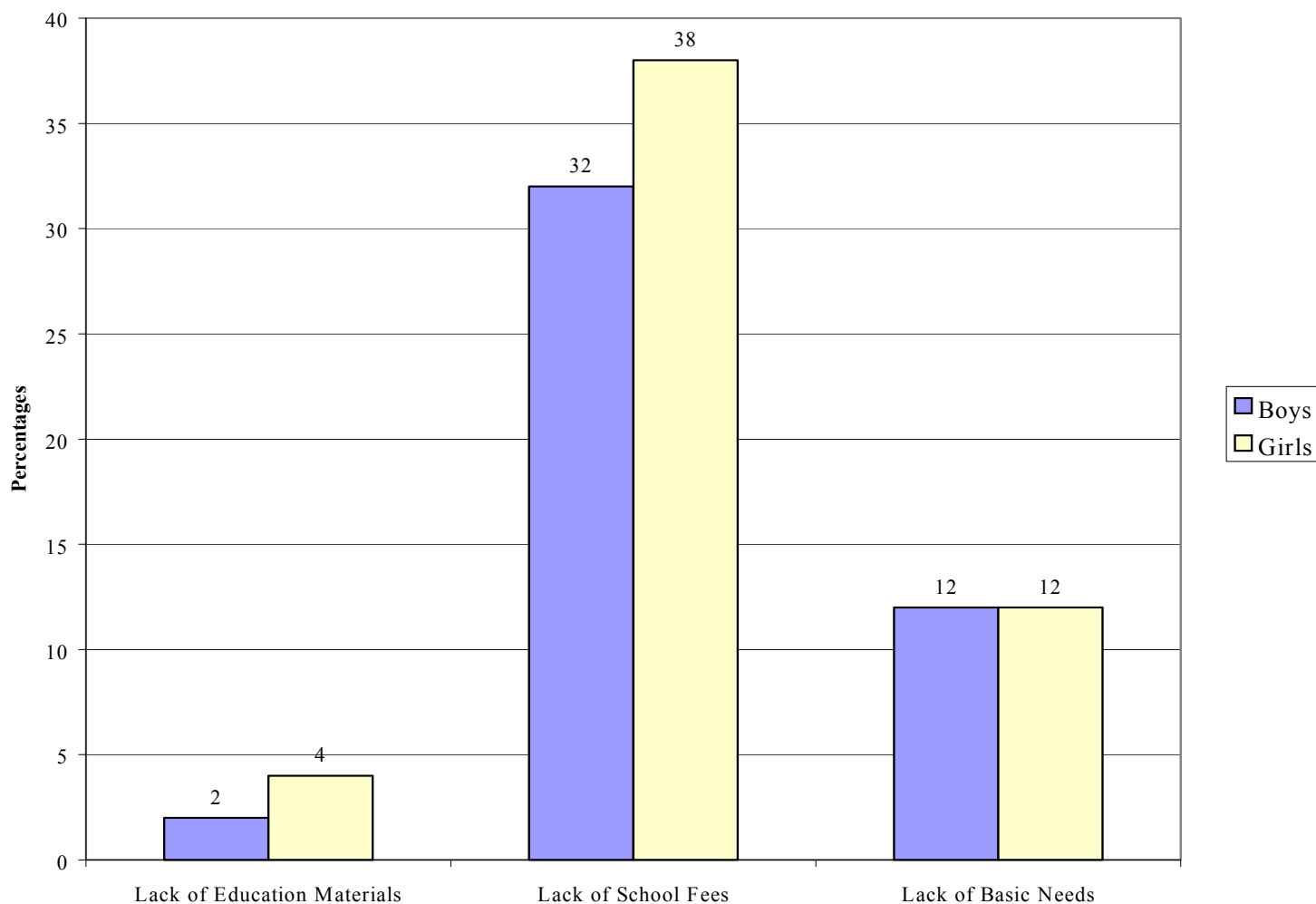
When an official from the D.E.O.'s office, Busia, was asked how many teachers are infected and have died of HIV/AIDS, he said,

'every week there is a burial. Two or three people are being buried. It affects the teaching fraternity. Once a teacher dies, the information is brought to me personally. Officially none of the deaths is associated with AIDS'.

An informant from the DEO's office Kisumu indicated that majority of the cases were HIV/AIDS since he had personal contact with most of them as they came for his assistance for transfers to their home areas or explain their long absence from their stations or seek sick leave. Headteachers of the schools visited indicated that they had lost some teachers over the past one year. Again it was not possible to conclusively relate the deaths to HIV/AIDS. Below is a table on teachers' deaths from some selected schools.

Table 11 Teachers deaths in the last one year as reported by headteachers in selected schools

SITE	NO. OF SCHOOLS VISITED	MALE	FEMALE	TOTAL
BUSIA	12	3	3	6
KILIFI	6	1	1	2
KISII	11	1	5	6
KISUMU	17	8	8	16
MACHAKOS	8	-	1	1
MOMBASA	14	1	2	3



NAKURU	7	2	1	3
THIKA	16	3	4	7
TURKANA	10	-	1	1
Total	91	19	27	46

From the 91 schools out of the 126 where school data was collected by the research team in the various study sites, headteachers reported that they had lost teachers due to death. A total of 46 teachers (19 male and 27 female) were reported to have died over the past one year. All the same, it was not possible to authoritatively isolate deaths due to HIV/AIDS. It is important also to note that teacher deaths were reported in all areas to have affected performance. The research team came across a case of a school in Busia where the headteacher died in 1999 reportedly due to HIV/AIDS. Prior to his death in 1998, the school performance was a mean score of 329 down from the previous three years' average of 350. The present headteacher attributed the drop to the fact that the Headteacher was sick and mostly out of school.

3.4.3.3 Lack of educational resources

To be able to pursue education effectively, pupils require school fees, educational materials such as books and uniforms and such basic needs as food, shelter and clothing. Johnston and Ferguson (1999) study on adolescent AIDS orphans in Rusinga, found that some 30% of adolescents dropped out of school because of family poverty and inability to locate funds necessary for books, uniforms and school fees. The results of this study show that 51% of the boys and 46% of the girls among the 186 pupils indicated that HIV/AIDS had led to lack of educational resources. Below is a table summarising pupils' perception of lack of resources as an outcome of HIV/AIDS.

Table 12 Perception that HIV/AIDS has led to lack of education resources by gender and region by percentage N = 186

	Lack of educ.	Lack of fees	Lack of basic	Total
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	Materials		needs	
Boys	2	32	12	46
Girls	4	38	12	54
Total	6	70	24	100

From the above table, it seems that lack of school fees was seen by most pupils as one of the impacts of HIV/AIDS on the availability of educational resources. 70% of all the children in the study areas mentioned that HIV/AIDS had led to a reduction of educational resources by way of lack of school fees. These results may suggest that HIV/AIDS may have resulted into a reduction in the amount of resources available to support education in the country. Pupils as well as community leaders indicated that there is increased shortage of school fees and other school materials for pupils; children basic needs are not being adequately met and that the community's capacity to participate in education has been reduced. HIV/AIDS was also being seen as leading to a diversion of resources away from education.

Boys and girls from both primary and secondary schools in the sites in which the study was carried out stated that when HIV/AIDS infects and kills their parents and/or guardians, pupils and students have to leave school because there is nobody to pay school fees and levies for them. Also boys and girls from Kisumu, boys from urban secondary schools in Thika and a primary school boy from Garissa indicated that with parental death, there results a lack of material support by way of school books, uniforms and any other materials required for learning in school. An Education Officer in Turkana put it thus, 'as it is many parents are unable to pay school fees', while a key informant from the District Education Office in Mombasa stated that uniforms are not bought when parents are infected.

3.4.3.4 Reduction of community participation in education

HIV/AIDS has also led to a reduction in the capacity for communities to support education. The 1999 World Bank report on 'HIV/AIDS and the education sector in Kenya' indicates that families affected by the epidemic will have fewer resources available for supporting education. This study's results show that pupils' perspective on this aspect was that a lot of resources are presently going towards curbing the spread of the disease as well as killing people who could be working for the prosperity of education. This is a position which was expressed by secondary school boys from urban Nakuru, Turkana, Garissa and Machakos urban and girls from urban secondary schools in Busia and Nakuru.

It was also felt that money is being spent on medication for those infected by HIV/AIDS instead of education. This was expressed by both boys and girls from secondary schools in Thika, secondary school boys in Kisumu, Machakos, Kisii, Turkana and secondary school girls from Nakuru urban areas. The general view was that the resources going into medication and control of HIV/AIDS could have been spent on improving education. For instance, a 16 year old secondary school girl from Thika stated, 'Money used by the parents to buy drugs could have been used to take their children to place of higher education'.

These results are similar to those of Carr-Hill, Kataboro and Katahoire (2000:11) who found out that,

'Most of the family resources are saved in order to cater for sick parents and members of the family. The medical costs for AIDS related diseases have been observed to be high and unaffordable to many families in the developing world. The tendency has therefore been to withdraw resources from other family expenditure, including education to take care of the medical costs'.

Pupils also felt that HIV/AIDS is also resulting to wastage of resources. Secondary school girls from Thika, secondary school boys in Kisumu, Garissa and Turkana, felt that as pupils become infected, they have to drop out of school and this is as if money has been wasted on their education because society will not benefit from their education. Indeed, boys from Thika, Kisumu, Kisii, Turkana, and Nakuru put it that AIDS is killing future professionals hence a waste. A Catholic priest in Turkana stated that "AIDS is taking

