

**FACTORS AFFECTING EDUCATION OF CHILDREN
LIVING WITH HIV AND AIDS: A CASE STUDY OF
NYUMBANI CHILDREN'S HOME, NAIROBI (KENYA)**

BY

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**A THESIS SUBMITTED IN FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF
EDUCATION (SPECIAL NEEDS EDUCATION) IN THE
SCHOOL OF EDUCATION KENYATTA UNIVERSITY**

NOVEMBER 2012

DECLARATION

This thesis is my original work and has not been presented for a degree or any other award in any other university.

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DEDICATION

To my beloved wife Carolenny, son Terrence, daughter Serita and my friend Jesus Christ for the encouragement they accorded me during the course of the preparation of this work and hope that this work will be an inspiration to the two young ones in their future undertakings.

ACKNOWLEDGEMENTS

For the successful completion of this project I am indebted first and foremost to the almighty God for giving me the gift of life, willpower and energy to carry out this research. I would also wish to sincerely recognize the assistance and encouragement given to me by various individuals without whom it could have been difficult to complete this work.

My special gratitude and appreciation goes to my supervisors Dr. Rachel Kangethe and Dr. Calvine Kayi, who diligently taught and guided me on how to write a commendable research thesis with much enthusiasm and confidence, to Dr. Nelly Otube and Prof. Karugu, my other lecturers who also willingly and cheerfully taught me and all the lecturers who taught me in the department of Special Education in Kenyatta university.

I am also grateful for the assistance and encouragement given to me by my sponsors Mr. Ahmed Bajaber and Dr. Gita K. Shah who paid my university fees to ensure my studies went on uninterrupted.

Many thanks go to Sister Mary Owens, the executive director of Nyumbani Children's Home for her intervention and persuading the board of Nyumbani to allow me carry out research there despite a change in policy concerning doing research at the home, and to Rev. Festus Gitonga for facilitating for me to carry out pilot study at PCEA Tumaini Children's Home.

Finally, I feel greatly indebted to all those people who have assisted me in the process of successfully completing my work in one way or the other and may God bless you all.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency syndrome
ANECOA	African Network for Care of Children affected by AIDS
ARV	Anti Retro-Viral
EFA	Education For All
GOK	Government of Kenya
HIV	Human Immune Virus
HRSA	Health Resource Services Administration
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
MDG	Medium Development Goals
MSF	Medecin Sans Frontiers (Doctors without Borders)
MTCT	Mother to Child Transmission
NCCS	National Council for Children's Services
NIAID	National Institute of Allergy and Infectious Disease
ODA	Overseas Development Assistance
PCEA	Presbyterian Church of East Africa
SOS	Save Our Souls
STD	Sexually Transmitted Diseases
UNAIDS	United Nations organization for HIV/AIDS
UNESCO	United Nations Education Scientific and Cultural Organization
UNICEF	United Nation Children's Education Fund
USAID	United States Agency for International Development

VSO Voluntary Services Overseas

W.H.O World Health Organization

ABSTRACT

The role that education plays in the life of an individual human being cannot be gainsaid. There are a number of factors that influence children's access to quality education. One such factor today is the HIV/AIDS pandemic. The onset of HIV/AIDS has upstaged various aspects of the education sector. The sector has been adversely affected by this epidemic with the resultant effect that children are losing out on education due to the death of their parents. Some of these children are themselves infected with HIV/AIDS. It is this cadre of children who are infected that this study concentrated on. The main purpose of this study was to investigate the factors that hamper the academic progression of children living with HIV/AIDS in Kenya with a specific reference to Nyumbani Children's Home – Nairobi, Kenya. Specific objectives were to: Find out the challenges faced by Nyumbani Children's Home in providing education to the children living with HIV/AIDS; establish the innovations adopted by the home to circumvent challenges, find out the effect of the children's seropositivity status on their academic performance, investigate how the learners cope with their seropositivity status and establish successful interventions and lessons that can be replicated in similar programs elsewhere. The study design used was survey. Purposive sampling technique was used to select respondents for the study. Only children in upper primary classes were involved in the study plus seven workers. There were 3 types of questionnaires: One type meant only for the children, one for workers and the other for the management. Data obtained were analysed using descriptive statistics. Frequency distribution tables, pie charts and bar graphs were used in the presentation of the results and data were then analysed according to objectives, by percentages. On the gender composition of children infected with HIV/AIDS, 64.3% were male while 35.7% were female. On the gender distribution of caregivers, 43.8% were male while female were 28.6%. However, caregivers' gender composition is not representative since 28.6% of the respondents did not indicate their gender. The findings revealed that discrimination on the account of the child's seropositive status is one of the major challenges that hinder pupils' academic progression. Others cited are the children's health status, the government's unwillingness to take a proactive stand on the education of HIV positive children, lack of proper food and nutrition, over reliance on donors for funding thus causing donor fatigue which has a resultant negative effect on the education of the children. The findings also reveal that the children's awareness of their serostatus affects their performance. However, to mitigate against this, the caregivers offers them psychosocial support through periodic counselling. Also some members of the community come to visit them while others take them out for an outing. This offers them a sense of belonging. The findings of this study were used to make strong recommendations to the relevant authorities on how to improve the education of children living with HIV/AIDS. Among the recommendations made were that a serious HIV/AIDS awareness campaign should be mounted in all public and private schools, both primary and secondary, so as to create sensitization on the rights of HIV positive children.

CHAPTER ONE

INTRODUCTION

1.0 Background to the Study

“In June of 1981, we saw a young gay man with the most devastating immune deficiency we had ever seen, we said, ‘we don’t know what this is, but we hope we don’t ever see another case like it again’ “ (WHO, 1994 in Avert, 2006)

These words attributed to Dr. Samuel Broder then of the national cancer institute in the United States of America, remind us how much the world has changed within a quarter century since the physicians first saw the earliest cases of AIDS in hospitals in the United States, the Democratic Republic of Congo and on the slopes of Lake Victoria, East Africa. When AIDS first appeared on the global scene, no one could have predicted how the epidemic would spread across the world and how many millions of lives it would alter in one way or the other. There was no real idea what caused it and consequently no real idea on what protective measures to take against it. It is one disease that confounded human mind at that time and still does to this day. The epidemic of AIDS continues today and will continue into the foreseeable future with possibly no sign of abating (Avert,2006).

The gravity of this epidemic has been revealed in the sobering numbers reported in the epidemiological studies. It has been reported that since its emergence, this pandemic has decimated more than 25 million people worldwide and rendered millions of children orphans in its wake (UNAIDS, 2005; Avert, 2006). However, children are not only affected, but also infected. NIAID (2004), for example, it was estimated that at the end of

2003, 2.5 million children worldwide under age 15 were living with HIV/AIDS. Approximately 500,000 children under 15 had died from the virus or its associated causes in that year alone.

There is no doubt that education sector has borne the full brunt of HIV/AIDS onslaught hence hindering the academic progression of the infected and affected children. For instance, the projection on teacher mortality indicates that Kenya will lose 1.4% of its teachers each year from year 2000 till 2010 (GOK, 2003). Estimates indicate that 2.2m Kenyans are HIV positive, 1.5m have already died of AIDS. Among these are parents and guardians of school going children (GOK, 2002). As the HIV/AIDS scourge continues unabated, some of the major challenges facing the education sector include the loss of or low earning capacity caused by AIDS which makes it difficult for the infected and affected parents or guardians to support the education and training programs of their children; the increased drop out rate from education and training institutions due to the effects of HIV/AIDS and the danger caused by the HIV/AIDS epidemic to national socio-economic development and to the survival of the society (Republic of Kenya, 1999).

The parents' role is paramount in the academic well being of the child. HIV/AIDS has reduced many parents to bedridden status causing myriad problems to the children and the entire family. The trauma and hardship that children affected by HIV/AIDS are forced to endure cannot be overstated. They try to help, but can only watch as their parents die one after the other. Under such circumstances, there may be no or little planning for the children's future. A myriad of interrelated factors take their toll: grief over the death of a

parent, fear about the future, separation from siblings, distress about worsening economic circumstances and HIV-AIDS related discrimination and isolation.

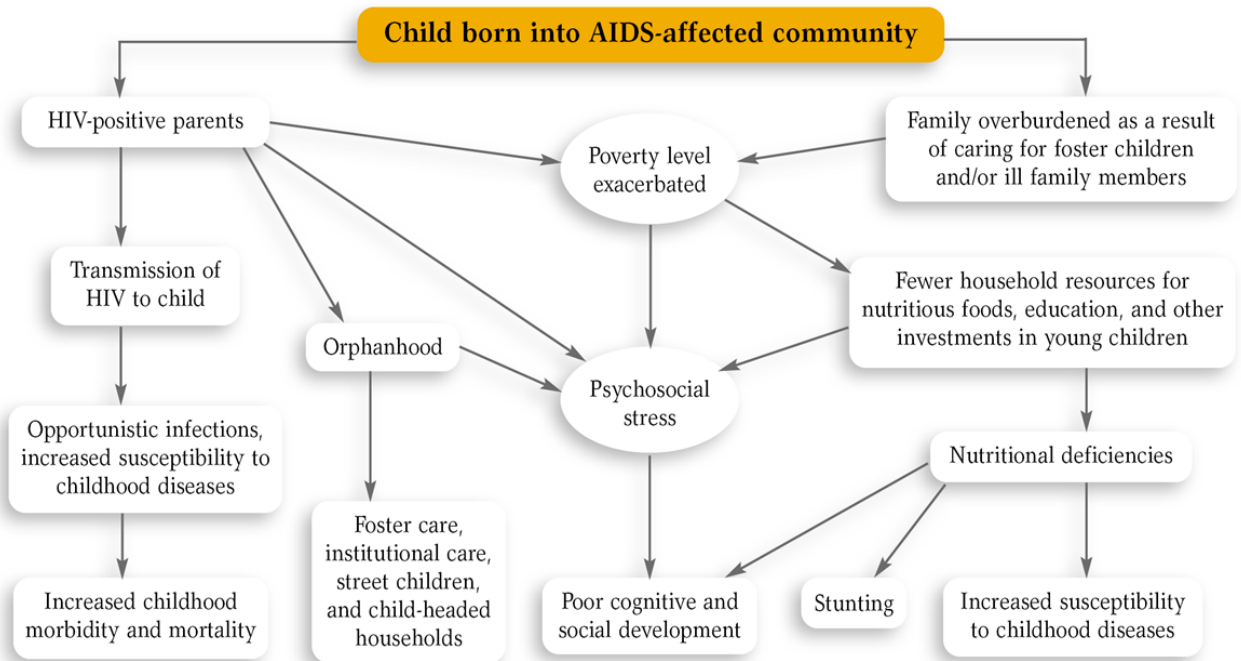
The impact of HIV/AIDS on children is complex and multiphased with socio-economic cost both high and long term. Overall, AIDS is increasing the number of vulnerable, malnourished, poorly socialized and uneducated young people which in turn heighten the prospect of social instability. With scarce resources stretched well beyond their limits the impact of the pandemic is placing tremendous strain on the families, communities and governments who are attempting to help (UNAIDS 2002).

Children and adolescents need to grow up in a conducive family and community environment that provides for their changing needs, which enhances their healthy and sound development. A good number of orphans are adopted within family network. However, it is not self evident that extended families have an inexhaustible capacity to absorb the growing number of these children. Some of these children find themselves sheltered in children homes, also known as orphanages, such as Nyumbani.

Nyumbani is one of the few hospices in Kenya that caters for children who are living with HIV/AIDS. It caters for children from newborn to eighteen years of age. Father Angelo D'Agostino, a Jesuit priest and medical doctor, from United States of America, established it in 1992. The home tries as much as possible to cater for the children's medical, emotional, spiritual, social and educational needs which they would otherwise

have difficulty obtaining in a normal communal environment as portrayed in the figure below.

Figure 1.1: Implications for Young Children Who Are Born Into AIDS-Affected Communities



Source: World Bank (2009)

1.1 Statement of the Problem

It is estimated that 2.2 million Kenyans are HIV positive, 1.5 million have died leaving behind 1.3 million orphans under 15 years of age and most of these orphans are themselves infected with the devastating virus. With HIV prevalence of 13% and mortality rate of 700 per day, the country is producing orphans and other vulnerable children at an alarming rate and the figure is projected to reach 2 million by the year 2010 (GOK, 2002). These children are likely to be taken care of in the child-headed

households or by widows/widowers and old caregivers, especially grandparents. They are thus likely to be exposed to difficult and impoverished socio-economic environment with their rights to grow and be educated violated.

These children are likely to be exposed to insecurity, stigmatization, poor education, medical and nutritional care, neglect, emotional vulnerability and other effects of poverty. As a result of the breakdown in cohesive social fabric of the extended families, these children find themselves homeless and vulnerable to bad social influence such as engaging in prostitution, drug peddling and becoming drug abusers. These types of activities are all conduits to faster spread of HIV/AIDS. This also explains the mode by which these children also get infected with HIV/AIDS if not acquired through the mother to child transmission. In most cases these orphans find themselves placed in orphanages or children's homes. Most of these homes face a myriad of challenges in trying to bring them up as wholesome members of society. Most of them operate on a shoe-string budget and as result the quality of education accorded to these children is heavily compromised. From the foregoing, it is clear that the education sector has experienced devastating effects of the HIV/AIDS pandemic. The pandemic is uniquely threatening to children as far as their educational well being is concerned. It is thus within this context that this study sought to investigate factors affecting the education of children living with HIV/AIDS in Kenya, but with special reference to Nyumbani Children's home.

1.2 Purpose of the Study

The main purpose of this study was to establish factors affecting education of children living with HIV/AIDS in Kenya with special reference to Nyumbani children's home.

1.3 Specific Objectives

The specific objectives were aimed at:

- i. Finding out the challenges Nyumbani children's home faces in providing education to the HIV/AIDS infected children.
- ii. Establishing the strategies adopted by the home to circumvent challenges.
- iii. Finding out the effect of the children's sero-positivity status on their academic performance.
- iv. Investigating how the learners cope with their sero positivity status.
- v. Establishing successful interventions and lessons that can be replicated in similar programmes elsewhere.

1.4 Research Questions

The following research questions were used to guide this study:

- i. What are the problems faced by the Nyumbani Children's Home in providing education to children living with HIV/AIDS?
- ii. How does the home cope with the challenges, if any?
- iii. To what extent does children's seropositivity affect their academic performance?
- iv. What are the measures that can be adopted to empower the home to provide education to these cadres of children?