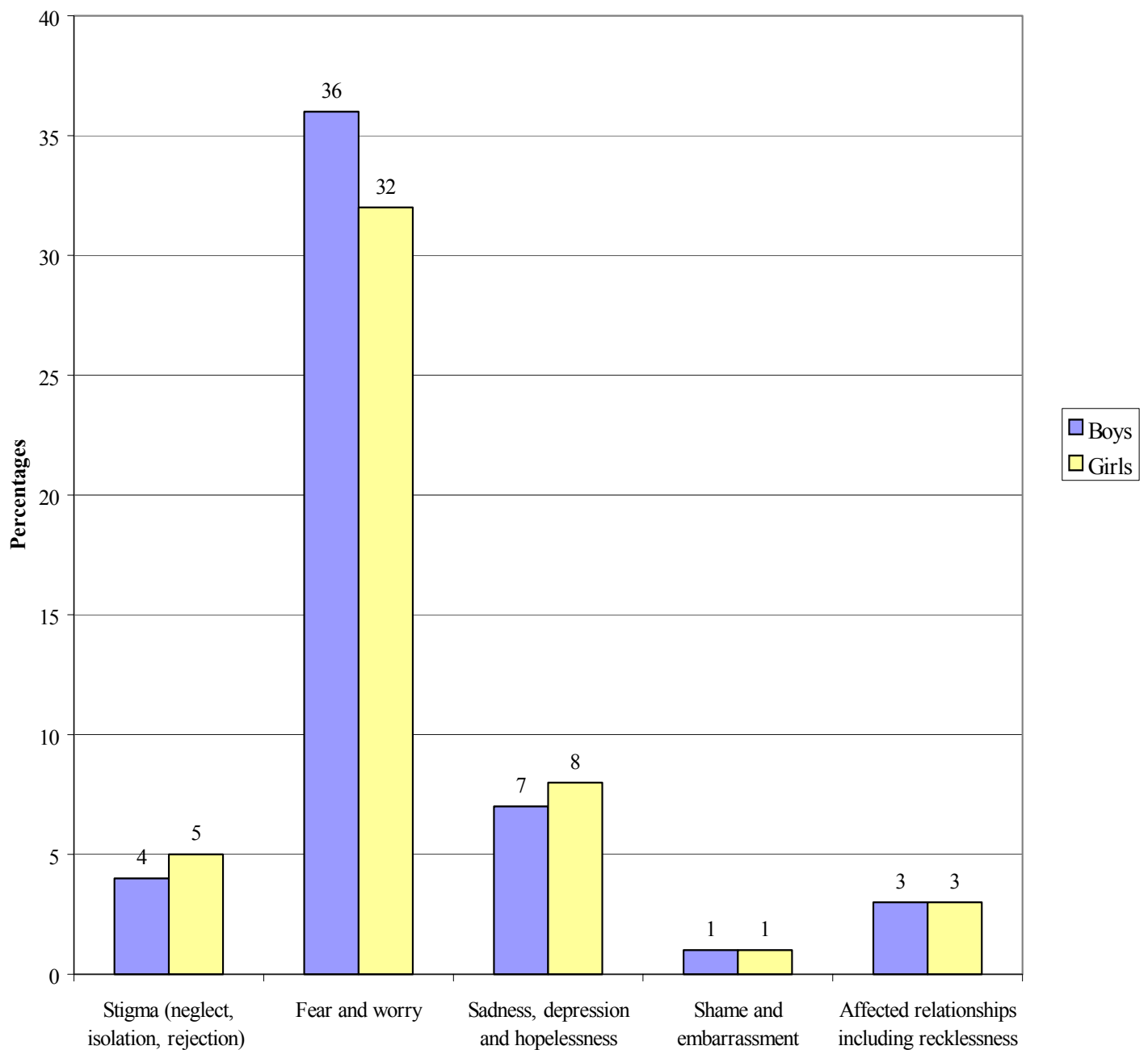
the intelligent in the society, including teachers". Also, wastage of resources occurred where parents have to employ teachers to replace those who are dying, a situation which would not have been if there was no AIDS. This is also according to an opinion raised by a Kisii community leader. It therefore may be deduced that HIV/AIDS may have resulted into a reduced capacity of communities to support education.

3.4.3.5 Perception that HIV/AIDS has had psycho-social impacts on school children

Data from children as well as key informants from the various study sites indicate that HIV/AIDS has a wide range of psycho-social impacts on children. These include stigma, fear, depression, shame, anger, guilt and recklessness among others.

Table 13 Proportion of boys and girls who mentioned various psycho - social impacts of HIV/AIDS on learning N = 909

	Boys	Girls	Total
Stigma (neglect, isolation, rejection)	4	5	9
Fear and worry	36	32	68
Sadness, depression and hopelessness	7	8	15
Shame and embarrassment	1	1	2
Affected relationships including recklessness	3	3	6
Total	51	49	100



Of the children from all the study sites who wrote essays on 'How HIV/AIDS had affected our learning', 51% were boys while 49% were girls. Fear and worry was the most mentioned psycho-social impact of HIV/AIDS on education by the majority of the pupils, that is 68%.

3.4.3.6 Fear and Worry

Pupils from all study areas were of the view that HIV/AIDS has resulted into them suffering various forms of fear. They indicated that they are increasingly worried. All this it is feared may affect their learning. Foremost, pupils reported that they fear contracting the disease through sharing school facilities as well as learning in a school where a person has died of AIDS. These were fears expressed by boys from Thika urban secondary schools, girls and boys from Nakuru urban secondary schools. Pupils also indicated that infected pupils fear and worry what their friends will say about their infection and when they start suffering the associated illnesses and eventual death. They worry that when other pupils know of their infection they will victimise them. Equally, they worry about their impending death. Consequently, because of this scenario, a secondary school boy from Mombasa said that infected children run away from home. Girls from rural secondary schools in Busia and boys from Turkana had the same sentiments. Again pupils worry

about their future when their parents have died of AIDS. A 12 year old primary school girl from Thika said,

'When your mother or father dies of the virus, you cannot listen to the teacher because when he or she is teaching, you keep on thinking of them'.

The net effect of all the fear and worry may be said to be that pupils may not concentrate in their school work. Their relationship with their peers and teachers will most likely be impaired. Consequently their performance in school will suffer. Generally, children living in a world with AIDS are subject to many situations of fear and worry. These include fear of increased responsibilities in and outside the home when parents are sick; fear of their parents dying and what will happen to them thereafter and fear and worry that they are also likely to get infected by HIV/AIDS. This fear and worry translates into uncertainty and it diverts pupils' energies away from education.

3.4.3.7 Stigma

According to Kelly (2000) children from families which have experienced AIDS may find school attendance hateful and repellant because of the AIDS related stigma and scorn that they may have to endure. The trauma is accentuated for children who become aware that they will soon be orphaned. The stigma experienced by pupils takes the form of isolation and rejection by other pupils for fear of infecting them. Also it takes the form of mistreatment and neglect for those affected and or infected with HIV/AIDS. Affected children are abandoned by relatives and the community at large as outcasts. The children in turn feel unwanted and unloved.

In Thika, girls from urban and rural secondary schools reported that affected and infected pupils suffer rejection by the classmates who do not like associating with them. A 16-year-old secondary school girl from Thika stated that,

'An infected school boy or girl has no peace in school. Other students don't want to associate with you. They treat you like a plaque that has invaded them. This leads to depression, stress and to some extent suicide that brings a stop to your life. Once you get the virus into your blood stream one is prone to many diseases that will keep you out of school for a while. This distracts your school learning programme. If a student is known to be having it, he or she is sent out of school because the staff believe you are a threat to the society'.

Turkana secondary school boys indeed reported that when infected, others run away from you. They are also abandoned by relatives and community. The boys from urban primary and secondary schools feel harassed in school by fellow students because their parents have died of AIDS. They also reported that the affected pupils are sent away from school because teachers fear they might infect other students. The same is reported by secondary school boys from Turkana, Garissa, Kisii and Mombasa and by boys from primary and secondary in Kilifi. Indeed a 16-year-old secondary school girl from Thika reported that even when it is known that your parents have AIDS, you are likely to be sent away from school. She said,

'If the teacher knows the parents of the child are sick, they may send away the child reasoning or claiming that the child will spread the disease in school'.

The stigma associated with AIDS is also such that infected pupils may be sent away from school and or not admitted to any school. Affected pupils are also teased about their parents' illness. A 13-year-old primary school boy from Thika reported,

'Sometimes when you are in school you may be harassed by your fellow students that your mother died of AIDS and also when you are being taken from school to school you are being send home because the teachers say that you might infect your fellow students with HIV. In some other community, you can be banned and if your mother or father died of HIV you might also think that you have it and try to commit suicide'.

Primary school girls from Kilifi and Busia indicated that no teachers can agree to teach a pupil who is infected. Consequently, infected pupils are sent away from school. On the other hand, pupils also fear teachers who are infected. These views were confirmed by key informants in Thika who reported that children fear infected teachers thinking they can get HIV/AIDS. An official from the DASCO office in Kilifi observed that children are stigmatised. He said, 'they see their parents going down and then other children go on to shun them'. A farmers leader in Kilifi also observed that orphaned children are lonely and therefore psychologically affected.

3.4.3.8 Sadness, depression and hopelessness

The perceptions of pupils and students from all the study sites was that HIV/AIDS has created a situation where children are suffering sadness, depression and hopelessness. This is being caused by death of parents and friends as well as the many problems and suffering in the wake of HIV/AIDS. They are quite uncomfortable and lose morale to work hard in school. Boys and girls from secondary schools in urban areas in Thika and Mombasa and secondary school boys from Kilifi rural and Garissa, and boys and girls from rural secondary schools in Machakos reported that infected pupils become depressed and demoralised when they realise they are infected as they see they have no future and leave school. Pupils also stated that they felt hopeless when their parents die. Their heart is broken especially given the possibilities of quitting school. These were views expressed by primary and secondary school girls from Thika and secondary school girls from Mombasa. Again because of the hopelessness accompanying HIV/AIDS, pupils reported that infected pupils feel like they want to kill themselves especially because people tease them and therefore feel that they have no life. A 15 year old primary school girl from Busia stated, 'HIV/AIDS has made many of us to stop learning in such a way others want to kill themselves before it can cause serious illness'. Another student, an 18 year old secondary school boy from Kisumu put it thus, 'Many students who have HIV/AIDS have committed suicide to escape the real life situation'.

They also feel like committing suicide because they feel unwanted and unloved and also want to do this before people know of their infection. These views were expressed by secondary school boys from Garissa, primary school boys from Machakos, secondary school girls from urban areas of Kisii and Mombasa primary school girls. Indeed a 15 year old secondary school boy from Garissa also indicated that some parents may want to kill their infected children. He stated that 'Many children have been infected by the disease and if the parent saw the student is having a disease they will destroy (kill) the person and will not take care for them'. However, the issue of committing suicide before people knew of their infection was very prominent amongst primary and secondary school girls in Busia and boys from Turkana. Indeed Turkana boys indicated that they felt hopeless and humiliated about infections. Below is an essay written by an 18 year old secondary school girl indicating hopelessness experienced by an infected child.

(18 year old secondary school girl, Kilifi)

3.4.3.9 Shame and embarrassment

Children reported that they are suffering shame and embarrassment as a result either being infected and have to learn with others not infected or when their parents have the disease. They also feel that it is shameful to die from the disease. The children generally felt that AIDS gives a bad image to people and the school where infected children are learning. These views were expressed by secondary school boys from Garissa and Mombasa, and secondary school girls from Busia and Thika.

3.4.3.10 Affected relationships

Perception of pupils and community leaders in all study areas was that HIV/AIDS has affected relations at the family level, in the school and also amongst the pupils themselves in school. The net effect was reported to be poor participation and performance in education. For instance, a 15 year old primary school boy from Garissa said, 'It also affected the interaction between school pupils suspecting that they are AIDS victims and cutting their friendship'. Secondary school girls from Thika reported that because of HIV/AIDS, parents no longer trust the relationship between boys and girls. Due to this mistrust, the relationship between children and parents become strained resulting to children running away from home. Consequently, they do not attend school. The pupils really felt this disappoints parents. This was reported by primary school girls from Kisii and secondary school girls from Busia.

A KNUT official from Kisii indeed observed that, 'this is a dreaded disease especially when you are with somebody who is infected. The pupils fear a teacher who is infected. Their concentration in learning is limited'.

It was also reported by the students from Thika and Kilifi also said that relationships between students have been affected in the sense that other students do not associate or discuss with those infected.

Relationships between pupils and teachers in schools have also been affected. This was expressed by secondary school boys and girls from Thika and secondary school boys from Kilifi. Their observation was that where a teacher is infected, students minimise their relationship with that teacher and therefore learning is affected..

3.4.4 Perception that HIV/AIDS has not affected education

It is also significant to note that both primary and secondary schools boys and girls from Garissa reported that their learning has not been affected by HIV/AIDS. This was reported by four primary school boys, one primary school girl, ten secondary school boys, and five secondary school girls. Some secondary school boys in Garissa also reported that they do not know anybody in their area who has been affected by HIV/AIDS. The general view amongst most of the children and some of the adults was that HIV/AIDS was a curse from God.

3.4.5 Positive impacts of HIV/AIDS

Pupils also indicated that as a result of the HIV/AIDS some positive aspects on children may also be noted. These include that HIV/AIDS has led many pupils to be strict children, that is careful. It has also made children to withdraw from pre-marital sex; and some of the children may become street boys/girls because they want to help themselves. Indeed an 18 year old secondary school boy from Kisumu reported as follows: -

<p>'HIV/AIDS has also affected children's learning as it has made them cautious and careful when trudging in different paths. For example, in the sharing of clothes, this has in effect improved the children's learning in basic health and hygiene. HIV/AIDS have also affected learning by making children aware of its causes and spread and the risks therein, when one is exposed to it. This has made children more withdrawn from pre-marital sex, that is not only dangerous but also a great sin. In this, the student relationship have been checked, so that they do not lead into the spread of the dreaded disease. HIV/AIDS has also cemented</p>

families together guiding them to live as a unit at home. This has encouraged learning while at the home and school environment.

HIV/AIDS has also affected learning by impacting various virtues that are good for the youth. For example, the people became more sensitized on values such as harmony, honesty, and perseverance that boost the general spectrum of education as a whole.

HIV/AIDS has also brought into light morality as a key issue in education. This has further offered a boost on education as children's morals improve after hearing or learning about the dreaded scourge and its effects on the development of an individual, physically, spiritually and psychologically. As a result of this, people look forward to role models who are morally upright and have a settled lifestyle'.

(18 year old secondary school boy, Kisumu)

From the testimony, it can be deduced that, HIV/AIDS may have resulted into bringing to light the issue of morality in education. It seems like it is the prayer of this 18 year old boy that as pupils adopt upright virtues, education will produce pupils who may serve as positive role models.

3.5 ROLE OF EDUCATION IN STOPPING HIV/AIDS

3.5.1 Perceptions of education

The Government of Kenya's commitment to achieve universal primary education (UPE) by the year 2000, (Republic of Kenya - 1994) may not be realised. In primary schools, the Gross Enrolment Ratio (GER) has been on the decline since 1989. In 1989, the enrolment was 90.6%, in 1990,1991,1992 and 1993, it was 88.6%, 88%,87.7% and 84.6% respectfully. The state of the World's Children 2000 has the gross enrolment ratio in primary schools in Kenya as 85% (1997).

Secondary education has recorded a decline in GER over the years as well as fluctuations in absolute enrolments and number of institutions. From an enrolment of 30.2% in 1990, it had declined to 22.9% in 1996 (CESA Report 1999).

The report identifies the underlying factors for this decline to be poverty, introduction of user fees in public sectors and population growth rate. Households are making difficult choices about investing in education and instead they are concentrating in short-term survival areas like food, security and income generation.

In an instrument administered to groups of children aged 10-17 in primary and secondary schools, males and females in Garissa, Kisumu, Machakos, Mombasa, Thika, Busia, and Turkana, children were asked their perceptions of Education:

Responses were in answer to the statement: 'What I think and feel about learning'. (Instrument 16 - an essay). Responses were categorized as follows: -

3.5.2 Importance of learning

Children from all the regions identified learning as a means to get a good job, acquisition of skills and knowledge, developing of good behaviour, promotion of dignity and respect and that it enables choice of career. Two boys from Garissa said:

'Learning brings unity among people of different ethnic groups'.

Other respondents said they felt great when they learn new things and when their relatives are learned.

3.5.3 Benefits of learning

Respondents from all the regions identified various benefits that accrue from learning. From Thika and Mombasa, children said learning was fun, adventurous and interesting. Learning enables them to discard ignorance and develop talent. Respondents from all the regions identified learning as the sure way of good life in future for it ensures that one gets a job and earns a living.

Respondents from all the regions said they felt comfortable when with others. When they learn and pass exams, they are able to socialize and interact well with others without feelings of prejudice.

Do all children learn?

Children were asked whether they all go to school or, if there are others who do not go. They gave similar responses that not all of them go to school. Asked why they don't go to school, respondents in Turkana, Garissa, Kisii and Thika identified lack of fees and parents' unwillingness to take them to school - suggesting lack of proper parental guidance.

In Mombasa, children wrote that coming from a rich family background was a reason why some children opt not to go to school. Children also reported that beach attractions were responsible for non-enrolment in school as children preferred to work on the beach, which assures them of an income. The loss of one's parents was said from all the regions to be responsible for non-enrolment in school. In Garissa, parent's capacity of supporting children's education was said to be lacking, as their parents didn't see the importance of education.

Decision making and school rules

Children were asked whether they were involved in making decisions on matters affecting them or what they thought of the decisions made for them. Apart from Mombasa, the rest of the respondents said they are not consulted. Even in Mombasa, they are only consulted when they intend to make educational trips - and this is when they have paid for such a trip. In Garissa, children said that teachers do not respect them and that they are not allowed to argue with them.

Children in Kisii said that education in this country is affected by leaders who have tribalism, that learning is complicated, and that the 8-4-4 system is a burden. Some of the respondents reported that they felt teachers were only preparing them for examinations but not the future.

Participation in learning process

Respondents when asked what they thought about participation in education, said that it is great to go to school, and that learning is like a trip which is long but the end is good. They however noted that it is difficult for orphans to be enrolled in schools, the orphans are therefore not able to participate. Respondents from the regions said that they felt good when in school and that it is comfortable. Only one respondent from Turkana, a boy, 17 years of age said that:

'School is a place to waste time and that it requires things which are costly'.

3.5.4 Role of general education

At the school level

In a briefing paper UNAIDS (1999) 'key ideas and issues of action', the education sector is seen as a tool for spreading HIV/AIDS information and awareness. It often receives the lions share of public revenues and is usually the major employer of public staff in a country. If the education sector was effectively used as a channel of promoting HIV/AIDS awareness, one could reach a very large audience. Not only could teachers and administrative staff in the education sector be reached, but also pupils at all levels, their parents and extended families.

The education sector represents an already existing infrastructure and the use of it as a channel for promoting HIV/AIDS education would hence be cost-effective compared to other innovations, provided that sound planning and administration is catered for. Teachers need to be appropriately trained for the successful integration of life skills and AIDS education as well as working with peer educators. The above observation corresponds with responses that children gave in the regions visited when given an essay to write on; "How education can be used to stop the spread of AIDS" (Instrument 6). The children's responses were categorised as follows:

3.3.5 Integration of AIDS education into other subjects

Children from Busia Garissa, Kilifi, Kisumu, Machakos, Mombasa , Thika and Turkana recommended that schools should have subjects tailored towards HIV/AIDS education and incorporated in the curriculum.

In all the regions mentioned, a total of 144 out of 626 respondents made the above recommendation suggesting that HIV/AIDS was not taught in schools. There is therefore need to refocus and integrate AIDS education into various subjects. The subjects suggested include; Social Education and Ethics, Christian Religious Education, Biology, Home Science and the languages.

3.3.6 Introduction of AIDS education as a new subject

The children's main concern is that not much emphasis is given to the teaching of HIV/AIDS in schools. This was strongly expressed by a 17 year old boy from Mombasa, who said;

'Education is one of the most surable way of controlling AIDS because the people who are mostly vulnerable to this disease are the youth who are currently at the age of 15 - 24 and who are learning. Through schools, youth are taught various subjects which help them in future and thus when they are taught about AIDS in school, they tend to follow the advice given to them and do not engage into activities with would make them contract the HIV virus'.

3.5.6 Introduction of sex education, sexuality and moral teaching.

The lack of sex education in schools cited by children has brought out the fact that children do not feel adequate to help stop the spread of the virus. 31 respondents out of the 626 interviewed indicated that through sex education, they could learn good behavior and ways in which they could fight HIV/AIDS. One particular girl aged 15 years from Thika said;

'Sex education should be introduced in the syllabus so that when we as leaders of tomorrow understand the dangers, we can lead our country out of AIDS'

Use of resource persons in schools

The use of resource persons in schools was also identified as a way of stopping the spread of HIV/AIDS. Children cited doctors, health workers, specialists and other professionals being invited to give talks within the schools. This was a recommendation that was made by children from each region. Out of the 626 respondents, 53 children advocated for the use of resource people in schools. From this same number of

respondents, 1 child had never come into contact with an HIV/AIDS infected person, or even seen one. There was therefore the desire that such a person be invited into schools to talk to pupils and narrate to them their experiences. This seemingly would have a greater effect on the pupils in helping them either change their behavior or spread the word about the dangers of the disease.

Inter –school activities

Participatory methods have been recognized as bearing fruit in approaching HIV/AIDS issues (UNDP 1999), in a paper on "Adolescent, sexuality, gender and HIV epidemic". Children feel activities like drama, poems and games are valuable in gaining knowledge and information about HIV/AIDS.

Twenty children out of a total of 626 felt that in educational institutions, discussions on AIDS should be encouraged and made open in various club activities like debating, drama, plays and poems. This, the children suggested could be a vehicle to pass on AIDS messages.

Enter-education_

Among the tools that children cite as important and powerful in educating people in the prevention and control of HIV/AIDS are puppetry, song, dance, drama, poems and stories. This is a new and entertaining method of passing information, yet very real. One respondent said that as they act in plays, it becomes like real life and they fear it. Participatory methods such as dance and drama are effective ways of spreading information, and may help both actors and audience to name important experiences and issues. The use of participatory methods is supported by research findings from Uganda (Carm et al 1999), and are therefore encouraged.

Guidance and counseling in schools.

The role of guidance and counseling in the prevention and control of HIV/AIDS was identified as an effective channel for HIV/AIDS education. 41 children from Kilifi, Thika, and Machakos pointed out that guidance and counseling enables them to distinguish between good and bad. These children suggested that teachers should strengthen guidance and counseling centers in schools especially in rural areas.

Effective/creative time use

Having too much free time and nothing constructive to do was cited as a channel for getting into bad company and engaging in behaviour that put people at risk of HIV/AIDS. This was a sentiment that was expressed by 11 respondents from Busia, Garissa, Kisumu, Mombasa and Thika. These same children also advocated that parents and teachers should give them a lot of work so that they are not left idle. Being busy both at home and at school would check their movement and they would not engage in loitering about.

Teacher education on HIV/AIDS education.

The government recognizes that reaching young people with information on HIV/AIDS is an important step in dealing with the HIV/AIDS epidemic (MOH<1997,1999). The government however has not done much in training teachers to specifically teach AIDS education. In a report Carr - Hill et, al (2000) on HIV/AIDS and education saw the need for training of teachers and education managers as the keys to success if schools are to become an open channel for information. However, the issue of HIV/AIDS requires a different methodology from the usual curriculum. Most teachers therefore need to be trained to use new material, to handle new curricula, and not least how to communicate with children and adolescents.