- v. What successful intervention and lessons can be replicated to inform vulnerable children programs?

1.5 Significance of the Study

It is an undeniable fact that HIV/AIDS crises have adversely affected the education sector. It is therefore imperative that strategic and policy measures be adopted to curb HIV/AIDS prevalence reducing its hold on children to ensure quality and quantity achievement of the children's aspirations, in as far as their academic progression is concerned. Such strategic and policy measures, however, need to be based on solid empirical evidence. This could be done by assessing the effects of HIV/AIDS on the children's rights to education.

It is thus hoped that the recommendations emanating from the findings of this study will be useful to the institution's managers in their attempt to alleviate some of the problems they face with regards to meeting educational needs of the children living with HIV/AIDS. The study is also expected to be useful to educational policy makers when formulating policies that concern HIV/AIDS pandemic; being more sensitive to the needs of the infected children and designing HIV/AIDS awareness programs that prohibit discrimination and stigmatization of the infected children.

In theoretical context, the study is expected to contribute to the advancement of knowledge about the effects of HIV/AIDS on infected children's education in Kenya. The study is expected to assist the government of Kenya, civil society groups that deal

with HIV/AIDS and other philanthropic organizations to understand the needs of the children's homes and consequently provide the necessary resource allocation to these homes to mitigate against some of the problems that such homes face.

1.6 Basic Assumptions of the Study

The study was guided by the following assumptions:

- That all respondents would cooperate and provide reliable answers;
- That the children's sero positivity status does not in any way interfere with their academic pursuits;
- That the home has developed elaborate coping mechanism to counter the challenges she faces;
- That the government has put in necessary policy framework concerning education of children living with HIV/AIDS; and
- That all pupils/students selected for this study attend school regularly

1.7 Scope of the Study

The study dealt only with the educational aspect of children living with HIV/AIDS, and especially looked at the unique hindrances that the children's homes face in according them an educational opportunity. It only involved children from class four to secondary school level as it was hoped that they would be able to understand the subject under study. Children below class four were precluded as they were deemed to be too young to comprehend the questions and answer appropriately. The population included in the sample were those in session at the time of the study. Those absent were not included

even if they would have had some useful inputs. The study was confined to the study locale i.e. Nyumbani Children's Home.

1.8 Limitation of the Study

The study faced the following limitations:

- A lot of time was spent with some respondents to obtain data from them especially during face to face interview, hence not all respondents sampled for face to face interview took part;
- Due to the sensitive nature of the research some respondents felt uncomfortable to take part in the study because of the trauma they may have experienced. This especially emanated from the HIV positive children;
- Communication between the researcher and some respondents did not flow smoothly due to the researcher's hearing impairment.

1.10. Theoretical Framework.

This study was grounded on 2 theories: the health model and the Maslow theory of motivation.

1.10.1 The Health Model.

This model was developed by Rosenstock (1996) and Becker (1977). It holds that health behaviour depends on individual knowledge about a particular health problem. In this model, action or behaviour changes giving the people the relevant information on health aspect so as to make informed choices. The caregivers should have information on health

aspects such as nutrition and proper hygiene. This model was developed by social psychologists in the United States of America to explain lack of public participation in the health screening and prevention programs. The model holds that the health behaviours are a function of individual socio demographic characteristics, knowledge and attitude.

At independence, political leaders mentioned diseases as one of the three enemies of the state and hence vowed to eradicate the diseases as part of their cardinal duty to the people of the republic of Kenya. The other two being poverty and ignorance. Ignorance was to be eliminated through promotion of the populace. Elimination of these two would consequently keep poverty at bay. Hence health is a key pillar of a healthy and prosperous nation. Political leaders are wont to say that the health of a nation is directly tied to the health of its people. In this regard children living with HIV/AIDS are part and parcel of the nation and their health status has a direct bearing on the health of the nation. They should thus be accorded all the due care they require so that they can take part in nation building later in life, through acquisition of education. Children bogged down by diseases occasioned by HIV/AIDS may not fully take part in learning activities. However their situation, though looking dire, can be lessened through medication and proper nutrition. In some cases, children who once were seropositive have been reported to have converted to seronegative status after proper nursing care has been administered to them.

1.10.2 Abraham Maslow Theory of Motivation

Maslow's hierarchy of needs is a theory in psychology first proposed by Abraham Maslow in 1943. He posits that human behaviour is normally driven by motivation in response to our needs.

Maslow's hierarchy of needs is predetermined in order of importance. It is often depicted as a pyramid consisting of five levels: the lowest level is associated with physiological needs, while the uppermost level is associated with self-actualization needs, particularly those related to identity and purpose. The higher needs in this hierarchy only come into focus when the lower needs in the pyramid are satisfied. Once an individual has progressed upwards to the next level, needs in the lower level will no longer be of necessity. If a lower set of needs is no longer being met, the individual will temporarily re-prioritize those needs by refocusing attention on the unfulfilled needs, but will not permanently regress to the lower level (Maslow, 1970). These stages or needs include:

1. Physiological _____ food, shelter, water, clothing, health among others
2. Safety needs _____ protection from danger, feeling
3. Love and belonging _____ affection, care and love
4. Self esteem needs _____ recognition, respect
5. Self actualization _____ self fulfilment, feeling of having arrived, reached
the highest apex of one's aspiration

Physiological needs

These needs, also known as physical needs, are obvious - they are the basic requirements for human survival. If these requirements are not satisfied (with the exception of clothing and shelter), the human body simply cannot continue to function. Examples of physiological needs are: breathing, homeostasis, water, sleep, food, clothing and shelter.

Safety needs

With their physical needs relatively satisfied, the individual's safety needs take over and dominate their behavior. These needs have to do with people's yearning for a predictable, orderly world in which injustice and inconsistency are under control. In the world of work, these safety needs manifest themselves in such things as a preference for job security, grievance procedures for protecting the individual from unilateral authority, savings accounts, insurance policies, and the like (Maslow, 1970).

It is mostly in the developed countries that physiological and safety needs are reasonably well satisfied. The obvious exceptions, of course, are people outside the mainstream — the poor and the disadvantaged. They still struggle to satisfy the basic physiological and safety needs. They are primarily concerned with survival: obtaining adequate food, clothing, shelter, and seeking justice from the dominant societal groups. Safety and Security needs include: personal security, financial security, health and well-being, safety net against accidents/illness and the adverse impacts.

Social needs

After physiological and safety needs are fulfilled, the third layer of human needs is social. This psychological aspect of Maslow's hierarchy involves emotion-based relationships such as friendship, intimacy, having a supportive and communicative family.

Humans need to feel a sense of belonging and acceptance, whether it comes from a large social group, such as clubs, office culture, religious groups, professional organizations, sports teams, gangs, or small social connections (family members, intimate partners, mentors, close colleagues, confidants). They need to love and be loved (sexually and non-sexually) by others. In the absence of these elements, many people become susceptible to loneliness, social anxiety, and clinical depression. This need for belonging can often overcome the physiological and security needs, depending on the strength of the peer pressure; an anorexic, for example, may ignore the need to eat and the security of health for a feeling of control and belonging.

Esteem

All humans have a need to be respected, to have self-esteem and self-respect. Also known as the belonging need, esteem presents the normal human desire to be accepted and valued by others. People need to engage themselves to gain recognition and have an activity or activities that give the person a sense of contribution, to feel accepted and self-valued, be it in a profession or hobby. Imbalances at this level can result in low self-esteem or an inferiority complex. People with low self-esteem need respect from others. They may seek fame or glory, which again depends on others. It may be noted, however,

that many people with low self-esteem will not be able to improve their view of themselves simply by receiving fame, respect, and glory externally, but must first accept themselves internally. Psychological imbalances such as depression can also prevent one from obtaining self-esteem on both levels.

Most people have a need for a stable self-respect and self-esteem. Maslow noted two versions of esteem needs, a lower one and a higher one. The lower one is the need for the respect of others, the need for status, recognition, fame, prestige, and attention. The higher one is the need for self-esteem, strength, competence, mastery, self-confidence, independence and freedom. The last one is higher because it rests more on inner competence won through experience. Deprivation of these needs can lead to an inferiority complex, weakness and helplessness. Maslow stresses the dangers associated with self-esteem based on fame and outer recognition instead of inner competence. Healthy self-respect is based on earned respect.

Self-actualization

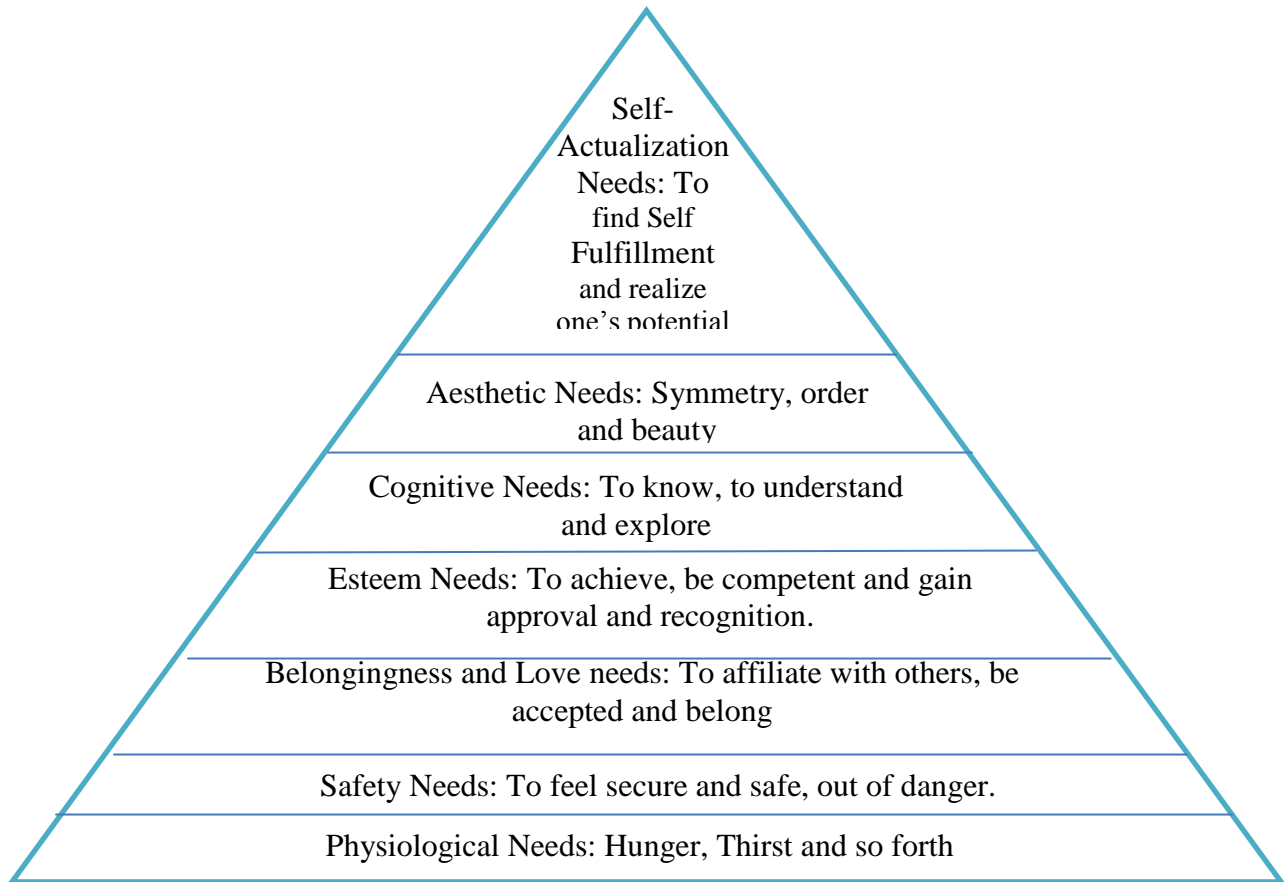
The motivation to realize one's own maximum potential and possibilities is considered to be the master motive or the only real motive, all other motives being its various forms. In Maslow's hierarchy of needs, the need for self-actualization is the final need that manifests when lower level needs have been satisfied (Maslow, 1970).

Thus the people affected by AIDS find it difficult to find fulfilment in their lives since they cannot be able to meet even the basic needs of their lives. Thus according to Maslow

theory, one must fulfil the first needs before he/she can go to the other stage. In the case of children in the homes, the first and foremost need is the provision of their basic needs such as food shelter, water and clothing.

Education transcends the whole spectrum of Maslow's hierarchy of needs, as it is a basic prerequisite for one to achieve socio-economic success in life. As a result of education one may be able to realize his dream in life hence his/her self-esteem will be enhanced and can consequently reach self-actualization. Hence children living with HIV/AIDS will have impediments to overcome so as to realize their dreams through education. Due to the societal belief that educating these cadres of children is a waste of resources, their social standing that would otherwise be promoted through educational progression, would not be enhanced and this will have a detrimental effect on their self-esteem. Hence education is of paramount importance and qualifies to be termed as one of the basic needs in adherence to Abraham Maslow's hierarchy of needs.