HIV/AIDS touches very sensitive issues and taboos like sexuality, power relations and gender equity and thus requires a sensitive approach. Participatory learning and teaching techniques where discussion, communication and action are the focal points is a fruitful way of approaching the issue of HIV/AIDS. One way of preparing teachers for this new methodology is to train them as peer educators, practising participatory methods to train the pupils as peer counsellors. This was the sentiment expressed by children in Busia, Garissa, Kilifi, Kisumu, Mombasa, Thika and Turkana.

Out of the 626 children in the above-mentioned regions, 15 advocated for specialized teacher training. One child in Thika, a boy aged 17, was the only respondent who said the government should employ people to teach HIV/AIDS, and that these people should be well trained.

Offer free education

The offer of free education with provision of free books, pencils and pens especially in primary schools was a suggestion given by respondents in Thika, Kisumu and Busia. A total of seven children out of the 626 interviewed were of this opinion. In addition, they suggested that girls need to be given special education so as to give them the will to resist temptation. Also that youth need to be provided with all they need to avoid engaging in sex.

Mass education.

Mass Media Education was also identified as one of the channels through which education can be used in the prevention and control of HIV/AIDS. Books and magazines were cited as one of the tools that are easily accessible to most people. It was suggested that libraries be established and equipped on the subject. Authors should also write books in a language that is understood by everyone. Sharing educative films and videos in schools would also educate pupils in schools. The use of radios and television should also be employed to change attitudes.

Peer Education

The youth perceive some of the HIV/AIDS messages designed by adults as ignorant of their life styles and likely to send incorrect information to them. Table 14 shows how the youth may perceive some common messages on how to protect oneself from HIV/AIDS. (Daily Nation, 22/03/2000).

Table 14 Perceptions of Youth on some common messages

Message	Shortcoming
1. Wait until marriage to have sex.	Implies you can only get infected outside marriage. How about infected married people?
2. Avoid unprotected sex.	Some youth who have had unprotected sex may think they are automatically infected and continue in risky behavior.
3. Be faithful to your partner.	The youth often have many short-lived relationships.

The youth in this case feel that although adults have the right information, they often fail to address the issue of changing times, a situation that creates a generation gap.

There is also a bond among peers that was cited by children in Kisumu, which they said, is crucial in the fight against AIDS. They talked of being able to advice each other to abstain from sex better than their parents would advice them.

At the home level

In traditional African societies, parents played a pivotal role in educating children on appropriate gender roles but the task of educating children was relegated to peers, selected elderly men and women, grandparents and persons acting as guardians to initiates (Njau, undated).

In contemporary Kenyan society, parents play a minimal role in teaching children about sex and sexuality. (AMREF, 1998 and NCPD 1999). The children are exposed to information about sexuality mainly through their peers, teachers, mass media and other social networks. In an instrument administered to 626 children aged 13-17 in eight regions namely Busia, Garissa Kilifi, Kisii , Kisumu, Mombasa, Thika and Turkana, children were asked to write an essay on ‘How education can be used in the prevention and control of HIV/AIDS.’ In Thika, (this was the region with the highest number of respondents) out of the 192 children who responded to this question, 12 girls and 16 boys said that children should listen to what parents and teachers say about HIV/AIDS, both at home and at school respectively. In Mombasa and Kilifi, five boys out of a total of 126 children said that sex education should be taught both at home and at school.

11 respondents in Thika and two out of a total of 51 children in Kilifi said there is need for family members to open up and discuss HIV/AIDS matters with them. One particular response from a 13-year-old girl in rural Thika reflected the need for parents to give clear education on sex and HIV/AIDS. She said; ‘.....I would prefer to prevent it, before it gets worse, as you know; prevention is better than cure

At the community level

Community Institutions (mosque, church, duksi)

The community plays a great role in educating people on the prevention and control of HIV/AIDS. People have been educated through co-operative societies, family welfare societies, church groups and schools. 18 children across the research regions advocated for institutions to be established to educate people. Those in rural areas, it was suggested, were to be reached through schools, churches and public hospitals. Seminars were also to be organized to advocate for abolition of some cultural practices. Wife inheritance and circumcision. These are some of the practices that were cited as predisposing people to HIV/AIDS.

NGO/CBO training

The Ministry of Education, Science and Technology, NGOs and other government departments are involved in carrying out the strategy of educating youth in and out of school. The Kenya Institute of Education (KIE) has also made considerable attempts towards integrating AIDS education into school curricula, training of identified beneficiaries and introduction of peer education to such groups as teachers' associations, youth leaders and groups.

Four respondents in Busia, Mombasa and Thika reported having knowledge of NGO/CBO training going on, and reported that they played a major role in creating awareness and educating children and the public at large.

Adult education

Adult education was another important channel of education that was mentioned. Children in Busia, Mombasa and Thika reported that the aged or mature people did not believe in the existence of AIDS. It was suggested that these people be given education about HIV/AIDS in schools established by the ministry, specifically for mature people. Education they receive would enable married couples to remain faithful and illiterate people in remote areas would be reached.

Resource persons

The role of professionals such as doctors and counselors was indicated to be concentrated in hospitals. The children felt there was a great need for the professionals to organize some outreach programmes at the village level to educate people on the dangers of the disease.

Community education

This was about sensitizing the community at large. Everybody was to be included, including bus touts, street children, hawkers and vendors. Through sensitization, people would adopt modern ways of preventing the disease such as use of condoms. People would also learn to be more self controlled. This would be achieved through having face to face conversations with knowledgeable people. Here teachers and elders in the society have a role in making sure information gets to everybody around them.

People were to be encouraged to participate in National AIDS days, seminars and essay writing about the disease. The government was encouraged to organise and fund projects such as the seminars and the essay writing. 144 respondents out of 626 identified the government as one of the channels to be used in educating people to do away with traditional practices that put people at risk of HIV/AIDS. They cited it as having the necessary machinery to reach a reasonable number of people in remote areas where many times information is lacking.

Another way in which people could be reached is by setting up guidance and counselling stations, where infected people could learn how to live with the disease and the affected people, how to live with AIDS victims.

Campaigns

AIDS awareness campaigns both in school and in the community was another method reported, of reaching large numbers of people. Through these campaigns, students were given a chance to actively participate and give their views, and at the same time, pass messages to people. It is as a result of these campaigns that AIDS associations and clubs were set up.

The use of students in campaigns was cited as a very effective way of passing information to people. One boy, 18 years of age in Form four from Busia said;

'The students should also be given a chance to participate in AIDS Awareness Campaigns and also give their views concerning this epidemic and as such they will develop a positive attitude towards matters concerning this deadly disease'.

Campaigns however, are not a method that was mentioned in all the regions. 16 children from Busia, Garissa, Kisumu and Turkana out of the 626 interviewed talked about campaigns as a way of educating people.

Mass- media

The Kenya Demographic and Health Survey (KDHS) 1998, after interviewing 7,881 women aged 15-49 years and 3,407 men aged 15-54 years, found out that the most single common source of knowledge about HIV/AIDS is the radio. This study found out that 73% of the women and 87% of the men interviewed said they get HIV/AIDS messages from the radio. The next most commonly cited source of HIV/AIDS were newspaper for men (42%), and friends and relatives for women (56%). The study generally found out that men obtained their HIV/AIDS messages through the mass media and work place, while women on the other hand are likely to receive these messages from community level networks, for example churches, friends, schools and health facilities.

This survey only used one instrument, a questionnaire, targeted households and not the youth and children. It also did not look at the impact of HIV/AIDS on education and how education to prevent and control the disease. It is rather difficult to compare the results of this study with responses of children from Busia, Garissa, Kilifi, Kisii, Kisumu, Machakos, Mombasa, Thika and Turkana, who stressed the power of mass media in educating and hence combating the spread of HIV/AIDS. These respondents aged 15 and above ranked print and electronic media as the best tools one can use to educate large numbers of people.

3.6 Role of HIV/AIDS education

How HIV/AIDS education can help stop the spread of HIV/AIDS

The introduction of HIV/AIDS education is observed in a report by Carm et al (1999) to strive for openness at school in order to help children communicate their experiences and knowledge about HIV/AIDS.

In three different instruments, children were asked to write an essay on, "How HIV/AIDS education can be used to prevent the spread of HIV/AIDS" (Instrument 17). Several other instruments sought to know what learners thought about HIV/AIDS education (Instrument 1B), and what teachers thought about what they taught in HIV/AIDS education (Instrument 1C).

The responses from the instruments were categorised as awareness, prevention and control, coping and caring for infected people, content of HIV/AIDS education and effects of HIV/AIDS among others.-

Awareness

Various responses from the regions visited identified AIDS education awareness as necessary in the fight against HIV/AIDS. In an essay, (Instrument 16 - list the things children can do to stop the spread of HIV/AIDS) children expressed the need to be shown programmes on how AIDS has affected human beings, the need to be given information on AIDS so that they could inform the immediate family members and the need to reach those in remote areas.

In Busia, a 17 year old Form 111 boy observed the same. He said;

'to me the only solution to HIV/AIDS is the introduction of its education in schools..... When HIV/AIDS education is introduced in schools, it will make the students to spread the message. For example, my tribe is actually pastoralists, and pastoralists usually move from one place to another. As a result, most of us (students) usually visit our families in the interior (bush) during holidays. Therefore, once I reach there, (for government and health officials don't never step in those areas) I will use my little education on the effects of AIDS to educate my people'.

Children also said that the youth can be told how to protect themselves through drama and songs which they like, books and pamphlets should be written and given to people to read and that cinemas and videos should be used to reach as many people as possible. The children observed that guidance and counselling stations should be set up where people can go and be educated.

An analysis of children's awareness, showed that out of 522 children , (116 boys and 238 girls), 360 reported that they were aware of the existence of the disease. They also knew about modes of transmission and how to protect themselves.

They further reported that creating awareness was a very important tool in helping to stop the spread of HIV/AIDS. Six children out of the 360 gave no information on awareness.

Prevention and control

Education was reported to be the major channel through which information on prevention and control of HIV/AIDS could be imparted. Children said , HIV/AIDS could be used in preventing and controlling the spread of the disease by, teaching married people to be faithful to each other, learning how to protect

oneself by use of condoms, avoiding pre-marital sex and avoiding abuse of drugs. The youth should be discouraged from watching pornographic material which arouses their emotions and passions, putting them at risk of irresponsible sex, young girls to be discouraged from using their bodies for material gain (prostitution).

Children suggested that people should be taught not to share things such as toothbrush, needles, syringes and razors. Children observed that prevention and control is being made difficult by peoples ignorance and obstinacy. A boy, 17 years of age observed that;

'...some people think that AIDS is a myth. What they believe is that they themselves can't get the disease but others. People like this one need the education abundantly to know that the disease can get anybody but not specified people.'

"..... some people think that AIDS is a myth. What they believe is that they themselves can't get the disease but others. People like this one need the education abundantly to know that the disease can get anybody but not specified people"

Other ways that children said could be used as prevention and control measures include: -

- Teaching people (men and women) to be faithful to one another.
- People should learn how to protect themselves, for example, by the use of condoms, abstinence, avoidance of premarital sex, avoidance of the use of drugs.
- Young girls are to be discouraged from using their bodies for material gain (prostitution).
- People should be self-controlled.
- People should be taught not to share certain things for example toothbrush, needles, syringes, and razors.

Coping/Caring for infected people

Responses across the regions indicated that children did not understand what coping meant. Instead, they were giving suggestions as to how one can care for infected people and in several instances they themselves wanted to know what to do when caring for infected

In Busia, urban boys age 17 years sought to know the following:-

- How to relate with HIV positive people.
- How to live with AIDS without infecting others.
- How to support those infected .

Similar questions also came from rural boys aged 17 years from Machakos. From Machakos also came a radical suggestion whereby the children talked of isolating infected people as a way of coping and a way of controlling the spread of HIV/AIDS.

Content of HIV/AIDS education

Quite a lot of information was reported by children in all the regions on what they learn in HIV/AIDS education. The respondents who reported receiving information were older children in schools, which suggests that teachers give children detailed information when they are already mature. (respondents from Kisumu, girls 17 years, Turkana, girls 17 years, Machakos, boys and girls and Mombasa girls 17 years.

On what they are taught, children identified, signs and symptoms of the disease, how it is transmitted, the traditional practices that expose them to HIV/AIDS, prevention, the effects, blood testing, good morals and how to care for the sick. This suggests that there is a need for the under 17 year olds, those who are entering puberty stage, to receive the same content early in life because studies in Kenya - Kahindo et-al (1997) shows the age of first sexual contact to be lower than 15 years, hence the need to start the same content early.

Constraints of using HIV/AIDS education

Across the regions where the instruments were administered, children did not report experiencing any constraints. The teachers, on the other hand, reported having constraints in carrying out HIV/AIDS education. The over crowded curriculum and lack of clear guidelines in the syllabus on how to teach HIV/AIDS was identified as the main constraint. Teachers expressed dismay that since the directive to teach HIV/AIDS education in all schools was issued, (Daily Nation 26th November 1999) nothing in form of circulars or guidelines have reached their schools.

HIV/AIDS education was also reported by teachers as being a controversial subject, and therefore, teachers did not feel free to discuss it or any other issues about it. This, the teachers observed was because talks that touch on sexuality is taboo in many communities. Coupled with the fact that there are cases of some of the children being affected, the teachers reported shying away completely from the topic.

Another constraint reported by teachers was failure by schools to establish peer-counselling groups. Peer counselling groups have been identified as the best channel in communication on HIV/AIDS (UNAIDS 1997). In addition, lack of resource books and other materials on HIV/AIDS in schools was said to be a handicap especially when teachers wanted to refer the pupils for further reading. The fact that some children are very young and may not understand what the teacher is talking about was also identified as a constraint. There was the suggestion that the younger children be taught in vernacular, a language they understood better.

The talk about condoms is a controversial issue especially with particular religious groups, hence teachers avoid such talks. Teachers also talked of demoralization from children whenever they talk about HIV/AIDS. Comments such as 'it is just like a cough hence we can die any time' are common, and thus demoralize teachers.

Effects of HIV/AIDS education on children

The effect that HIV/AIDS education is having on learners was given only by teachers. They said that children have taken initiatives and are looking for more information about HIV/AIDS, they are asking more questions and they get scared when they are shown a film on AIDS. Making some of them change their behaviour.

Teachers also identified negative effects that HIV/AIDS education has brought. They say students are bored when they are told about HIV/AIDS. The students assume they know and they laugh, hence they do not take the messages seriously. The adolescents particularly, are very difficult to counsel and girls become withdrawn, and they do not like the idea of stopping sex.

Subjects in which HIV/AIDS is taught

AIDS education content is not new in the school curriculum. This is because AIDS is one of the diseases that infect people and can be taught together with related topics in Science and Home Science. In view of

the importance of AIDS education in the school curriculum, the best strategy is to incorporate the AIDS education content in the existing subjects instead of creating a new subject. This is done through infusion. This means that AIDS messages are taught at appropriate points when the main subjects are being taught.

Subject and content of what is taught

In a focus group discussion with pupils (Instrument 1B) and with teachers (Instrument 1C), respondents were asked to name subjects where HIV/AIDS was taught. Table 15 shows the subjects in which HIV/AIDS is taught alongside the regular subjects in the areas the study was done.

Table 15 Subjects where HIV/AIDS is taught

Subjects	Regions									
	Busia	Garissa	Kilifi	Kisii	Kisumu	Machakos	Mombasa	Nakuru	Thika	Turkana
Science	✓	✓	✓	✓	✓	✓	✓			✓
Biology	✓		✓		✓			✓		
Social Education and ethics	✓				✓			✓	✓	
Home Science	✓	✓		✓	✓	✓	✓	✓	✓	✓
Personal Health	✓						✓	✓		
CRE/IRE	✓	✓	✓	✓	✓	✓	✓			✓
Kiswahili			✓							
Geography			✓							
Agriculture									✓	✓
GHC										
Guidance and Counseling	✓			✓	✓				✓	
Health Education		✓								
Others - TV,Church,Club.					✓					

Subject and content of what is taught

In all the regions visited children reported learning about HIV/AIDS. In Busia and Garissa, though it was reported that HIV/AIDS was offered, there were no records to show the content of what was learned. Children said it was only mentioned but not taught in detail. Teachers on the other hand reported teaching various topics which they identified as; causes, preventive and control measures, coping, care of infected, environmental diseases, abstinence, effects of the disease, treatment, signs and symptoms, physical and emotional development and cultural practices that expose one to HIV/AIDS.

Children's knowledge on HIV/AIDS

Except for Machakos and Nakuru children identified school as the place where they learned about the spread of HIV/AIDS, ways of control, history, signs and symptoms and its impact on education. Children from other areas blamed their teachers for being evasive and only mentioning the disease without giving details. They said their teachers were not well informed on HIV/AIDS issues and that they are confused about the use of condoms. On the one hand they are taught to use condoms as a means of protection, on the other the church tells them not to use it.

Children also said that some customs expose people to HIV/AIDS and these should be done away with. They also asked that information be extended to those who are not in schools as well as parents and that people should be faithful to one another.

Teachers express their feelings about what they taught in HIV/AIDS education. One teacher in Thika said, 'As I teach this, I am also in it - your husband maybe roaming around. One is also not very safe as you preach it to them. This is a major obstacle for teaching.' Other feelings the teachers had included:

- I don't like to teach about the final stage of HIV/AIDS as you may know a person who is going or is gone (Kilifi)
- Teaching is not in detail because it is not a topic on its own - subject not adequately covered.
- Teachers do not like teaching about symptoms as people in the community start pointing fingers at those who have symptoms.
- There is a general feeling that HIV/AIDS is not real.

What youth can do to control HIV/AIDS

Various responses cut across the sites visited concerning what youth could do to control HIV/AIDS. Among the responses were: -

- Peer counseling centers being set up to cater for needs of youth and children.
- The youth talked of not using adults who did not abstain from sex but were telling them to abstain. They need adults to set good examples.
- The youth talked of abstinence instead of using condoms.

A few radical suggestions also came up from the children on the control of HIV/AIDS. These were as follows: -

- Those infected should be injected to die quickly or made sexually inactive or separated from the society and given basic needs without family visits (Garissa and Thika).
- It is not easy to abstain from sex, condoms should be used, although they encourage youth to have sex, and their quality should be improved, so that they can be 100% safe (Kilifi).

Suggestions on teaching of HIV/AIDS

Teachers suggested that the best way they can give HIV/AIDS information and messages is by giving advice to girls one by one, make AIDS education a separate subject instead of integrating it into other subjects and availing materials to schools for the teaching of HIV/AIDS. Children in the lower classes should be taught in mother tongue and people infected with the virus, should be invited to give talks to pupils.

There were also suggestions to have teachers trained on how to teach HIV/AIDS within pupils' cultural context. Materials on HIV/AIDS need to be up dated and parents need to be given education to support HIV/AIDS programs in schools.

Changes in behaviour after receiving HIV/AIDS information

Asked whether they have seen changes among peers and friends since receiving HIV/AIDS information, children responded that they fear misbehaving with girls and boys and that they now use condoms. Young girls have become more provocative however, especially in manner of dress. In some places, behavior has not changed because there is a lot of peer pressure. Children are however aware and many of them practice self-control and self-discipline.

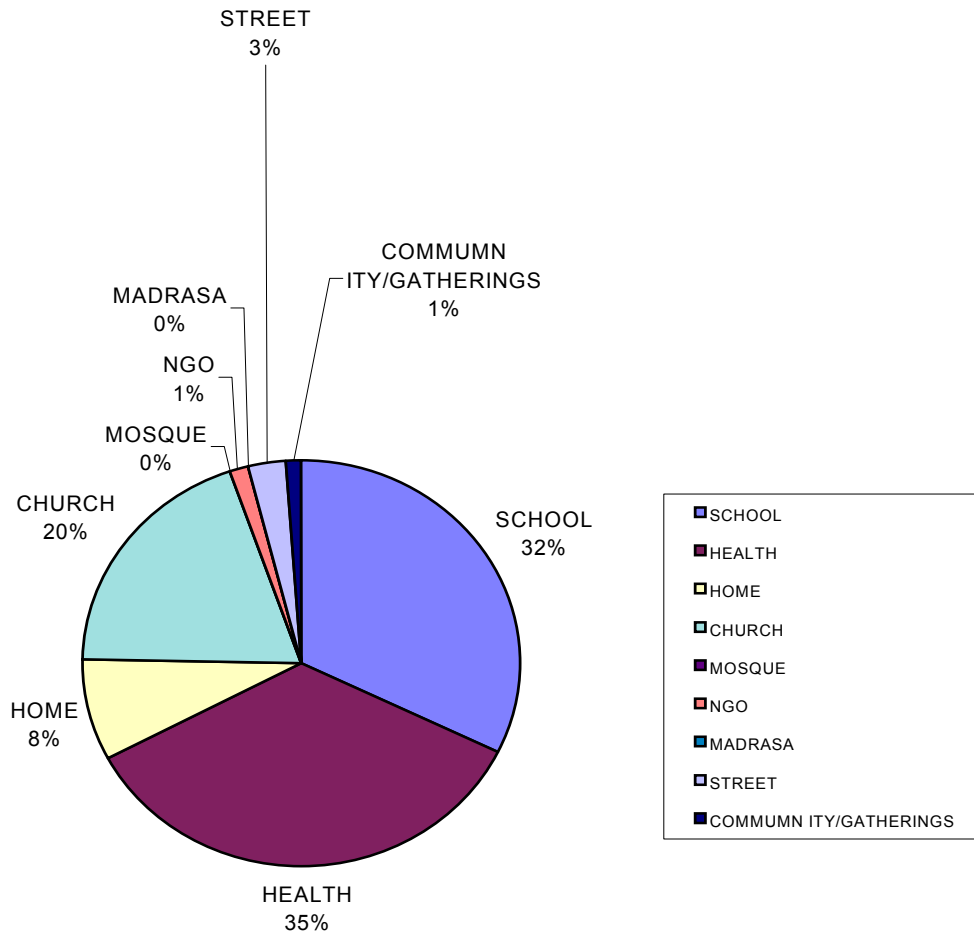
3.7 Role of information and messages on HIV/AIDS

A baseline survey conducted by Kenya Institute of Education (KIE) in 1994 to identify appropriate sources and channels of communicating HIV/AIDS education so as to interviewed consisted of teachers, students, sponsors and community leaders from eight districts found that, the sources and channels for communication HIV/AIDS education were as follows:- radio, television, teachers, friends, siblings and newspapers. This survey further pointed out that most youth express confidence and openness among their peers and this was also considered an important avenue for conveying the messages to the youth facilitate the AIDS education project for the youth in and out of school, where the sample.