Figure 1.2: Diagrammatic Representation of Maslow Hierarchy of Needs



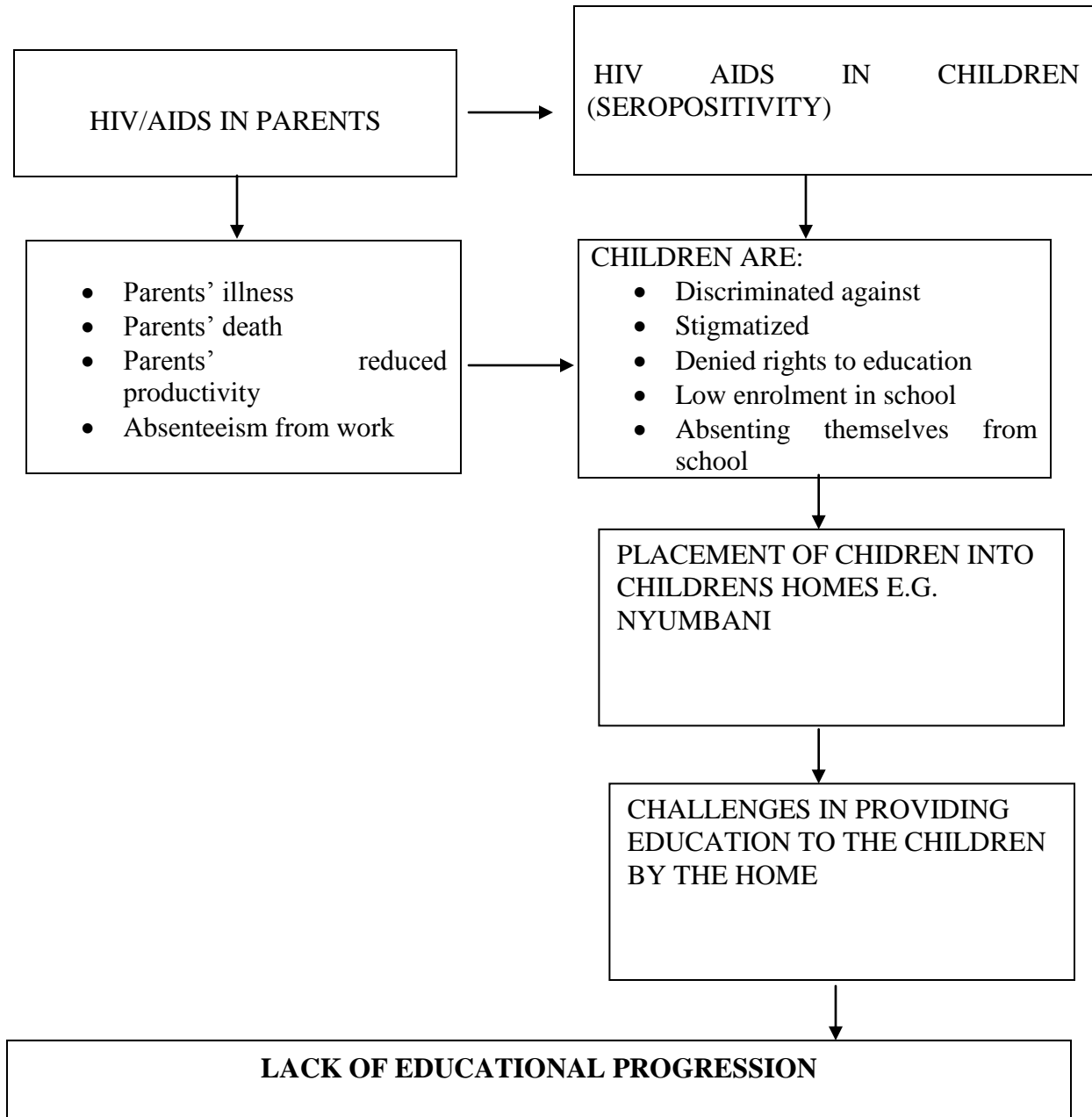
Source: Atkinson (1983)

1.11 Conceptual Framework

As demonstrated in figure 1.3, HIV/AIDS in parents has a direct effect on the children, as it is the principal mode of transmission of HIV/AIDS in children. This consequently has a negative resultant effects in that they face discrimination, stigmatization and as well as being denied rights to take part in learning activities. Also as a result of their health status and lack of parental care, those attending schools may withdraw from schools resulting in low enrolment. These children subsequently find themselves in children homes such as

Nyumbani. The home faces attendant challenges associated with taking care of children, which in turn affects their educational progression. It is in this regard that the study sought to find out what these challenges were and came up with ways to mitigate them.

Figure 1.3: Conceptual Framework



Source: researcher's own (2009)

1.12 Operational Definition of Terms

- AIDS** - Acquired Immune Deficiency Syndrome.
- HIV** - Human Immuno Virus - this is a virus that attacks and weakens the body's immune system making the infected person susceptible to other life threatening diseases.
- Affected** - Refers to a person who experiences the impact of AIDS through loss of relatives, friends or colleagues.
- AVERT.org** - An international AIDS and HIV charity.
- Infected** - Person living with HIV/AIDS.
- Orphan** - A person under the age of 18 years who has lost one or both Parents.
- Stigma** - A mark or state of shame, disrespect, blame, condemnation and negative opinion on an individual either affected or infected with HIV/AIDS.
- Nyumbani** - Kiswahili word meaning home. This is a hospice catering for children infected with HIV/AIDS, based in Nairobi.
- Lea Toto** - Kiswahili word which means to raise a child.
- Challenged** - Facing certain difficulties/problems.
- Sero positivity** - Presence of HIV virus in a person.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of the literature relevant to the current study. It discusses the role of education, the rights of the child, the socio – economic impacts as well as giving a sneak preview of HIV/AIDS and the infected children.

2.2 HIV/AIDS: The Global Picture

According to UNAIDS (2005), a child dies from AIDS related illnesses every minute. Approximately 2,000 children are infected with HIV every day. These statistics show that millions of children around the world are affected by the crisis unfolding around them. They watch their families, teachers and community members suffering and dying from this highly stigmatized disease. They are silent witnesses to the severe impacts of the pandemic. Ultimately, many children miss out on their own childhoods because of the extra responsibilities they bear and the economic and social insecurity that results from the sickness or death of their parents or caregivers.

HIV-positive children are particularly invincible. Some 2.3 million children under the age of 15 are living with HIV worldwide (UNAIDS/WHO, 2005), majority of them with no access to any form of care or treatment. Currently, less than 5 per cent of HIV-positive children have access to the paediatric AIDS treatment they desperately need (UNICEF/UNAIDS, 2005). Without treatment, most children with HIV will die before their fifth birthday (UNICEF/UNAIDS, 2005).

Children account for only 14 per cent of overall HIV infections, but they represent 18 per cent of all AIDS deaths (UNAIDS/WHO, 2005). Over 90 per cent of children living with HIV live in sub-Saharan Africa (UNAIDS/WHO, 2005). These children also have the least access to any treatment - either to prevent infection or to combat the disease, an inequity with disastrous consequences, as AIDS has already caused infant mortality in Africa to increase by more than 19 per cent (ANECCA, 2004) and contributes strongly to increases in under-five mortality in this region as well (WHO, 2005). According to the report of the Global Movement for Children (2006), the international community has been warned that unless it takes urgent account of the specific impact of AIDS on children there will be no chance of meeting Millennium Development Goal (MDG) number 6 which is to halt and begin to reverse the spread of the disease by 2015. The report further warns that failure to meet the goal on HIV and AIDS will adversely affect the world's chances of progress on the other MDGs. The deaths of these children are not inevitable. HIV-positive children can and do respond to antiretroviral treatment. They must be accorded a chance to live.

International and national commitments to fight HIV and AIDS have gained momentum over the last two decades - between 2002 and 2004 alone, AIDS funding nearly tripled (UNAIDS, 2004). However, the commitments still fall far short of needs, and children in particular do not explicitly appear in AIDS funding commitments. It has been recommended that coordinated action must be taken now to protect the rights of children infected with HIV and to invest in their future (WHO, 2005 in Global Movement, 2006).

2.3 Children's Homes in Kenya

The number of Children's Homes in Kenya keeps on fluctuating from time to time. Some homes get established while others close down; lending credence to the fact that these homes may be experiencing teething problems mostly financial. According to the senior children officer (personal interview) at the Nairobi Provincial Children's Home Affairs, some homes are registered while others are not registered thereby operating illegally. As of May 2008, the total number of children's homes in Kenya was 759 of which 331 were registered and 428 not registered. These homes are distributed all over Kenya while majority concentrated in the Rift Valley Province. The high concentration of the homes is as a result of the expansive nature of the Rift Valley in terms of land acreage.

2.4 Children of Nyumbani

In September 8, 1992, Nyumbani children's home was founded by Father Angelo D'Agostino, an American Jesuit priest of Italian descent. This home was founded as the first hospice for children with HIV/AIDS in Kenya. He had received support from Mwai Kibaki, the current President of Kenya who was the Minister of Health at the time. Based in Nairobi, Nyumbani has become a place where innocent children who have been the recipients of heavy discrimination find love, compassion, and true friends that remain at their sides through the good and the bad times. The home's residents consist of children whose parents have died because of complications associated with HIV or AIDS, and those who, because they have been infected with HIV themselves, have been abandoned by their parents or guardians (Nyumbani, 2007).

One of the initial achievements of father Angelo's efforts was the establishment of a facility that provides shelter, food, education, antiretroviral therapy, and much more to nearly 100 children, from newborns to those in their early twenties. Infants are cared for until a clear assessment of their HIV status can be made. The reason for this is because newborns whose mothers are infected with HIV often play host to antibodies within their system that yield false-positive results for a prolonged period. Nyumbani matches the children who ultimately prove to be free from the virus with parents willing to adopt them. The orphans who remain with the home are given the best nutritional, medical, in particular, anti-retroviral therapy, psychological, academic, spiritual care available and live at Nyumbani until they become self-reliant (Nyumbani, 2007).

However, due to the magnitude of the AIDS pandemic in Kenya and with Nyumbani having limited capacity to house only about 100 orphans, Father Angelo was well aware of the fact that countless children in Kenya were in need of help. Thus in 1998, Father Angelo launched "Lea Toto" program. The goal of this outreach program is to provide home-based care to HIV-positive children throughout Nairobi, especially those living in the slums such as Kangemi, Mathare, Kibera among others. Under this program, basic medical treatment, spiritual guidance, counselling, and other services are provided. Lea Toto has been proven to save money that would have been spent on hospital care, while allowing the children and their caretakers to live more positively and comfortably in their homes.

2.5 Mode of Transmission in Children

Every day, more than 1500 children become infected with HIV (UNAIDS, 2002). According to Medecin Sans Frontiers (MSF), a child under the age of 15 is infected with HIV every minute (MSF, 2005). The vast majority of these children (more than 90%) acquire the infection from their mothers (UNAIDS, 2002). Since the beginning of the pandemic, over 5 million infants have been infected with HIV, 90% of whom were in Africa. However, the number of cases in Central Asia, Eastern Europe, India and South-East Asia is rising. In the year 2001, an estimated 800 000 children became infected in these regions (UNAIDS, 2002).

Children may acquire HIV infection during pregnancy, labour, and delivery or after birth during breastfeeding. Fortunately, most children born to HIV-infected mothers are not infected. Estimates of the rates of mother-to child transmission (MTCT) of HIV have ranged, (without the use of antiretroviral (ARV) drugs during pregnancy and in the newborn) from 15–25% in industrialized countries to 25–35% in developing countries.

Among infected infants who are not breastfed, about two-thirds of cases of mother to child transmission (MTCT) occur around the time of delivery and the rest during pregnancy (mostly during the last two months). In societies where breastfeeding is the norm, it accounts for about one-third of all transmissions. As a result, the proportion of infants infected through MTCT is higher in these societies than in those where mothers with HIV infection can safely avoid breastfeeding (UNAIDS, 2002).

HIV infection can also be transmitted through blood transfusion and the use of contaminated needles and syringes. In Europe, in the late 80s more than half the children with AIDS lived in Romania, where they were infected in that period through contaminated blood products (used during transfusion) and syringes (UNAIDS, 2002). However, strategies such as the screening of all donated blood and avoidance of the inappropriate use of blood and/or its products have been adopted and are succeeding in reducing transmission by this route (UNAIDS, 2002).

Child sexual abuse is another significant cause of childhood HIV infection. Information from several studies indicates that sexual abuse may be a problem of similar magnitude to that described in industrialized countries (UNAIDS, 2002).

In developing countries, many gains were achieved in the 1990s, by WHO/UNICEF's child survival programmes in immunization, oral rehydration therapy, effective case management of acute respiratory infections, and promotion of breastfeeding, good weaning practices, family planning and growth monitoring. But the HIV/AIDS pandemic has reversed these gains in many countries.

Children with HIV infection suffer from the same common childhood illnesses as those who are not infected. The illnesses are, however, more frequent, last longer and may respond poorly to usual treatments. Most illnesses are initially caused by common harmful germs. However, as HIV infection progresses, the illnesses may be due to harmless germs that take advantage of the body's inability to fight infection as a result of

HIV illness. These may be difficult to diagnose. Unless concrete action is taken now, under-five child mortality rates will more than double in countries such as Botswana, Kenya and Zimbabwe by the year 2010 (UNAIDS, 2002).

As in adults, HIV infection in children is a chronic condition with a wide spectrum of clinical expression, varying from no symptoms to AIDS. The management of specific conditions is similar to that for uninfected children. Without access to highly active anti-retroviral treatment, the disease progresses rapidly, with up to 45% of infected children developing AIDS and dying within the first two years of life. However, some children with HIV infection have an adult pattern of disease, with HIV-related symptoms appearing 10 or more years after initial infection.

In industrialized countries, where infected infants have easy access to ARV therapy, more than 80% are still alive at the age of six. Some children are now surviving into their twenties and are having children of their own. It is a different picture in developing countries where children with HIV infection often die from common childhood diseases even before developing severe immuno suppression (UNAIDS, 2002). Early awareness, early diagnosis and the correct management of common childhood diseases can prevent many HIV-related deaths in developing countries.

2.6 Societal Response to AIDS

Since the year 1981, when scientists discovered HIV/AIDS, social responses of fear, denial, stigma and discrimination have accompanied the epidemic. Discrimination has

spread rapidly, fuelling anxiety and prejudice against the groups most affected as well as those living with HIV and AIDS. HIV and AIDS are as much a social phenomena as they are a biological and medical one. According to UNAIDS (2003), the global epidemic of HIV/AIDS has shown itself capable of triggering responses of compassion, solidarity and support bringing out the best in people, their families and communities. HIV/AIDS is also associated with stigma, repression and discrimination as individuals affected (or believed to be affected) by HIV have been rejected by their families, their loved ones and the communities. UNAIDS (2001), describes stigma as a powerful tool of social control. Stigma can be used to marginalize, exclude, and exercise power over individual who show certain characteristics. While the rejection of certain social groups (for example, homosexuals, injecting drug users and sex workers) may predate HIV/AIDS, the disease has in many cases, reinforced this stigma. By blaming certain individuals or groups, society can excuse itself from the responsibility of caring for and looking after such populations. Such groups are denied access to the services and treatment they need.

Even in education set up, discrimination against HIV positive students is very much inherent and well manifested. Cases abound of learners who have been ostracised as a result of their seropositive status. For instance, the three Ray brothers were expelled from their school and their house was razed by arsonists. This forced their family to flee from their Arcadia home in Florida, USA, and become internally displaced persons in a different state (Geocities, 2009). Parker et al (2002) posits that:

“Children with HIV/AIDS or associated with HIV through infected family members have been stigmatized and discriminated against in educational settings in many countries. Stigma has led to teasing by classmates of HIV-positive school children or children associated with

HIV (Gilborn et al. (2001). Discrimination against HIV-positive children in the USA and Brazil, including exclusion from collective activities or expulsion from school, has led to non-discrimination legislation (Public Media Center 1995; Galvão 2000). However, less concern has been shown for young people who are perceived to be responsible for their HIV infection and who are already stigmatized and discriminated against because they are sexually active, homosexual, or drug users. In the USA, for example, HIV-positive young gay men have been expelled from school and, in some cases, subjected to violence (Kirp et al. 1989)".