The Kenya Institute of Education 's (KIE) AIDS Education project for youth has been providing and publishing HIV/AIDS educational materials for primary and secondary schools. They also publish facilitators' handbook, good health magazines and curriculum for the same. However, these materials have not yet been disseminated at national level to all education institutions. Furthermore, the project although also intended for youth out of school does not address how similar HIV/AIDS education messages can be communicated to this group. Besides the mentioned avenues for dissemination of HIV/AIDS, children cited several other avenues across the research sites visited.

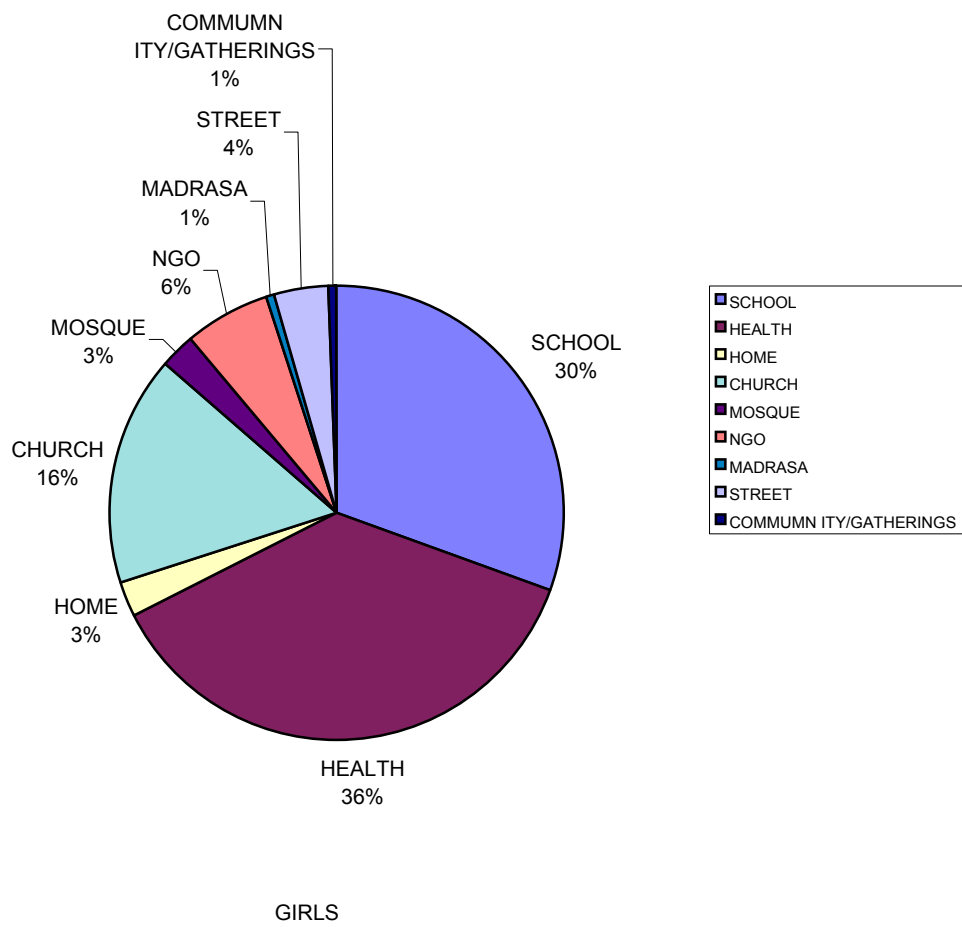
Children also reported getting information from specific locations or sites, which include, school, health institutions, home, church and mosque. The table below, shows that children mainly got information from schools and health institutions, regardless of the fact that teachers were reported not to teach HIV/AIDS education.

SITES/ LOCATION WHERE CHILDREN GET HIV/AIDS INFORMATION



BOYS

SITES/ LOCATION WHERE CHILDREN GET HIV/AIDS INFORMATION



In Kisii and Kisumu, children reported not getting information at home. In Garissa, boys did not get

HIV/AIDS information at home; while in Busia, Kilifi and Turkana, girls got their information from the other locations, but not from home. The other avenues for dissemination of HIV/AIDS were:

Peers/friends/colleagues

Peer counseling was identified to be effective because it was contextualised by peers and was adjustable to local realities. Peer counselors represent an important group of young people who natural role models for friends, siblings and the family. Out of 547 respondents Thika came out with largest number of children who received information on HIV/AIDS through their peers (64 children).

Print media

The development of HIV/AIDS teaching, learning and leisure, reading material is beneficial in making AIDS education less dependent on individual teachers. In urban Mombasa, print media was a major source of HIV/AIDS message and were used mainly by the girls. (46 out of 73 children).

Electronic media

A major disadvantage of this channel in the importing of information is its relatively low reach and high production costs. This was the case in the various regions visited where children reported having no access to T.V's, videos and computers. Every home however, has a radio through which they can get HIV/AIDS information. Children in Mombasa are reported to be using electronic media more than children in other areas. This may be attributed to the fact that they are in an urban area (city) where the media is easily accessible. All in all, 61% of the 547 children across the 9 regions do get information from electronic media.

Entertainment - education

Considering the extent of the HIV/AIDS epidemic, an important challenge for HIV/AIDS awareness programme is how to reach as many people as possible, as soon as possible with relevant and correct information.

Entertainment - Education is usually a crowd puller both in and out of school, but contrary to this, the use of entertainment education was not a popular channel with children in the research sites. 8% out of the 547 children interviewed said it as a channel through which HIV/AIDS information could be passed on to people.

Church leader/Sheikh

Kenya has diverse cultural and religious communities and each of these communities has certain rules and norms, which are their regulating mechanisms.

Religious and cultural practices have relevance to social behaviour, which are related to transmission and spread of HIV/AIDS and also the way children relate to the community. Children across the regions visited reported getting some information from the religious leaders. The numbers of children who regularly attended church was however low, compared to the total number interviewed. (40 (7%) out of 547) 1% of Muslim children were the ones who reported receiving HIV/AIDS messages from their leaders.

Parents

Parents have a duty to educate their children on matters pertaining to sexuality and in particular on matters of HIV/AIDS. Across the regions visited however, children reported that parents did not talk to them much about HIV/AIDS. Mothers too, in the same region did not talk to their sons. The girls were luckier to have some information from their parents. Across the regions, 43% of the children interviewed said they received information from their fathers while 44% got it from their mothers.

Siblings

In Kisumu, siblings did not talk to each other about HIV/AIDS. In other regions, there was some interaction among the siblings. In Busia, Kilifi, Kisii, Thika and Turkana interaction was between boys. In Garissa and Mombasa, the interaction was between girls. A total of 7% of the children reported getting information from siblings.

Grandparents

Across many areas of the research sites, grandparents were not a source of information. In Busia, boys reported talking to grandparents and in Machakos it was the girls who got HIV/AIDS information from their grandparents. 1% of all the children interviewed cited grandparents as their source of HIV/AIDS information.

Other family members

Kisumu is the only area reported as where children did not get HIV/AIDS information from other family members. A total of 56 (10%) of the 547 children received information from other family members across the regions visited.

In Kilifi and Machakos, boys did not get information from other members of the family. In Busia, it was the girls who were not given information by other family members.

Teachers

Focussed group discussions with teachers and children revealed that teachers did not have adequate information on HIV/AIDS and do not therefore feel competent to talk to students about it.

When the children were however asked to list the sources of HIV/AIDS information, teachers were listed by a large number of the children, 229 (42%) of the 547 children. Boys in Kisumu however reported not getting information from teachers, while 20% of the girls in this area gave teachers as the source of information.

School Clubs

Kisumu, Mombasa, Machakos and Thika are the only areas where school clubs were mentioned as a source of HIV/AIDS information.

In Machakos and Thika, boys got their information from the clubs while in Kisumu and Mombasa, it was the girls who got information from clubs. A total of 2% of the children got information from school clubs.

Experiential

All across the research regions, 13% of the children reported having interacted with an HIV/AIDS infected person and there by getting information about HIV/AIDS. It is interesting to note however, that all the children interviewed in Kisumu had no experience with HIV/AIDS victims, yet this is the area where a large number of HIV/AIDS orphans were found.

Seminars/lectures

Seminars or lectures were not a popular channel with children. 7% of the children across the regions are the only ones with the experience of seminars or lectures.

Celebrations

Very few children, 1% reported getting information about HIV/AIDS from celebrations. This was mainly captured in Busia, Garissa, Kisii and Thika where few children reported attending these celebrations.

Youth activities

Involvement by children is a way of having children being open in order to help them communicate their experiences and knowledge about HIV/AIDS.

A total of 2% of the children were involved in youth activities from where they recorded HIV/AIDS information.

Children in Garissa, Kilifi, Kisumu and Turkana reported no involvement in youth activities.

Community figures

Children in all the research regions reported having interactions with community figures and thereby getting HIV/AIDS information from them. 15% of the children fell into this category.

Authority figures

Children in Kisumu, Machakos and Mombasa reported getting HIV/AIDS information from other sources but not from authority figures. 2% of all the children in the research regions have had a chance to interact with authority figures, and thus get information from them.

Professionals

Professionals, were cited by children (24%) across the regions as one of their sources of HIV/AIDS information. Kisumu however, is the only area where children did not interact with professionals to get HIV/AIDS information.

Neighbours and others

Neighbours play a major role in importing information. 15% of the children interviewed across the regions cited this as their source of HIV/AIDS information.

I do not know

1% of Children interviewed had no idea of any sources of HIV/AIDS information. These children came mainly from Machakos, (1 boy) and Thika (2 girls).

Having it (HIV/AIDS)

25% of the children across the regions reported having the HIV/AIDS and this is the one way in which they got information about the disease.