In many societies, people living with HIV/AIDS are often seen as shameful. In some societies the infection is associated with the minority groups or behaviours, for example homosexuality. In some cases, HIV/AIDS may be linked to perversion and those infected will be punished. In some other societies, HIV/AIDS is seen as the result of personal irresponsibility (UNAIDS, 2001). Sometimes HIV/AIDS are believed to bring shame upon the family or community.

There are a number of factors that may explain HIV/AIDS related stigma. Firstly, HIV/AIDS-related illnesses are life-threatening hence people are scared of contracting it. Secondly, people living with HIV/AIDS are often thought of as having become infected due to their irresponsible lifestyle. Thirdly, some religious or moral beliefs lead some people to believe that having HIV/AIDS is the result of moral fault that deserves to be punished (Linyiru, 2004, Mishra, 2008).

Sexually transmitted diseases are well known for triggering, for example, tuberculosis, the real or supposed contagiousness of the disease has resulted in the isolation and exclusion of infected people. From the beginning of the AIDS epidemic, a series of

powerful images were used that reinforced and legitimized stigmatization (UNAIDS, 2003). Observing some of the banners, placards and publications used by HIV/AIDS awareness lobbyists from 1994 to 2004, one could draw the following observations, according to Mishra (2008):

- HIV/AIDS as punishment (for example for immoral behaviour);
- HIV/AIDS as a crime (for example, in relation to innocent and guilty victims);
- HIV/AIDS as war (for example, in relation to a virus which needs to be fought);
- HIV/AIDS as horror (for example, in which infected people are demonized and feared); and
- HIV/AIDS as otherness (in which the disease is an affliction of those set apart).

Together with the widespread belief that HIV/AIDS is shameful, these images represent ready-made but inaccurate explanations that provide a powerful basis for both stigma and discrimination. These stereotypes also enable some people to deny that they personally are likely to be infected or affected. In some societies, laws, rules and policies can increase compulsory screening and testing as well as limitation on international travel and migration. UNAIDS (2003) observes that in most cases, discriminating practices such as the compulsory screening of the risk groups, both further the stigmatization of such group as well as creating a false sense of security among individuals who are not considered at high risk.

Laws that insist on the compulsory notification of HIV/AIDS cases, and the restrictions of a person's right to anonymity and confidentiality, as well as the right to movement of

those infected, have been justified on the grounds that the disease form a public health risk. As a response, numerous countries have now enacted legislations to protect the right and freedom of people living with HIV/AIDS and safeguard that from discrimination. Much of the legislation has been sought to ensure their right to employment, education, privacy and confidentiality, as well as the right to access information, treatment and support (Linyiru, 2004).

According to UNAIDS (2002) governments and national authorities sometimes cover up and hide cases or fail to maintain reliable representative systems. Ignoring the existence of HIV/AIDS, neglecting to respond to the needs of those living with HIV infection and failing to recognize growing epidemics in the belief that HIV/AIDS “can never happen to us” are some of the most common forms of denial. These denials fuel AIDS stigmas by making those individuals who are infected appear abnormal and exceptional. Stigma and discrimination can arise from community level responses to HIV/AIDS. The harassing of individuals suspected of being infected or of belonging to a particular group has been widely repeated. It is often motivated by the need to blame and punish and in extreme circumstances can be extended to acts of violence and murder. Attacks on men who are assumed to be gay have increased in many parts of the world, and HIV/AIDS murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand (UNAIDS, 2003).

The impact of HIV/AIDS on women is particularly acute. In many developing countries, women are often economically, culturally and socially disadvantaged and lack equal

access to treatment, financial support and education. In a number of countries, women are mistakenly perceived as the main transmitters of Sexually Transmitted Diseases (STDs). Together with traditional beliefs about sex, blood and the transmission of other diseases, these beliefs provide the basis for the stigma of women within the context of HIV/AIDS (UNAIDS, 2003). HIV-positive women are treated very differently from men in many developing countries. Men are likely to be excused for their behaviour that resulted in their infection, whereas women are not.

In majority of developing countries, families are the primary care givers to sick members. There is clear evidence of the importance of the role that the family plays in providing support and care for people living with HIV/AIDS (UNAIDS, 2003). However, not all family responses are positive. Infected members of the family can find themselves stigmatized and discriminated against by their nuclear and extended families. There is also clear evidence that women and non-heterosexual family members are more likely to be badly treated than children and men (Mishra, 2008).

While HIV is not transmitted in the majority of the workplace settings, the supposed risk of transmission had been used by numerous employers to terminate or refuse employment (Linyiru, 2004). There is also evidence that if people living with HIV/AIDS are open about their infection status at work, they may well experience stigmatization and discrimination by others. Pre-employment screening takes place in many industries particularly in countries where the means for testing are available and affordable. In poorer countries screening has also been reported as taking place, especially in industries

where health benefits are available to employees. Employer-sponsored insurance schemes, providing medical care and pensions for their workers have come under increasing pressure in countries that have been seriously affected by HIV/AIDS. Some employers have used this pressure to deny employment to people living with HIV/AIDS. A case in point is that of Justine Adhiambo Ombuor who took her employer to court for denying her employment on account of her seropositivity status. The court ruled in her favour by awarding her Ksh. 2.25 million for wrongful dismissal (Otieno, 2009).

Many reports (UNAIDS, 2001) reveal the extent to which people are stigmatized and discriminated against by health care system. Many studies reveal the reality of withheld treatment, non-attendance of hospital to patients, HIV testing without cause, lack of confidentiality and denial of hospital facilities and medicines. Also fuelling such responses are ignorance and lack of knowledge about HIV Transmission. A survey conducted in 2002 among some 1000 physicians, nurses and midwives in four Nigerian States (UNAIDS, 2003) returned distressing findings. One in ten doctors and nurses admitted having refused to care for an HIV/AIDS patient or had denied HIV/AIDS patient admission to a hospital. Almost 40% thought a person's appearance betrayed his/her HIV-Positive status and 20% felt that people living with HIV/AIDS had behaved immorally and deserved their fate. One factor fuelling stigma among doctors and nurses is the fear of exposure to HIV as a result of lack of protective equipments.

Lack of confidentiality has been repeatedly mentioned as a particular problem in health care settings. Many people living with HIV/AIDS don't have to choose how, where and

to whom to disclose their HIV status. According to UNAIDS (2001), 29% of the persons living with HIV/AIDS in India, 38 % in Indonesia and over 40 % in Thailand had their HIV-Positive status revealed to someone else without their consent.

Huge differences in practices also exist between countries and between health care facilities. In some hospitals, signs have been placed near people living with HIV/AIDS with words such as HIV-positive and “AIDS” written on them. Clearly, HIV-related stigma and discrimination remains a serious barrier to effectively fighting HIV and AIDS epidemic. This is because fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly. People with or suspected of having HIV may be turned away from health care services, employment, refused entry to foreign countries. In some cases, they may be evicted from home by other family members and rejected by their friends and colleagues. The stigma attached to HIV/AIDS can extend into the next generations, placing an emotional burden on those left behind. This in turn interferes with the educational progression of the orphaned and the infected children as there will be no one to accord them moral and financial support.

Denial goes hand in hand with discrimination, with many people continuing to deny that HIV exists in their communities. Today, HIV/AIDS interferes with the welfare and well being of people throughout the world. At the end of the year 2003, 10 million people were living with HIV/AIDS and during that year 3 million died from AIDS related illness (UNAIDS, 2003). Combating the stigma and discrimination against people who are

affected by HIV/AIDS is as important as the medical cures in the process of preventing and controlling the global epidemic.

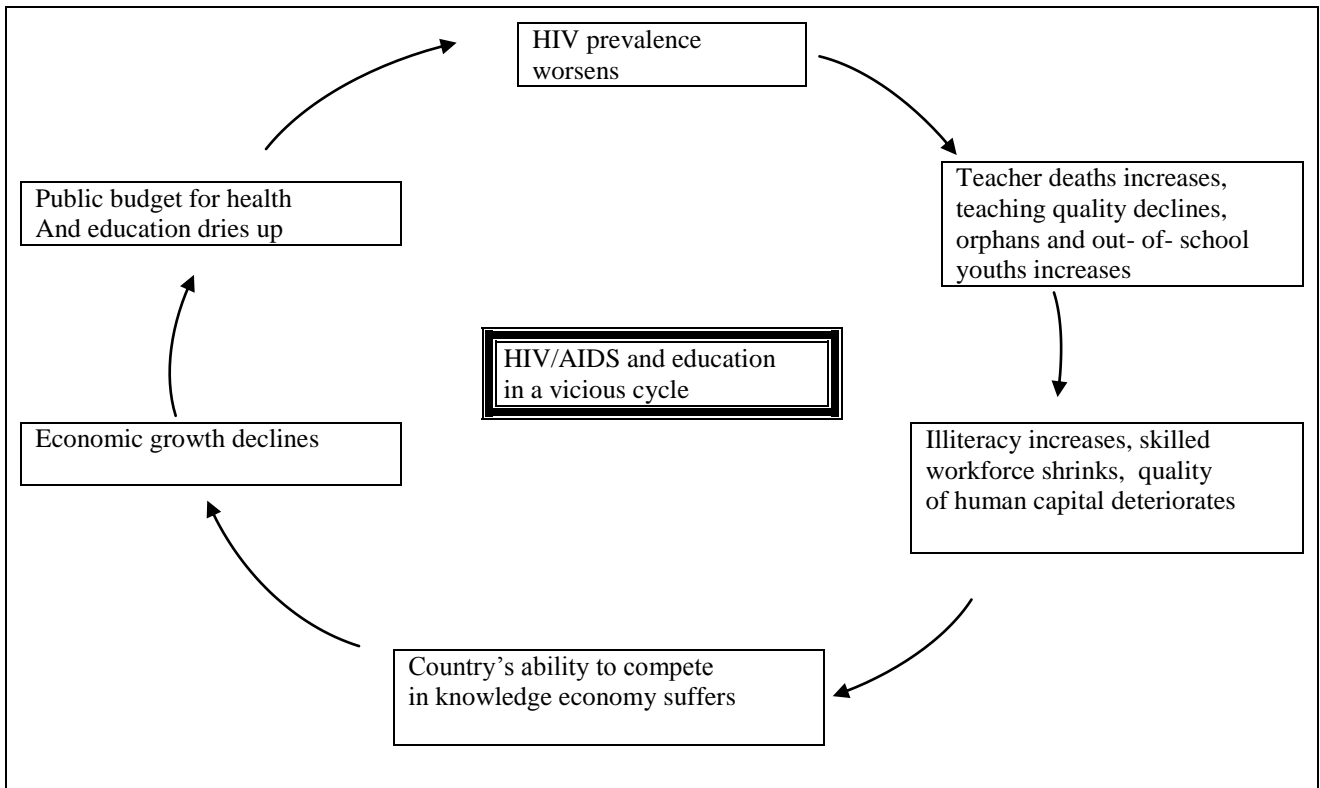
2.7 Impact of HIV/AIDS on Education

Throughout the world, HIV/AIDS is having a dramatic effect on the lives of individuals, families and communities. Family members have died, others may be sick and in need of care, and all face the daily threat of stigmatisation and discrimination. Particularly severe is the epidemic's impact on schools and education. HIV/AIDS reduces the supply of education by reducing the number of teachers who are able to carry out their work and resources available for education. The epidemic reduces the demand for education as children are withdrawn from schools and colleges in response to rising household expenditure to provide care for infected family members. The quality of education is also affected as a result of the strains on the material and human resources of the system and on the health and presence of the learners. In many countries, especially those in sub-Saharan Africa, HIV/AIDS is undermining institutional capacity needed to protect the health and development of children and young people. Student enrolment and achievement are falling as more children become infected, orphaned or burdened by the impact of AIDS. The epidemic therefore, impacts negatively on the quality of education and consequently on the progression through educational systems (Mishra, 2008).

Management of education system is threatened by illness and death of qualified persons. Thus the vicious cycle of increasing HIV/AIDS leading to decreasing educational

services, which thereby leads to greater vulnerability, is dramatic. This cycle poses a long term threat to the attainment of EFA goals and, more broadly, to development.

Figure 2.1: HIV/AIDS and Education



Source: Mishra (2008)

2.8 The Role of Education

Education is a process concerned with universal functions. That is the function of transmitting skills, norms, knowledge and values from generation to generation (Eshiwani, 1993 in Karanja, 2005). It aims at socializing individuals to fit into their society and to function adequately within it when they become adults.

Generally, at a very young age, children learn to develop and use their mental, moral and physical powers, which they acquire through various types of education. Dimpy (2000) defines formal education as the process of learning and obtaining knowledge at school. However, the process of education does not only start when a child first attends school. Education begins at home. One does not only acquire knowledge from a teacher; one can, and actually does learn and receive knowledge from a parent, family members and even acquaintances. In almost all societies, attending school and receiving an education is extremely vital and necessary if one wants to achieve socio-economic success. Although education is vital, great inequalities do exist around the world with regard to accessing educational opportunities (Dimpy, 2000).

The process of education has been part and parcel of Kenya's social, economic and political development. There is realization among Kenyans that good education carries with it socio-economic benefits. This is reflected in income differences and social status associated with the level of schooling that a person obtains. The role of parents, teachers, governments and other educational stakeholders in education of the child must be underscored. Absence or failures of stakeholders' participation may result in dismal academic achievement of the learner. This is because the child is a dependent being and higher success in the academic arena is highly influenced by the stakeholders' support.

Despite the ravages of AIDS, children living with HIV and AIDS have every inalienable right to quality education as part of their fundamental human right as enshrined in the Dakar Framework for Education for All (EFA) goals. Dimpy (2000) posits that no matter

what, education is the key that allows people to move up in the world, seek better jobs, and ultimately succeed fully in life. Education is very important, and no one should be deprived of it.

2.9 Rights of the Child in Kenya

In 2001, the Kenyan parliament enacted legislative agenda concerning children. Under this act of parliament a child is herein defined as ‘any human being under the age of eighteen years’ (NCCs, 2007). Children are entitled to the following rights as per the children Act, 2001;

- Right to life
- Right to parental care
- Right to education-free compulsory basic education
- Right to religious education subject to appropriate parental guidance
- Right to health and medical care
- Right to be protected from economic exploitation and any work that is likely to be hazardous or to interfere with the child’s education, or to be harmful to the child’s health or physical, mental, spiritual, moral or social development
- Protection from taking part in hostilities or in armed conflicts
- Right to a name and a nationality
- A right to be protected from physical and psychological abuse, neglect, sale, trafficking or abduction
- A right for a child with disability to be treated with dignity, and accorded appropriate medical care, special care, education and training

- Right to protection from harmful cultural practices including circumcision, early marriage and other cultural practices that are likely to negatively affect a child
- Right to protection from sexual exploitation and use in prostitution, inducement or coercion to engage in any sexual activity, and exposure to obscene materials
- Right to protection from drugs-including hallucinogens, narcotics, alcohol, tobacco products and psychotropic drugs
- Right to leisure, play and participation in cultural and artistic activities
- Right to protection against torture, cruel treatment or punishment, unlawful arrest or deprivation of liberty-cannot be subjected to capital punishment or to life imprisonment
- Right to privacy subject to parental guidance

Looking at the above rights, there is no distinctive mention of the rights of the child living with HIV and AIDS. The above mentioned rights are in a more general perspective and there is an urgent need for the government of Kenya to develop children living with HIV/AIDS policy paper to guide stakeholders dealing with the overall welfare of the children living with HIV and AIDS, more so on the issue dealing with their educational progression.

2.10 Summary

From the above review it is clear that children have not escaped the severe impact of HIV/AIDS pandemic. They are affected in equal measure as adults. It is imperative that more attention need to be focused on children concerning their welfare as they too have

rights just like adults. They have right to life, education social equity and recognition. This study sought to unravel the problems they undergo in their quest for education. HIV/AIDS affects education system just as it affects the body. For many years, however, the effects of the sickness have remained unnoticed. According to Kelly, (2000), it has been “business as usual”. From the above it is apparent that there is need for something to be done in this area; therefore there was a gap which the study strived to fill.

The study sought to find out the factors that impede academic progression of children infected with HIV/AIDS in Kenya using Nyumbani’s children home as a case study and explored the intervention strategies that need to be put in place to address the impacts of the scourge on the educational progress of children living with HIV/AIDS.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the procedures and the strategies that were followed in conducting this study. Specifically, it focuses on research design, location of the study, research instruments, pilot study, data collection procedures and data analysis techniques.

3.2 Research Design

Research design is defined as the plan, structure and strategy of investigation conceived so as to obtain answers to research questions and control variance (Kerlinger, 1964). According to Orodho (2004), research design refers to all the procedures selected by a researcher for studying a particular set of questions or hypotheses. He summarised it as a programme to guide the researcher in collecting, analyzing and interpreting observed facts. For this study, survey design was adopted to investigate the factors affecting the education of children living with HIV/AIDS in Kenya with special reference to Nyumbani children's home and the strategies employed to mitigate against those factors. This type of design is used in preliminary and exploratory studies. It allows the researcher gather information, summarise, present and interpret data for purposes of clarification, Orodho (2003). Also according to Moser and Kalton (1985), a survey entails an extensive research on the nature of the existing conditions. The field survey helped the researcher to come up with primary data which were summarised and analysed. This design was chosen for its suitability in that it allowed the researcher to

explore information and establish factors hindering education of children living with HIV/AIDS in Kenya.

3.3 Study Locale

The locale of this study was Nyumbani Children Home based in the Karen suburb of Nairobi city. This locale was purposively sampled as it is so far the only well known children's home in Kenya that caters for children living with HIV/AIDS. It houses approximately one hundred children ranging from 2-22 years. This locale was ideal for this study as it caters for a homogenous population in as far as the serostatus is concerned. Other homes have heterogeneous population in that it consist of both HIV negative and positive children, and, as a result, it would be difficult to know which children are HIV positive since the management may want to keep the information confidential to protect the identity of those children.

3.4 Target Population

The population used in this study was composed of the children, caregivers, the manager and the director based at Nyumbani Children's Home. Due to the sensitive nature of this study and owing to Nyumbani's prevailing policy on carrying out research at the institution, the researcher did not directly interact with children in the course of carrying out the study.

3.5 Sampling and Sampling Procedures

Orodho (2004) defines sampling as the process of selecting a sub-set of cases in order to draw conclusions about the entire set. However, Nyumbani Children's Home being such a small institution, the whole population was to be studied and the researcher employed purposive sampling technique in selecting the respondents. Children in lower primary, from class one to three, were excluded as well as those in tertiary institutions though they were residing in the home. Since the study was undertaken during school sessions, the children in boarding secondary schools did not take part as they were away in their respective boarding schools, though their input would have been more useful. The Nyumbani management and some workers did take part in the study.

3.6 Research Instruments

The data was collected using questionnaires and interview schedules.

3.6.1 The Questionnaires

According to Nkapa (1997:74) "a questionnaire is a carefully designed instrument for collecting data in accordance with the specification of the research questions". The questionnaires are preferred due to their suitability for this type of study. Mugenda and Mugenda (1999:71) observed that:

Questionnaires are commonly used to obtain important information about the population. Each item in the questionnaire is developed to address a specific objective, research question or hypothesis of the study.

The questionnaire consisted of both closed and open ended questions. The closed-ended questions provide data that is easy to compute and analyse, while the open-ended questions permit a greater depth of response, thus adding quality to the data collected. For this study, there were three types of questionnaires used. One type was meant specifically for the children and the other two for the workers and the management of Nyumbani.

3.6.2 Interview Schedule

According to Koul (1984) an interview schedule is:

A device consisting of a set of questions which are asked and filled by an interviewer in a face to face situation with the interviewee.

As observed by Mugenda and Mugenda (1999) the interview schedule makes it possible to obtain data required to meet specific objectives of the study. This instrument was designed to address the issues that form the basis of this study, for seeking information concerning the views of management of Nyumbani on challenges they face in educating children living with HIV/AIDS.

The interview schedule had both semi-structured items. This enhanced clarification, analysis of data and also revealed deep and truthful views of the interviewees concerning the challenges of educating HIV-positive children as perceived by the management of Nyumbani.

3.7 Pilot Testing

The research instruments in this study were carefully constructed to ensure their reliability and validity in the attainment of the objectives of the study. They were thoroughly checked by the supervisors to ascertain their accuracy. They were piloted in one childcare institution after which they were adjusted. The piloting helped to modify and remove any ambiguous items on the instrument. The data collected during the piloting was analysed and the results used for appropriate amendment of the instruments.

The main objective of pilot testing was to ascertain the accuracy and validity of the instruments before they were used in the actual study (Mugenda and Mugenda, 1999). The instrument was piloted at PCEA Tumaini children's home as it also has come out openly that it also caters for children living with HIV/AIDS (Tumaini, 2009). Its population is also homogeneous in terms of serostatus. This instrument was piloted on the manager, two teachers, two caregivers and children in primary and secondary schools. During the pilot study, the adult respondents answered the questions as asked but the children in primary schools did not answer some questions as per the researcher's expectations. This could be attributed to the method used in administering the questionnaires by the Nyumbani management. As a result of this, the questionnaires were thoroughly checked and adjustments made to correct any anomalies encountered.

3.7.1 Reliability

Reliability of a research instrument concerns the degree to which a particular procedure gives similar results over a number of repeated trials (Orodho, 2003). In order to ensure reliability in the current study, the researcher employed the test-retest method. One foster

home (PCEA Tumaini) was selected and questionnaires were distributed to the respondents for completion. The questionnaires were administered to the same respondents twice, their responses scored and a comparison made between the first and second scores. A Pearson's Product Moment Formula for the test-retest was employed to compute the co-efficient in order to establish the extent to which the contents of the questionnaires were consistent in eliciting similar responses every time the questionnaire was administered.

3.7.2 Content Validity

Validity is the degree to which an empirical measure or several measures of a concept accurately measure(s) the concept (Orodho, 2003). In the current study, the questionnaires were exhaustively discussed with peers to assess their appropriateness and relevance. Other relevant authorities such as lecturers knowledgeable in this area were also consulted. The feedback arising from consultation was incorporated in the questionnaires.

3.8 Data Collection

Before proceeding with data collection, permission was sought from the National Council of Science and Technology offices. The researcher made an appointment with the management of Nyumbani Children's Home for the study in writing, at least two weeks prior to the actual visit. During the first visit, the researcher explained to the respondents the purpose of his visit and made appointment when he would come back for the actual collection of data. On the agreed date, the researcher visited the institution to meet the

respondents, to collect data using the instruments previously prepared. The researcher administered the questionnaires to the respondents in person through the management of the home. He also conducted interview with the director at the appointed time and date.

3.9 Data Analysis

Orodho (2004) defines data analysis as process of systematically searching and arranging interview transcript, field notes, data and other materials obtained from the field with the aim of increasing your understanding of them and enabling you to present them to others. Mugenda (1999:190) summarized it thus, “the process of bringing order, structure and meaning to the mass of information collected”. After the field work before analysis, all the questionnaires were adequately checked for data verification. The data was tabulated and classified accordingly in line with the objectives of the study. The coded, tabulated and classified data was subjected to both quantitative and qualitative analysis. Quantitative data was analysed through descriptive statistics in the form of frequencies tallies and percentages. The statistics were generated using statistical package for social sciences (SPSS) and data obtained were communicated through pie charts, tables and bar graphs. The Likert –type questions were also analysed by presenting raw data using frequency tallies and their corresponding percentages. Qualitative data was analysed by organising them in accordance with the research questions and objectives. After the whole analysis had been done, conclusions and recommendations were then made.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.0 Introduction

This chapter presents the analysis and discussion of data collected for this study. The results were interpreted and discussed in relation to the research questions raised in chapter one.

The study sought to establish factors affecting education of HIV positive children in Kenya. It was conducted in Nyumbani Children's Home. The home was purposively chosen because it was the only well known hospice in Kenya taking care of children living with HIV/AIDS. The children population at the time of the study stood at 111 with ages ranging from 2 to 22 years. The sample size included pupils from upper primary level only as those in high school were in boarding session at the time of this study, hence did not take part in the study. Students in tertiary institutions were excluded as they were outside the scope of this study. The responses were tabulated. The tables bear the frequencies and percentages of the responses given. The findings were presented under the following themes:

- Finding out the challenges encountered by Nyumbani Children's Home in providing education to HIV/AIDS infected children.
- Establishing the innovations adopted by the home to circumvent challenges.
- Finding out the effect of the children's sero-positivity status on their academic performance.
- Investigating how the learners cope with their sero-positivity status.

- Establishing successful interventions and lessons that can be replicated in similar programs elsewhere.

4.1 Demographic Characteristics of the Respondents

4.1.1: Gender and Age

Data was sought on the sex of the respondents in order to find out the participation based on the gender of the participants and the data obtained is presented on Table 1 which is next.

Table 4.1 Gender distribution of the respondents in Nyumbani

Gender	F	%
Male	18	64.3
Female	10	35.7
Total	28	100.0

According to Table 1, majority (64.3 %) of the respondents were male while the female were 35.7%. This could infer that majority of the children who suffers from the scourge of HIV and AIDS in term of gender are male while female children are in the minority.

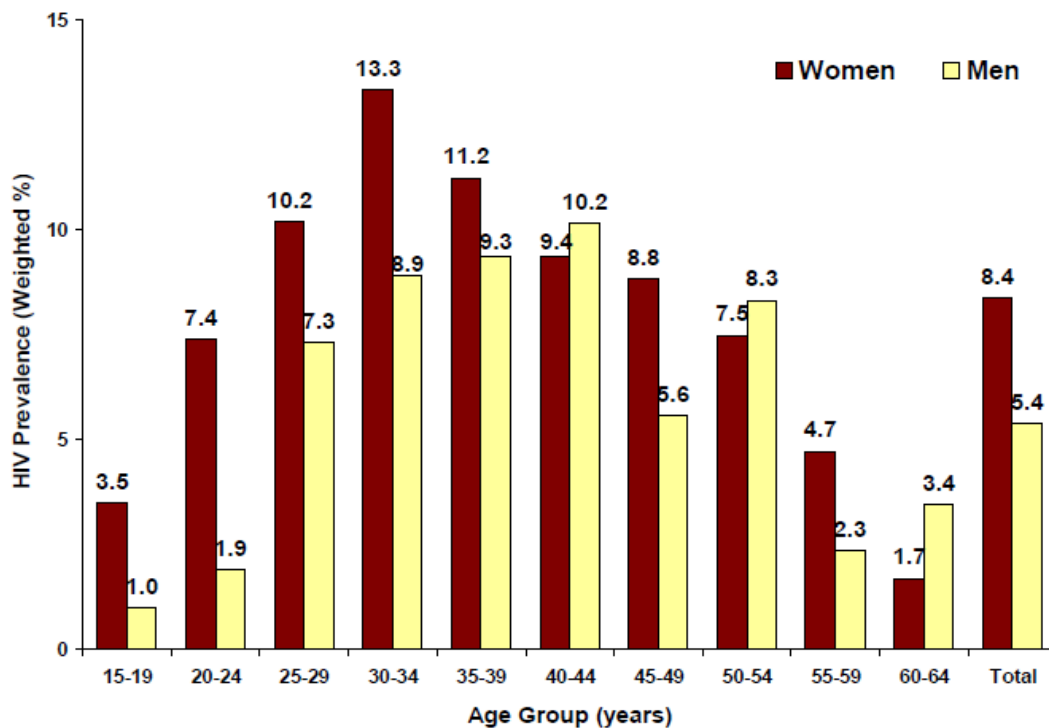
The age range for Nyumbani Children's Home is between 2 to 22 years, and has a population of 64 boys and 47 girls. However, it has been difficult obtaining information to do a comparative study concerning gender based statistics of children in age range of 0-14 living with HIV and AIDS in global, regional and local context. This may imply that no empirical study has been done on this. The data that is available basically concern the overall percentage of children infected with HIV/AIDS in the general population. For example, UNAIDS (2009) indicated that out of 33.4 million global HIV/AIDS sufferers

in 2008, 2.1 million children under the age of fifteen were infected with the virus, translating to 6.2%. No breakdown has been given concerning the number of girls and boys suffering from the virus.