Table 16 Sources of HIV/AIDS Information: 1

LOCATION	BUSIA			GARISSA			KILIFI			KISII			KISUMU			MACHAKOS			MOMBASA			THIKA			TURKANA			GRAND TOTAL			NO RESPONSES	TOTAL NO. OF CHILDREN	
	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T			
Peer/frie	No	19	7	26	4	5	9	4	10	14	4	6	10	0	3	3	7	7	14	8	16	24	34	30	64	9	10	19	89	94	183	364	547
	%	31	11	42	5	6	11	11	28	39	6	9	14	0	60	60	16	16	32	11	22	33	29	26	55	15	16	31	16	17	33		
Father	No	20	16	36	7	12	19	6	9	15	21	16	37	0	4	4	7	11	18	7	21	28	23	27	50	16	11	27	107	127	224	310	547
	%	32	26	58	9	15	32	17	25	42	30	23	54	0	80	80	16	25	41	10	29	38	20	23	43	26	18	44	20	23	43		
Mother	No	22	16	38	9	13	22	5	8	13	21	16	37	0	4	4	8	11	19	7	21	28	24	28	52	16	11	27	112	128	240	305	547
	%	35	26	61	11	16	30	14	22	36	30	23	54	0	80	80	18	25	43	10	29	38	21	24	44	26	18	44	20	23	44		
Teache	No	19	7	26	12	15	29	7	13	20	12	10	22	0	1	1	5	14	19	7	25	32	23	19	42	21	17	38	106	121	229	318	547
	%	31	11	42	15	19	34	19	36	56	17	14	32	0	20	20	11	32	43	10	34	44	20	16	36	34	27	61	19	22	42		

Table 17 Sources of HIV/AIDS Information: 2

	BUSIA			GARISSA			KILIFI			KISII			KISUMU			MACHAKOS			MOMBASA			THIKA			TURKANA			GRAND TOTAL			NO RESPONSES	TOTAL NO. OF CHILDREN	
	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T	B	G	T			
Print	No	37	20	57	12	25	37	6	22	28	29	25	54	0	5	5	5	11	16	12	46	58	22	18	40	20	19	39	20	19	39	211	547
Media	%	60	32	92	15	32	47	17	61	78	42	36	78	0	100	100	11	25	36	16	63	79	19	15	34	32	31	63	32	31	63		
Elec.	No	29	18	47	17	31	48	6	19	25	30	27	57	0	5	5	4	8	12	13	46	59	32	33	65	20	21	41	151	208	359	184	547
Media	%	47	29	76	22	39	61	17	53	69	43	39	83	0	100	100	9	18	27	18	63	81	27	28	56	32	34	66	28	38	65		
Having	No	14	5	19	7	10	17	0	4	4	11	9	20	0	3	3	6	6	12	9	10	19	18	13	31	3	5	8	68	65	133	412	547
H/AIDS	%	23	8	31	9	13	21	0	11	11	16	13	20	0	60	60	14	14	27	12	14	26	5	8	13	12	12	25					

3.8 Constraints in using education to control HIV/AIDS

According to UNAIDS (1997), in a briefing paper, 'learning and teaching about AIDS at school', the constraints to HIV/AIDS education in schools includes;

the subject is considered controversial, the curriculum is already over crowded, education may be limited to certain age groups, behavioural skills are not taught - only facts about AIDS and that it may be only partially covered in a country.

Ways to overcome these constraints include; designing a curriculum adapted to local culture and circumstances, establishing a partnership between policy makers, religious and community leaders, teachers and parents and setting of sound policies on AIDS education through partnership.

The UNAIDS report fits childrens' and key informants responses from all the research sites visited , where they cited constraints as; lack of clear government policy on HIV/AIDS education. This makes it difficult for one to teach HIV/AIDS education to students freely. There also lack of money, materials and manpower in schools, hospitals and in the community. There is also opposition from religious groups, who do not want certain issues to be discussed.

Teachers are not trained well enough to tackle HIV/AIDS education and many of them shy away from certain topics .They may also be victimized by the community who still do not understand what HIV/AIDS education is all about.

3.9 Role of religion in stopping the spread of HIV/AIDS

Religious Institutions have an important role to play in helping create awareness and thus in helping to stop the spread and control of HIV/AIDS. A review of the various religious institutions in Kenya, done by the researchers found that various churches have different roles and practices which they have tried to instill in their children.

The Catholic Church recognizes the family as an important institution. In its effort to help stop the spread of HIV/AIDS, it has funded hospitals and schools and offered bursaries to individuals. As a church however, it withholds information on sex and sexuality to children but encourages adults to abstain.

The protestant churches look at children as special gifts from God who need protection. Children are supported and have special services in the church. In these services, matters pertaining to sex and sexuality are discussed.

The Islamic faith also believes that children are gifts from God. They have special schools where children are taught specifically on religious matters. They also have specific rules about marriage and divorce. On sex and sexuality, not much information is imparted to children.

The National strategic plan on AIDS (NACC 2000) for the year 2000 -2005, recognizes the importance of religious institutions in successive programme intervention on HIV/AIDS. The religious institutions have a responsibility in providing services to the infected and affected.

In an essay administered to groups of children in Nakuru, Garissa, Turkana, Kisii, Thika and Kilifi, Children were asked to write what their religions had done in the fight against HIV/AIDS. A survey carried out in various regions of the country on the role of religion revealed the following responses from children.

Activities

Respondents from Busia, Nakuru, Kisii and Thika said the Catholic Church has built health centres where patients seek preventive and curative services. In Busia, the Catholic Church has bought an ambulance which is used in transporting victims when they die, while in Kisii, a home has been opened for AIDS victims to be cared for.

As an institution, which offers education, the Catholic Church in Thika was said by children to be instrumental in AIDS education and awareness campaigns. Children spoke of being advised not to go to the 'bush'. They are advised not to engage in sexual-related activities and couples are advised to remain faithful to each other.

The protestant churches were also said by children to have been active by being involved in HIV/AIDS intervention programmes. A girl aged 17 from Busia said, 'Church leaders offer free samples like condoms to other Christians'.

Other Church groups like the Adventists, Anglican, Presbyterian and African Brotherhood Church were said to have built youth vocational centres in Kisii (Seventh Day Adventist church) ,where those who have left school learn skills so as to have sources of income and reduce idleness. In Nakuru, the Presbyterians

have constructed a centre where AIDS victims are cared for, while in Thika, the Anglicans and ABC church have mounted an aggressive awareness and counseling campaign.

Respondents in Garissa, Turkana and Kilifi said that Islam has discouraged prostitution by having prostitutes punished. A boy aged 17 from Garissa said;

'My religious group went to an extent of eradicating prostitution as they thought the disease was spread by these prostitutes. They drag prostitutes in town and shave their hair as a form of punishment.'

Islam accordingly has recommended modesty in dressing especially on ladies..., 'This is a major way that ideas spread..., Ladies who dress like the whites, e.g. half-naked attract the attention of the youth who are sexually hungry and active'.

Respondents from Garissa also said that Muslims are also encouraged to marry early and up to a maximum of four wives to reduce situations of promiscuity.

Constraints

Despite the church playing a leading role in the fight against AIDS, constraints were reported in Garissa, Kisumu, Busia and Kisii.

In a group discussion with community leaders in Kisumu, religious leaders were said to portray responses of love, compassion, integrity and humility towards all. This according to the discussants is a major weakness for the church as the fight against AIDS requires aggressiveness and stark truths, this is apparently in relation to people's unwillingness to disclose the cause of death even when it is AIDS-related.

Unfavorable community attitudes were said in key informants meeting in Kisii to hinder the campaign against AIDS. The attitudes were being blamed on failure to diagnosis HIV/AIDS as the cause of death, leaving the clergy to avoid mentioning AIDS and instead stick to spiritual issues.

Poverty / famine came out as a constraint in Turkana. In Lokichoggio and Kakuma, a key informants meeting said that what the people needed is food. The catholic priest of Kakuma said that his flock needs food before they can be preached to.

Spiritual guidance

Respondents in Garissa, Nakuru, Busia, Thika, Kisii and Kilifi reported the availability of pastoral and spiritual services for HIV/AIDS victims.

In Garissa, respondents blamed HIV/AIDS on fornication and irresponsible sexual behaviour. This according to Islam is sin and is punishable by suffering in hell. The youth are advised to observe, 'LAA TAKRABU ZINAA'- (which means abstaining from sex until marriage) as was reported by a 19 years old boy from Garissa.

Prayers to Allah were reported to result in getting a cure for the disease. Condoms were said not to offer protection but increase infections because it is forbidden to have sex outside marriage, instead, one respondent said:-

'They are encouraged to marry more than one wife to reduce the number of ladies moving from place to place'. This was said by a boy 19 years from Garissa.

In Nakuru, Busia, Thika, Kisii and Kilifi, children said that Christians were asked to be monogamous. Sex before marriage was forbidden and the youth were asked to remain committed to God. Churches teach and preach the dangers of adultery and fornication.

Respondents indicated that they were asked to tell those who have AIDS to repent, accept Christ and get saved. A boy 11 years from Busia said,'.... Our priest organizes Mass every Monday to pray for those suffering from the disease.....'

Care and hope

Responses from Garissa, Nakuru, Busia, Kisumu, Mombasa, Kilifi, Turkana and Kisii showed religion as having played a leading role in provision of care and hope to the infected and affected.

In Garissa, homes for orphaned children have been constructed. At the homes, some form of education is offered and children are engaged in various sporting activities. Respondents from Nakuru, Mombasa, Kilifi, Kisumu, Kisii, Busia and Turkana talked of visits to the sick where they pray with them and offer spiritual and material support. Community counselling is offered and prospective spouses are advised to undergo tests before marriage.

Education

Religious institutions also have a huge influence as educators. They are channels to inform and educate large masses of people in churches and mosques. In this respect, children from all the regions identified these institutions as having printed and published books, magazines, posters and other instructional materials. This have been used in mitigation on HIV/AIDS with the followers.

The institutions have also organized the youths into groups and movements which educate others in schools and communities on the dangers posed by the disease. They use entertainers like puppetry, plays and songs to keep their audiences glued.

Practices such as circumcision were being discouraged by the various religious institutions as they predispose people to infection.

Non-action, extreme reaction

There was only one respondent from all the regions visited who said that her church does not talk about HIV/AIDS. There was also one respondent who gave an extreme reaction that there is need to isolate infected people from those who are not infected.

3.10 WHAT CHILDREN CAN DO TO STOP THE SPREAD OF HIV/AIDS

According to articles 12,13, 28, and 29 of the CRC and articles 7,8,9,11, and 12 of the African Charter, children have a right of expression, association, thought, conscience, and participation in cultural activities. Despite the adoption of these conventions, Kenyan children feel that they are denied these rights. Children attending celebrations marking the 11th anniversary of the CRC observed that 'each time a dignitary comes here and addresses us, the next day it is his face that fills the screen. We feel sidelined and neglected...nobody reported what we said' (The Daily Nation, 24th November, 2000). This research study offered 694 primary and secondary pupils an opportunity to list the things children can do to stop the spread of HIV/AIDS (listing 13). Children made several suggestions that included abstinence, avoiding contaminated objects and situations that could lead to sexual activity, and having safe relationships (Table 18).

Table 18: Proportion of boys and girls who made various suggestions of what children can do to stop the spread of HIV/AIDS

Suggestions	BOYS		GIRLS		TOTAL	
	N	%	N	%	N	%
Abstinence	225	51	215	49	440	63.4
Avoid contaminated objects	192	50	189	50	381	54.9
Safe relationships	177	52	162	48	339	48.8
Avoid situations that could lead to sex	131	48	142	52	273	39.3
Use of condoms	82	68	39	32	121	17.4
Radical suggestions	57	59	39	41	96	13.3

Abstinence

Abstinence was the most commonly cited contribution that children can make. In all the ten districts, 63.4% of the children who responded, reported that children can control the spread of HIV/AIDS. Of those who mentioned, 51% were boys while 49% were girls. Specifically children suggested they could stop having love affairs and abstain from sex before marriage. A 17 year old secondary school boy from Kisumu observed that children can avoid infection by 'promising that true love waits.' From the researchers' experiences in the field, some of the children in schools are sexually active and concerned about being infected.