There is no national data too that gives the number of children living with the HIV/AIDS gender-wise. The demographic findings from Nyumbani, may not resonate well with some studies that have been done that portray that the number of girls with HIV/AIDS in Kenya as well as some developing countries are higher than that of boys. The reason advanced for this is that girls are more vulnerable to the effects of HIV/AIDS than boys. Girls are exposed to sexual violence than boys. Dr. Mumbi Machera, in her report to WOFAK, “Linkage between violence against women and HIV/AIDS” (2009), revealed that HIV prevalence in the age range 15-49 is 8.7% while that of men in the same age range is 4.6%. HIV prevalence in girls in the age bracket of 15-19 years is six times higher than that of boys in the same age range (Mumbi, 2009). Turmen (2003) also carried out almost similar study as Mumbi and concluded that young girls and women are more vulnerable to HIV/AIDS than men, one of the means is through gender based violence and the women’s low socio-economic status. Gender based violence against the girls is one of the factors that hinders academic progression of children. In the study by Turmen (2003), it is reported that women accounted for 67% of infected individuals between the ages of 15-24. These two studies compares favourably with the findings of KAIS(2009) which found that HIV prevalence in women was 8.4% and men 5.4% and concluded that women were four times more likely to be infected with the HIV virus than men as depicted in the figures 4.1, 4.2 and 4.3 below. UNICEF(2010) and

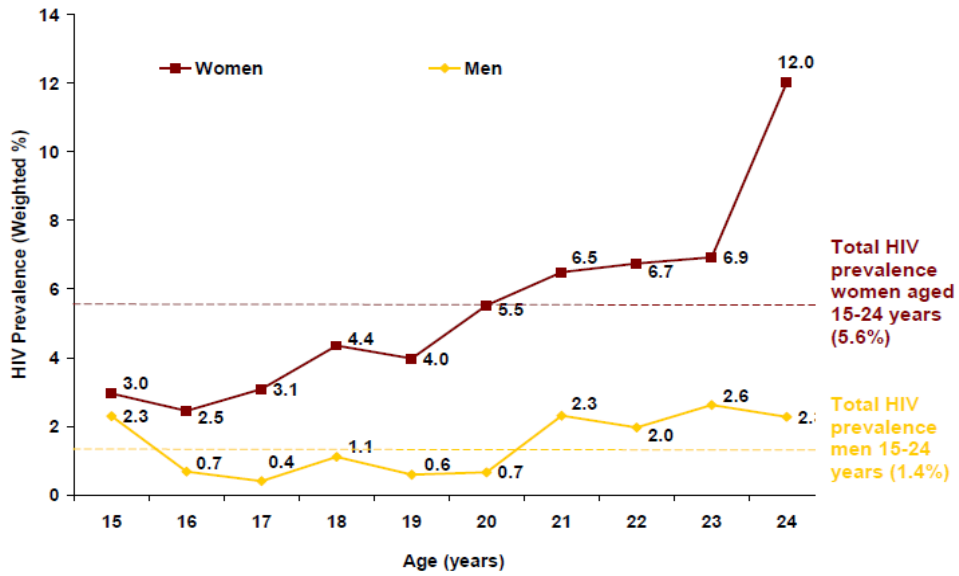
UNAIDS(2009) reveal that in the developing countries with the exception of East Asian countries, out of a total population of 5 million young people in the age range 15-24 years, 3.2 million were female translating to 64% while male aids sufferers were 34%. K'Oyugi (2002) also reveals that a survey done by NASCOP in Kisumu county showed that girls suffering from HIV/AIDS were more than boys in the same age range as shown in table 4.2. Other studies done in Swaziland show more female than male in the age range 10-30 years were infected with HIV (figure 4). Also results of survey done in selected nine west African countries are in tandem with the trends as discussed above as indicated in figure 4.4 (UNAIDS 2009).

Figure 4.1 HIV prevalence among women and men by five-year age group, Kenya 2007.



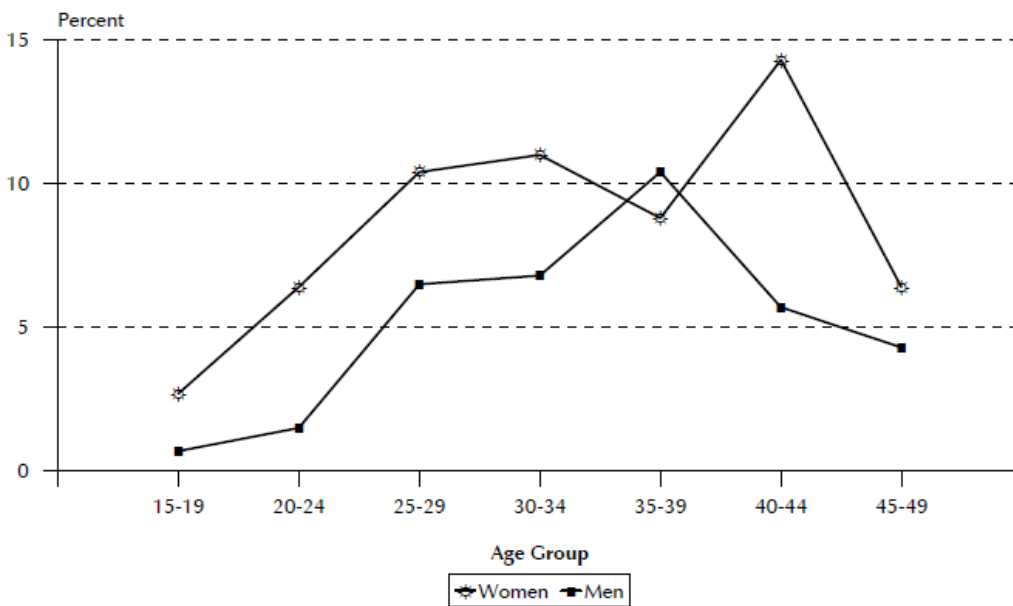
Source: KAIS (2009)

Figure 4.2: HIV prevalence among young women and men aged 15-24 years, Kenya 2007



Source: KAIS (2009)

Figure 4.3: HIV Prevalence by Age Group and Sex

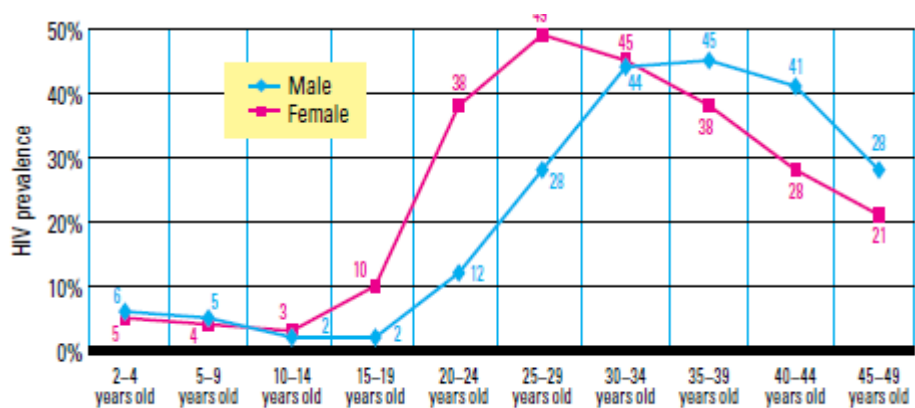


Source: KDHS (2009)

Table 4.2: HIV prevalence in Kisumu by age and sex, 1997

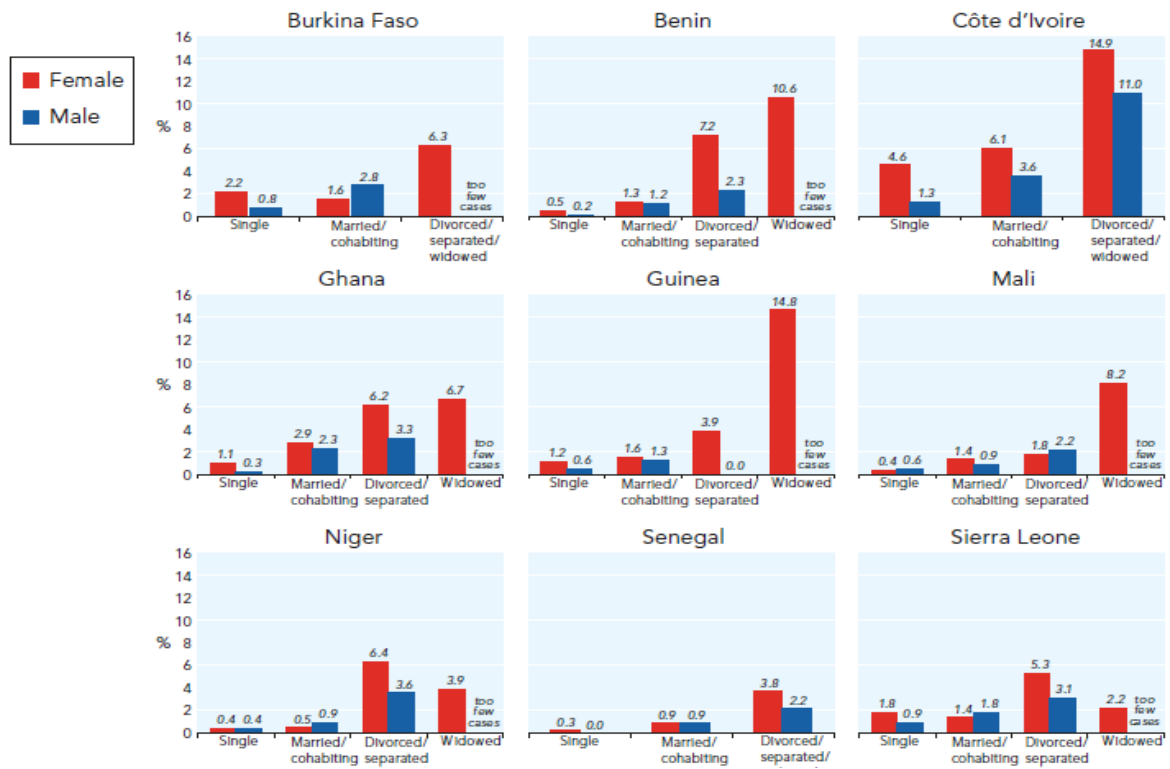
Distribution	15-	20-	25-	30-	40-	Total
Men	4.2	13.4	29.4	34.0	29.9	21.0
Women	22.3	39.0	38.6	31.7	19.4	30.9
Ratio	5.3	2.9	1.3	0.9	0.6	1.5

Source: UNICEF (2010)

Figure 4.4: HIV prevalence by age and sex, Swaziland, 2006-2007

Source: UNICEF (2010)

Figure 4.5: HIV Prevalence by marital status and gender in the general population of nine West African Countries



Source: UNAIDS (2009)

Therefore the data obtained from Nyumbani is not reflective of the global, continental and national trend. In an interview with the director of the home on how the children end up at Nyumbani, it was found that the children come via referrals from hospitals and police stations. Some are cases of abandonment, and these mostly consist of babies whom Nyumbani take and nurture up to adulthood. Some children are also referred to the home by the extended families of the children who may face financial constraint in caring for the children and as well may not have psychosocial capacity to care for them. SOS Children (2011) posits that “Orphans are often taken in by extended family members, but those families already afflicted by poverty may struggle to cope, both financially and

emotionally, and find themselves unable to care for these already-traumatized children". This situation may arise as a result of the demise of the biological parent. There is still no plausible reason to explain why Nyumbani have more boys' population than girls. This can be explained away that girls normally assume the roles of caregivers to their younger siblings upon the death of their parents as corroborated by Mumbi (2009). These girls may themselves be HIV positive (Mumbi, 2009).

4.2. Challenges encountered in educating HIV positive children

In trying to find out the challenges that hinders the researcher delved into studying the demographic characteristics of the workers based in nyumbani since they are the first people of contact with the children and what kind of ambience they create in the home as they interact with the children. They are classified as the primary caregivers.

4.2.1 Data on the contextual characteristics of the workers

Age and sex are important demographic variables and are the primary basis of demographic Classification. Data was sought on the gender of the workers.

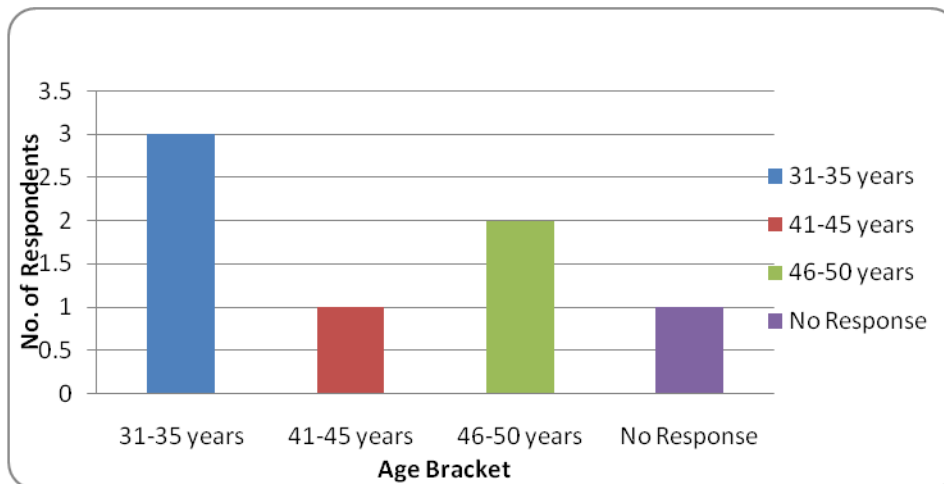
Table 4.3: Gender distribution of workers

Gender	F	%
Male	3	43.8
Female	2	28.6
Did not respond	2	28.6
Total	7	100.0

As depicted in the above Table 28.6% of the workers were female while the remaining (42.9%) were male. However, this finding does not give a true picture of the workers' gender composition in the home since 28.6% of the workers did not indicate their gender. Interpretation of the above data depicts that male care givers are more than female. However, this does not compare favourably with other studies that have been done which found that often there are more female caregivers than male. For instance, Donngern (2008) in his study of 80 case studies of caregivers to HIV positive children in Kalasin hospital, Thailand, found that 75% of them were female. This is also in tandem with the findings of the study done in South Africa by Moodley (2006) which quoted a high figure of 91% of caregivers as being female. In Kenya, most child headed households are led by girls, Mumbi (2009).

Data was also sought on the age of the caregivers and the result is as tabulated below.

Figure 4.6: Bar Graph Showing Age Brackets of Respondents



Source: Own, based on field work research (2011)

As data on age in the above table shows, majority of the workers (42.8%) were aged between 31-35 years, those aged between 46-50 years were 28.6%. While 14.3% were between 41-45 years and finally those who did not respond were 14.3%.

From the data above it shows that all the workers are 31 years and above. These are mature people who can deal with and understand the young children.

The above findings compares favourably with the study done by Moodley (2006) who gave the mean age of caregivers as 33 and Donngern (2008) who gave 45.5 as the average age of caregivers in his findings. Though some studies have given the age of caregivers as below 20 years, a scenario that usually manifests in child-headed households Mumbi (2009), age of caregivers is preferable to be above 31 years as they are more mature and capable of bearing distress in handling traumatised children. Taking care of children infected with HIV virus is no mean feat as these children having been diagnosed with life threatening illness carry with them attendant health and emotional burden. Hence caregivers should be endowed with strong emotional capacity in order to take care of them. The age of the care givers can be connected to the educational pursuits of the children living with the HIV virus. Because of their maturity in age and experience, they are able to counsel the children on the importance of education and help them in their day to day life activities. Also they are able to disclose to the children about their seropositivity status and offer calm assurance and guidance in an empathetic manner. Donngern (2008) and Moodley (2006) inferred that caregivers in this age group have a mature demeanour and have more knowledge about the disease and therefore are able to communicate to the children about their HIV seropositivity. In a study carried out

in Togo, one of the factors inhibiting disclosure to children about their seropositivity status, fear of discrimination was cited as the most common (Moore,2011). The same situation also pertains in Kenya where it has been reported that caregivers often face a dilemma on how to disclose to their children their serostatus (IRIN, 2009). In the interview between the researcher and the executive director of Nyumbani, it was revealed that the children are aware of their seropositive status, having been disclosed by the caregivers to them. They are periodically counselled to ensure that they always maintain a positive outlook in life. This is a positive development that helps the children to face their educational aspirations with confidence. Also at this age the caregivers will ensure there is adherence to the medication by the children.

Educational level parameters

This section deals with educational level characteristics of the adult respondents and how they impact on the education of the children living with HIV and AIDS.

Data was sought on the educational level of the caregivers and the result is as given below

Table 4.4: Table showing the workers level of education

Respondent	F	%
Diploma	3	42.9
Others (Specify)	3	42.9
No Response	1	14.2
Total	7	100.0

The above table shows that the majority (42.9%) and others (specify) had the same level of education while those who did not respond were only 14.2%.

KDHS (2009) posited that:

“Education is a key determinant of the lifestyle and status an individual enjoys in a society. Studies have consistently shown that educational attainment has a strong effect on health behaviors and attitudes”.

As per the above statement by KDHS, it is imperative that caregivers in order to offer quality nursing care to HIV positive children must be of high educational calibre. A study done in Togo by Moore (2011) hold the same view as he posited that:

“,because of the low socioeconomic status of caregivers with lower levels of education, they might not have the necessary skills to deal with caring for a child with HIV/AIDS.”

This means that with low level of education, caregivers may not properly adhere to the treatment and nutritional care of the HIV positive children as they may lack knowledge about the disease. However, with the higher level of education as the one that pertains in Nyumbani children, there is adherence to antiretroviral treatment and nutritional care to HIV positive children.

On another note, it can be assumed that the level of education of caregivers has a direct bearing on the educational progression of the children. This is because the caregivers act as role models. In normal cases there is a direct correlation between the level of education of the parents and their children. Children tend to follow after their parents footsteps. The higher the level of education of primary caregivers, the children too will find impetus to do the same, though this is not a general rule but observed tendencies. When

caregivers are educated, they will have confidence to also help the children with homework and guide them appropriately in their academic endeavours. An example is given of a nine year old girl who is talented in music. The girl reported that she was influenced by her mother who happens to be a musician too (Citizen TV, 2011). An inference can thus be drawn that a child's level of education is generally influenced by that of the parents/caregivers. They are the overriding factor in shaping the attitude and motivation of the children towards education. It is as a result of this educated workforce, with the executive director attaining a postgraduate qualification, that Nyumbani pays a keen attention to the education of children infected with HIV/AIDS. It is a success story towards empowerment of children living HIV virus since out of a total children population of 111, it has managed to enrol 17 in kindergarten, 65 in Primary schools, 22 in secondary schools and 5 in universities.

Figure 4.7: Nine Year old girl's gift of music boosted by parents



Figure 4.8: Nine Year Old girl's gift of music boosted by parent

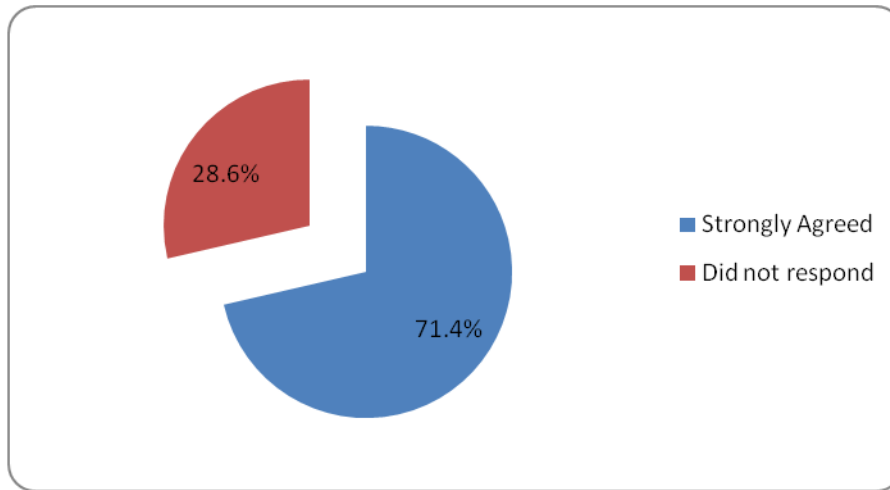


Source: Citizen T.V news bulletin (2011)

Workers' Attitude towards Education of the Children

The study tried to find out about the involvement and attitude of workers towards the children's education and the result is as indicated below

Figure 4.9: Pie Chart Showing Response on whether educating children was rewarding



Source: Own, based on field research (2011)

According to the workers, on whether provision of education to the children is rewarding, majority (71.4%) strongly agreed with the statement. While 28.6% did not respond. Since majority supports that educating these children is rewarding, this shows that there is positive attitude towards the education of these children.

The children in the centre are learning well

The caregivers were also asked to give their opinions if children are progressing on well with their education and the result is as tabulated below

Table 4.5: Table showing responses regarding the question if children in the centre are learning well

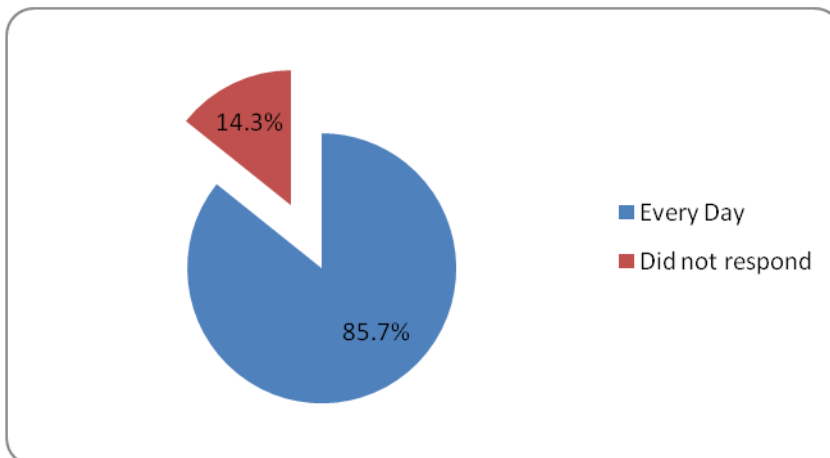
Response	F	%
Strongly Agree	1	14.3
Agree	3	42.9
Disagree	1	14.3
Did not answer	2	28.6
Total	7	100.0

On whether the children are learning well 42.9% agreed with the statement with 14.3% Strongly agreed and 14.3 disagreed.28.6% of the respondents did not respond to the question.

Level of interaction/monitoring

Information was sought on level of frequency of interaction between the caregivers with the children and result is given below

Figure 4.10: Pie Chart showing Rate of interaction with Children



Source: Own, based on field research (2011)

The above table illustrates that majority (85.7%) of the workers interact with the children every day. But 14.3% did not respond. Thus if they interact with the children daily, then there must be a contribution towards the formation of these children. The workers have a positive disposition towards education of these children as they are daily involved in the general academic welfare of the children. They thus monitor the children keenly. This is also corroborated by the responses elicited from children on the question of where they do their assignment and who supervises them, with majority (75%) indicating that they did their assignment at home and only 25% did them at school.

Home Environment (Characteristics of Nyumbani Children's Home)

The study also sought to find out the sort of environment that prevailed at Nyumbani and to show whether this has a direct correlation with the children's education. The study sought to find the job description of workers and the result is as tabulated below

Table 4.6: Table showing the type of job that the workers are involved in.

Respondent	Frequency(F)	Percentage (%)
Care takers	3	42.9
House Mother/ father	2	28.6
Nurse	1	14.3
No Response	1	14.3
Total	7	100.0

As the above data states that majority (42.9%) of the workers are care takers, 28.6% of the workers are House Mothers/Fathers and only 14.3% was a nurse while the same number (14.3%) did not respond.

The study sought to find out the residential nature of workers (whether they stay in the home or not) and the result is given below

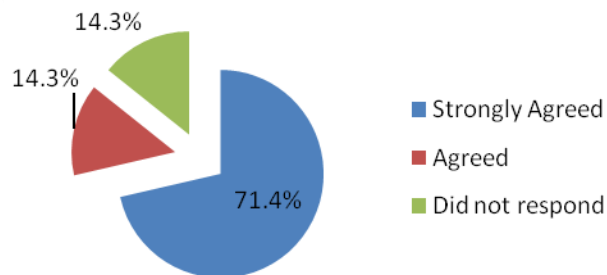
Table 4.7: Whether the workers are in house or non-resident workers.

Response	F	%
In House	3	43.8
Non- resident	2	28.6
Did not respond	2	28.6
Total	7	100.0

As depicted in the above Table7. The following 42.9 % are represented as being resident in the home. While 28.6% are non-resident and of the same number did not respond. The majority live within the centre thus can be able to monitor the activities of the learners, for instance to supervise the assignment and activities.

The workers were asked to give their views on whether they like working at Nyumbani children's home and the result is as given below

Figure 4.11: Pie Chart Showing Response of Workers

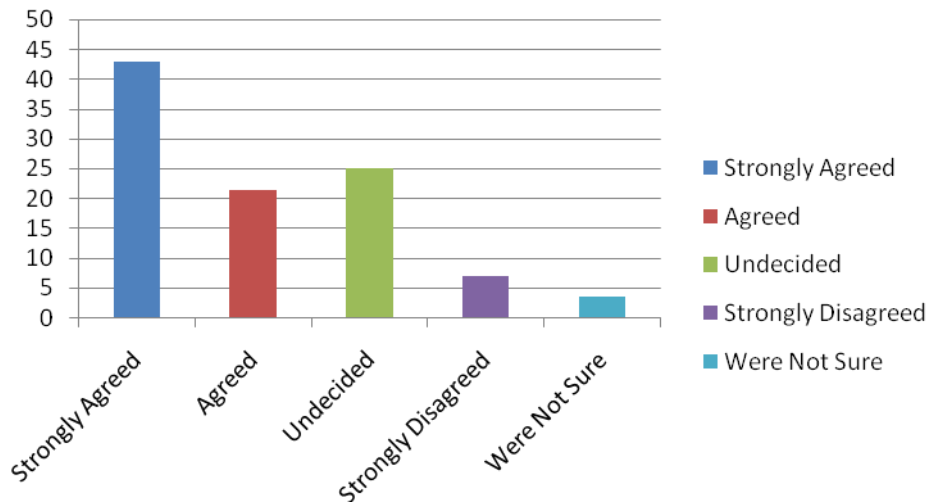


Source: Own, based on field research (2011)

When the workers were asked whether they liked the centre; majority of the workers supported the statement as 71.4% of them strongly agreed and 14.3% agreed and 14.3% did not respond to the statement. Thus the centre offers a conducive environment for the workers which contribute to the positive attitude towards their work. This liking of the centre can also influence the children positively through relating with the workers who like the area (or environment) they are working in.

-The children too were also asked if they like the centre, the result is as tabulated below

Figure 4.12: Bar Graph showing response of children



Source: Own, based on field research (2011)

According to the responses on whether the children like the centre, majority (42.9%) strongly agreed and 21.40% agreed with the statement. Just 25.0% were undecided and 7.1% strongly disagreed with the statement on whether the children liked the centre. While 3.6% were not sure.

The children too were asked about their views or feelings towards Nyumbani workers and the result is as given below:

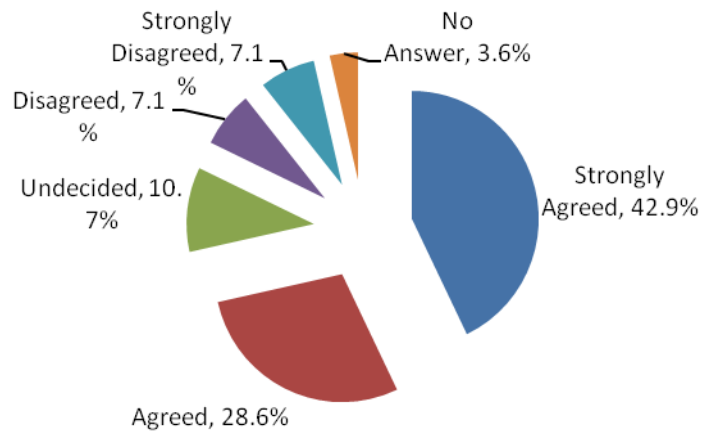
Table 4.8 The children's views on whether workers in this centre are good

Response	Frequency(F)	Percentage (%)
Strongly Agreed	11	39.3
Agreed	7	25.0
Undecided	5	17.9
Disagree	3	10.7
Strongly Disagree	2	7.1
Total	28	100.0

According to the children, on whether the workers in this centre are good, majority (39.3%) strongly agreed with the statement and 25.0% agreed while 17.9% were undecided. But 10.7% of the respondents strongly disagreed with the statement. Basically the study also sought to find out if the children at Nyumbani interact freely with the workers. HIV positive children, being a traumatised group, requires people who can offer them tender and loving care as they may feel that they are being ostracised and this in turn affect their holistic growth and as well as academic performance. The above result demonstrates that the workers are empathetic towards the children. In a study done by Batson et al (1997) it was revealed that feeling empathy for a member of a stigmatised group can improve attitudes towards the group as a whole. For instance, the same study gave an example of people living with HIV/AIDS by saying that inducing empathy for people with AIDS led to more positive attitude towards people living with HIV/AIDS.