Avoiding contaminated objects

Children also mentioned they could avoid using and sharing contaminated objects. Avoiding objects was mentioned by 54.9% of all the children who responded to listing 13. An equal number of boys and girls mentioned this measure. Some of the objects children cited were razor blades, combs, tooth brushes, clothes, pins, earrings and clothes. Children also suggested they could avoid contaminated blood by avoiding blood transfusion.

Safe relationships

Children also suggested they could have safe relationships to protect themselves from infection. This was mentioned by 48.8% of the children. Out of this, 52% were boys while 48% were girls. Specifically, children in all areas mentioned that children could avoid bad company, have one partner, select a partner wisely and be faithful to their partners. A 16 year old secondary school boy from Kisumu observed that children can 'avoid double dealing or getting into sugar daddies or mummies' (listing 13).

Avoid situations that could lead to sexual activity

Out of the total number of children who responded to listing 13, 39.3% mentioned avoiding situations that could lead to sexual activity. Of these, 48% were boys and 52% were girls. Some of the situations that children mentioned included avoiding pornography, substance abuse, walking alone at night, going out at night, and visiting clubs and discos.

Use of Condoms

Children also cited the use of condoms as a measure of protecting themselves from infection. Of all the children who responded to this instrument, 17.4% mentioned condom use. Of these, 68% were boys and 32% were girls. However, some of the children mentioned that condoms were not 100% safe and recommended that children should stop using condoms. A 13 year old standard eight girl from Thika observed 'avoid being cheated by anybody that condoms can prevent you from getting AIDS.'

Conforming to their religion

Conforming to religion was viewed as one of the ways in which children could stop the spread of HIV/AIDS. Specifically children suggested that they can become Christians and get 'saved.' Children in Garissa observed that following Islamic religion and 'sticking' to their culture was the best way of avoiding infection.

HIV/AIDS education

Children suggested that they could contribute by educating their peers, parents, and communities on HIV/AIDS through posters and advocacy. They also suggested that they could also educate communities on the risks associated with some of the socio-cultural practices that could lead to HIV/AIDS infection with a view to changing these practices.

Radical suggestions

Some children also made radical suggestions of how they can stop the spread of HIV/AIDS (Figure *).

Radical suggestions of what children said they could do to stop the spread of HIV/AIDS

- If you have AIDS, don't come out to play with others (10 year old boy, Mombasa);
- Kill those affected;
- Isolate people who are affected by HIV/AIDS. (17 year old boy, Turkana);
- Do not use a cup with an infected person (13 year old girl, Kilifi);
- We should not greet people with hands because if they have AIDS, it must pass through your body. (15 year old girl, Kilifi).

Some of these responses could be due to misconceptions and the stigma associated with HIV/AIDS. The responses also suggest that some children may be intolerant of infected persons. This intolerance could also be attributed to children's perception that HIV/AIDS infection is due to promiscuity, which may not always be the case.

The suggestions that children made clearly suggest that they can play an instrumental role in stopping the spread of HIV/AIDS. It is important that this potential is recognized and tapped in the design and implementation of HIV/AIDS programs and interventions.

4.0 SUMMARY OF FINDINGS AND RECOMMENDATIONS

General impacts of HIV/AIDS on children

Although researchers and organizations rarely give children opportunities to actively participate in projects, the findings of this study clearly indicate that children understand the impact of HIV/AIDS and can articulate how children are affected, and how they can contribute in stopping the spread of HIV/AIDS.

Children living with infected parents and orphans face numerous challenges. In all the districts, children reported that affected children lack basic needs. An analysis of the form of assistance provided by the various care structures showed that food, shelter, education and clothing were the most common form of assistance. The least available forms of assistance were health, guidance and counseling, and moral support. This may be attributed to the high cost of medical care in the country, stigma, and the breakdown of traditional structures that provided guidance to children. The lack of guidance and counseling support services for children affected by HIV/AIDS could be linked to the tendency for researchers, communities, and organizations to focus on basic needs of children.

Children's voices clearly show that HIV/AIDS has numerous ramifications for children's psychological and social development. Children whose parents have been affected by HIV/AIDS experience fear and worry. Children fear being infected by their parents, losing their parents and facing the future. They also face rejection, discrimination and mistreatment in homes, schools, and communities.

Children affected by HIV/AIDS are at risk of being infected. The loss of parental guidance, lack of basic needs leading to increased responsibilities outside the home and caring for infected parents could expose children to infection. Children also reported that some parents deliberately infect their children.

The extended family is playing an important role in providing care and support to children affected by HIV/AIDS. However, community resources are over stretched. Consequently, the quality of care provided to orphans is inadequate. The stigma associated with HIV/AIDS also limits the extent to which extended families and communities provide care and support to orphans.

Although the Children's Bill (1998) provides for the protection of children from sexual exploitation and abuse, children engaged in child labour and those living in the streets find themselves in environments that could expose them to infection.

Children in all areas reported the existence of social and cultural practices that could expose them to HIV/AIDS infection. These include early marriages, wife inheritance, circumcision, burial ceremonies, incisions of the body and '*sweetie parties*.'

Impacts of HIV/AIDS of Education

Pupils, community leaders, and key informants reported that HIV /AIDS had impacted on learning in different ways. Due to parental/guardian illness and/or death, children lack school fees and educational materials. This has led to absenteeism by pupils from school due to time taken off to care for sick parents, engage in work to earn a livelihood and raise school fees, and attend funerals. Owing to the loss of parental love and livelihood, children drop out of school.

The results also showed that pupils' participation and performance in education had been affected by teacher infection, absenteeism, and death, leading to the shortage of teachers. Pupils also reported that infected teachers are unable to teach effectively.

The psycho social impacts of HIV/AIDS affect pupil's participation and performance. Pupils reported fear of infected teachers and pupils, and getting infected. These fears were reported to have led some pupils to

drop out of school and impaired relationships between teachers and students, and between students. Infected and affected pupils are sad and depressed. They also experience shame, embarrassment, and rejection in the school setting. These were associated with reduced pupil participation and performance.

Pupils and community leaders in all areas reported that infected teachers sought transfers mainly to stations near their homes so that they could receive care and support from their families. These transfers affect learning and could lead to teacher shortages in some schools. Pupils also reported they had lost teachers whose teaching they understood best.

Pupils, community leaders and key informants reported that HIV/AIDS has reduced resources available for education. Resources that could have been used for educational purposes are used for medical care. Impoverishment at the household level has also led to a reduction in community participation in education. Resources invested in training teachers and educating children are wasted when teachers and pupils are infected.

On the positive side, pupils reported that HIV/AIDS had instilled in pupils a sense of responsibility and morality.

The role of education

Children and adults in all the districts reported that education is a powerful tool in stopping the spread of HIV/AIDS. Education enables children to acquire knowledge, skills and attitudes that could result in behavioural change. However, some of the pupils in Garissa and Turkana viewed school as a waste of time and money. In Garissa, some of the children viewed school as a source of HIV/AIDS infection.

Role of HIV/AIDS education

Although school was the most commonly cited source of HIV/AIDS information, pupils reported that most teachers are not teaching HIV/AIDS education. Similarly Children reported that parents do not discuss sexuality and HIV/AIDS with them. They expressed the desire to get information from parents and other family members. Children advocated for the integration of HIV/AIDS education into various subjects, and the introduction of AIDS education as a new subject.

Teachers are not aware of the government's policy on HIV/AIDS education. They also lack adequate knowledge on HIV/AIDS education and are constrained by the overcrowded curriculum. They face personal constraints such as shyness, embarrassment, fear that they too could be infected and victimized by their communities. Schools lack adequate and appropriate resources to implement HIV/AIDS Education. Teachers

Children reported that HIV/AIDS messages designed by adults are ignorant of their lifestyles and send incorrect messages to the youth. Despite the awareness about HIV/AIDS in communities, children and adults reported that behaviour change was minimal.

What children can do to stop the spread of HIV/AIDS

Children can play a significant role in stopping the spread of HIV/AIDS. Children made several suggestions of what they could do.

- Abstinence, and use of condoms;
- Avoiding situations that could lead to sex and infection;
- Educating peers, siblings, and parents, and

- communities on HIV/AIDS;
- Providing care and support to those who are infected and affected.

Knowledge gaps and misconceptions about HIV/AIDS

Children, teachers, and communities need more and current information about HIV/AIDS than is currently available. Children, teachers and communities hold several misconceptions about HIV/AIDS. These relate to:

- Symptoms
- Modes of transmission
- Prevention
- Treatment of HIV/AIDS
- Coping with infection and infected persons

Recommendations

It is important for researchers and organizations working with children to listen to children's voices and to involve them during project design, implementation, and evaluation.

Communities and institutions working with affected children should be sensitized on the psychosocial impacts and needs of children. This will enable care providers and structures for affected children to incorporate appropriate interventions, besides providing basic needs. There is also need to build capacities for addressing these needs. In the school system, it is imperative that all teachers and specifically those involved in guidance and counseling are trained to address some of the psycho social needs of infected and affected children.

There is need to address the stigma associated with the disease and to educate communities so that they can accept and assist affected children. Communities also need to be educated on the rights of all children and in particular on the rights of those affected by HIV/AIDS.

Although the Children's Bill (1998) provides for the protection of children from sexual exploitation and abuse, there is need to enforce these laws to protect all children and in particular those living in difficult circumstances. Owing to the reported sexual abuse and exploitation that child laborers and street children are exposed to, it is important that they are educated on the risks of HIV/AIDS infection so that they can protect themselves.

HIV/AIDS interventions should encourage communities to integrate safe procedures in socio-cultural practices that could expose children to HIV/AIDS infection. Communities should be encouraged to conceive alternative rituals and rites of passages.

Recommendations for the educational sector

It is important that there should be immediate interventions in schools ,in guidance and counselling for infected and affected children, who are experiencing the many psychosocial impacts, of HIV/AIDS in their learning.

Schools and communities should be made sensitive to the provision of special needs for the infected and affected children.

The government should take the initiative of training teachers to specifically teach issues pertaining to HIV/AIDS, and to make available resources for the dissemination of information to all areas. It is recommended that there is an urgent need for HIV/AIDS awareness and education in schools, given that teachers and pupils are getting infected and dying.

There is need for follow up on the implementation of policy on HIV/AIDS education

Despite the existing HIV/AIDS messages and campaigns, people are getting infected and dying, therefore there is need to re-evaluate and re-target existing HIV/AIDS messages and campaigns. There is need to design and disseminate appropriate HIV/AIDS messages targeting children in and out of schools.

Children need education in life skills, drugs and substance abuse and clear information on condoms so that they can protect themselves and educate other. There is need to train core groups of young people who can serve as peer educators and counselors in communities.

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