The same question too was posed to the children concerning their views whether their teachers were good or (empathetic towards) to them and the result is given below.

Figure 4.13: Pie Chart Showing Response by Children on whether the teachers in the school were good

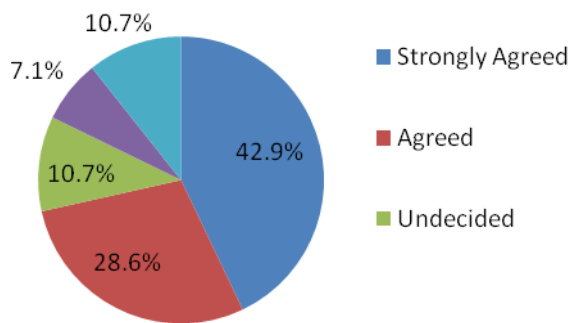


Source: Own, based on field work data (2011)

From the figure above, majority (42.9%) agreed with the statement, 14.2 disagreed while 10.7% were undecided.

The children were asked to give their views on whether they perceive the teachers in their schools to be teaching well and the result is as given below.

Figure 4.14: Pie Chart showing response of whether the teachers are teaching well



Source: Own, based on field research (2011)

From the above figure majority 75.5% of the learners admitted that the teachers are teaching well, with 17.8%, disagreeing with the statement but with 10.7% who were undecided.

The children were asked if they perceive the facilities at the centre are enough to afford them good academic environment. The result is as tabulated below.

Table 4.9: Table showing response on whether the centre is well equipped with resources to enable us learn well.

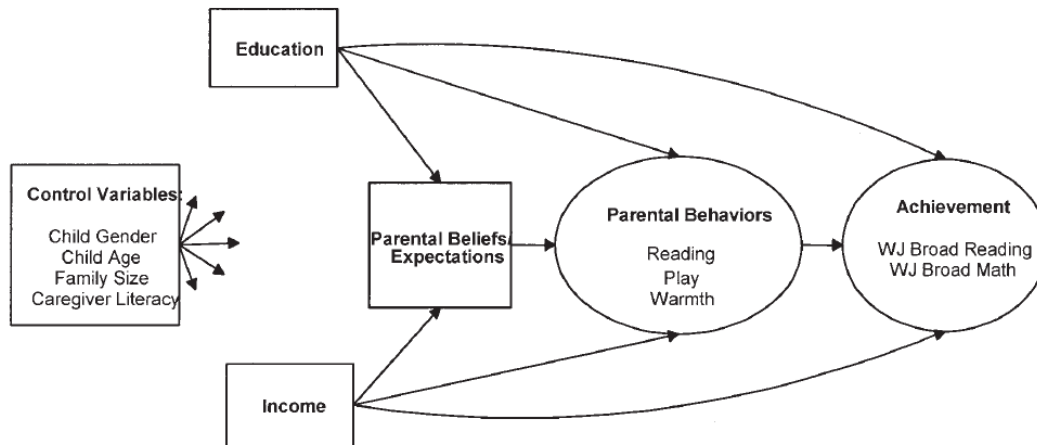
Response	Frequency(F)	Percentage (%)
Strongly Agreed	10	35.7
Agreed	10	35.7
Undecided	3	10.7
Disagreed	3	10.7
Strongly Disagreed	1	3.6
Did not answer	1	3.6
Total	28	100.0

Majority (35.7%) strongly agree that the centre is well equipped with resources to enable the children learn well and an equal number (35.7%) also agreeing with the statement. 10.7% disagrees with the statement and 10.7% too were undecided with the statement. While only 3.6% was in disagreement that the statement that the centre is well equipped with resources which enables the children to learn well. But 3.6% of the respondents did not respond to the question.

The main purpose of the study in this subsection was to find the effect of home environment on the academic progression of the children living with HIV/AIDS. Most studies have established that there is a direct link between the types of environment

pertaining at home with academic performance of the children residing therein. For this study, the environment refers to the kind of atmosphere or ambience that prevails in a home and the general disposition of the adult population living with the children. In this case, the aim was to look at what kind of atmosphere pertains in Nyumbani, what are feelings of the caregivers and children towards the home and as well as what were the feelings of children towards their caregivers. The general conclusion that can be deduced from all the findings in this subsection is that there is a conducive atmosphere at the home and both the children and the caregivers have good interpersonal relationships. This is commendable for mutual coexistence. As a result of this, the children are motivated and feel encouraged in the venture of their academic pursuits. This can be mainly attributed to the fact the caregivers are educated and thus understand the necessity of making the environment conducive for the children's holistic growth. This compares favourably with the findings of Carneiro (2007) who concluded that there is strong evidence that maternal education affects home environment and child outcomes. He further postulated that educated mothers provide better surroundings for their children. The findings in Kean-Davis (2005) study are also in tandem with Carneiro as portrayed in the conceptual model below.

Figure 4.15: Figure showing the conceptual model on the influence of home environment on children's education



Source: Carneiro (2007)

Gaitan-Delgado (1992) carried out a detailed study on the influence of home environment on the educational progression of the children. In his study, he looked at three components: physical resources, emotional climate and interpersonal interactions. These are the similar components as the one for Nyumbani. In his findings, he concluded that that environment has a direct bearing on the children's education. He observed that parents provided children with the emotional support that encouraged them to value education. The common thread which he noticed with all parents under his study was that they cared for their children's education.

Nutritional Factors

In this study children were asked to give their views on whether they are satisfied with the type of food they are offered in school. This was in order to seek the relationship

between food and academic performance. The result of the students view is as given below.

Table 4.10: Table showing response on whether the food in school where I attend is good

Response	Frequency(F)	Percentage (%)
Strongly Agreed	11	39.3
Agreed	7	25.0
Undecided	4	14.3
Disagreed	1	3.6
Strongly Disagreed	5	17.9
Total	28	100.0

From the table above majority of the children said that food in the school they attend is good with 39.3% strongly agreed and 25.0% agreed. While 21.5% disagreed with 17.9% strongly disagreed and 3.6% disagreed but 14.4% were undecided. The deduction that can be made from this finding is that those charged with the responsibility of taking care of these children have managed to meet their nutritional care. This finding compares favourably with that of KDHS (2009). There is no denying the pivotal role that nutrition plays in the life of an individual. Children living with HIV/AIDS are particularly vulnerable to poor health posed by poor nutrition which consequently exposes them to the vagaries of opportunistic infection. Krishna (2011) contended that: “both HIV/AIDS and under-nutrition, with lack of essential micronutrients leading to nutritionally acquired immune-dysfunction syndrome. Compromised immune defence increases susceptibility to infectious diseases and complicates case management”. A study carried out in

Tanzania, revealed that the country is beset by the heavy dual burdens of HIV/AIDS and malnutrition among children and the HIV positive there have continued to be plagued by unusually high under-nutrition toll fuelled by factors such as low birth weight, lower feeding frequency, house-hold hunger and low house hold socio economic position (Krishna, 2011). The effects of poor nutrition on a child's health and subsequently their academic performance are well documented. Several studies have shown that there is a direct correlation between nutrition and educational progression of children and this has been identified as one of the key factors that hinder children's academic performance. Mishra (2008) posits that:

“the premise that nutrition affects children's ability to learn is not new. The link has been recognised for some through anecdotal evidence and, more recently, through controlled research studies”.

Some studies have revealed the adverse effects of hunger and poor nutrition on cognitive abilities. Mishra (2008) reported that one such study found that among fourth grade students, those who had the least protein intake in their diets had the lowest achievement scores. According to Mishra (2008), children who are hungry or malnourished also have more difficulty fighting infections. Therefore they are more likely to become sick, miss school, and fall behind in class.

Financial Constraints

In the interview with the director of the home financial constraint was cited as one of the major cause hindering smooth running of the home and to offer quality education to children living with HIV/AIDS. Nyumbani, as indeed most children's homes, is heavily donor-dependent. This dependency is not sustainable in the long term as the home has to

contend with the phenomenon of donor fatigue which may be brought about by the dictates of circumstances beyond their control. For instance, the current global economic meltdown has heavily and negatively impacted on the donor supported programs and projects in developing countries. Kirigia et al(2011) in their study about the effects of economic crisis on funding to health sector in Africa, reported that in Asia and Latin America , there is ample evidence that past economic crisis resulted in drastic cuts in expenditures on health, lower utilization of health services, and deterioration of child and maternal nutrition and health outcomes. USAID (2010) posited that:

“Africa still relies to a large extent on external funding on health care, especially in the fight against HIV/AIDS pandemic, where in particular, overseas development assistance (ODA) is the primary source of financing. A contraction in donor-funded economies may very well lead to reduced funding for health programs, especially where donor countries had pegged their ODA to a percentage of their GDP; a contraction in GDP means lower ODA”.

The figure below gives a summary of USAID’s views. Other studies such as the one done by UNAIDS (2009) are in tandem with the findings from USAID. When a new government was installed in power 2003, there was a paradigm shift towards education at primary school level. The new government introduced the policy of free primary education, which saw thousands of school age going children, who were erstwhile locked out due to fee constraint, enrol in the program. Nyumbani also tried to enrol the children into public schools in order to reduce the effects of the cash flow problems they were facing in educating the children in private schools but were unfortunately rebuffed by the education authorities. The children were denied admission on account of their seropositivity status.

Table 4. 11 Impact of Global Crisis Donor Funding

Country	Impact on donor support
D.R. Congo	<ul style="list-style-type: none"> DFID Is decreasing its involvement in health. The Belgian Cooperation has decided that it is no longer necessary for it to support HIV programs since USAID, Global Fund and World Bank are working in HIV.
Lesotho	<ul style="list-style-type: none"> Irish Aid is limiting their contribution to the DHS and is not making other commitments until things settle a little.
Liberia	<ul style="list-style-type: none"> The drop in value of the British pound reduced the Pool Fund's (and other) DFID contributions by 25%. This has reduced the number of clinics supported by DFID, and also delayed the planned extension of the Price Waterhouse Coopers (PWC) contract to establish county financial management offices (with oversight from PWC) and it's now supposed to begin in July, if funds are available.
Benin	<ul style="list-style-type: none"> Switzerland has indicated that it may pull back from health sector support
East, Southern Africa Region	<p>At a regional level:</p> <ul style="list-style-type: none"> DFID has cut their regional HIV/AIDS annual budget by about 10M pounds in favor of investments into the South African bi-lateral agreement. Irish Aid anticipates a major cut in their regional OVC budget. There have been steady declines in EU contributions to regional HIV/AIDS programs over the past year. Cuts have been somewhat mitigated by the favorable exchange rate, but that difference has now been eaten up and the cuts are starting to be felt. Swedish SIDA is anticipating particularly heavy cuts in its foreign aid.

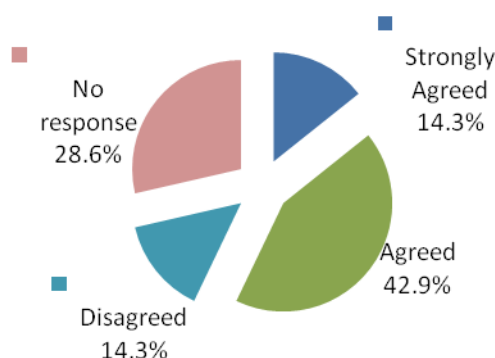
Source: USAID (2010)

Societal response to children's seropositivity status

This sub section deals with the issue of how society perceives children living HIV/AIDS.

Data was sought on whether children are discriminated against in the schools where they attend and the result is as given below.

Figure 4.16: Whether children in this centre are discriminated against in schools where they attend



Source: Own, synthesised from field work data (2011)

Majority (42.9%) of the respondents admitted that the children are discriminated against in the schools where they attend, while only 14.3 % disagreed with the statement. But 28.6% did not respond to the question. This finding reveals that discrimination on account of children's HIV positive status is actually prevalent in schools. This compares favourably with the reported case in Nepal where two children were expelled from school on account of HIV status (VSO, 2011). One of the most extreme cases of stigmatization and discrimination, since the advent of HIV/AIDS in the global scene, occurred in the United States. Three haemophiliac brothers, widely known as the Ray brothers, were expelled from school upon discovery that they were HIV positive. Their parents took the case to court and subsequently won but the community in reaction to the case burnt down their family home and forced them to relocate to another state (New York Times 1987, Geocities 2009, Ritchie 1992). There was also the case of Ryan White, another haemophiliac boy who died at the age of 18, whose lasting legacy is that he fought against discriminating HIV positive children in school. This was as a result of his own experience which he endured. As a result of his effort, the United States government enacted Ryan White CARE act for people living with HIV/AIDS (HRSA 2012, Gordineer, 2008). In many world-wide settings cases of stigmatization and discrimination is well documented. Many individuals infected with HIV/AIDS have experienced varying level of stigma and discrimination. In a study done by Surkan (2011), it is noted that apart from the significant physical and economic burden of HIV disease, those who are infected in resource poor settings do face significant degree of discrimination. Surkan (2011) cites an example of rural Haiti where being affected with HIV/AIDS can result in

ostracism, blaming the victim for the disease, withholding of food, social isolation, and denial of human dignity.

HIV/AIDS is a major public health issue in Kenya, its specific impact on infected school children did not receive media attention until a children's home caring for HIV-infected orphans sued the government, because its children had been rejected by various public schools by virtue of their condition. The late catholic Father Angelo D'Agostino, who managed the Nairobi-based Nyumbani children's home from its inception till his death, said it was spending about US \$14,000 yearly on maintaining its 41 children attending a private school, who continued to do so even after the government, had introduced free primary school education in January 2003. The high-profile case, which Nyumbani won, highlighted the daily discrimination being suffered by many of the country's HIV-infected orphans. However, the problem of admitting children infected with the HIV virus to Kenyan schools was largely attributable to parents bringing pressure to bear on schools to reject such children - as opposed to government policy.

Innovations Adopted

Enumerated below are some of the innovations adopted by the home to circumvent the challenges encountered in educating children living with HIV/AIDS.

- Strong family relationships have been achieved through counselling and emotional support;
- Seminars and peer counselling groups have helped to build self-awareness and self-esteem among the teenagers.

- A large drip-irrigated farm and livestock Unit supplements the home's sustenance.
- 50 acres of land have been planted with trees for both income generation and environmental protection

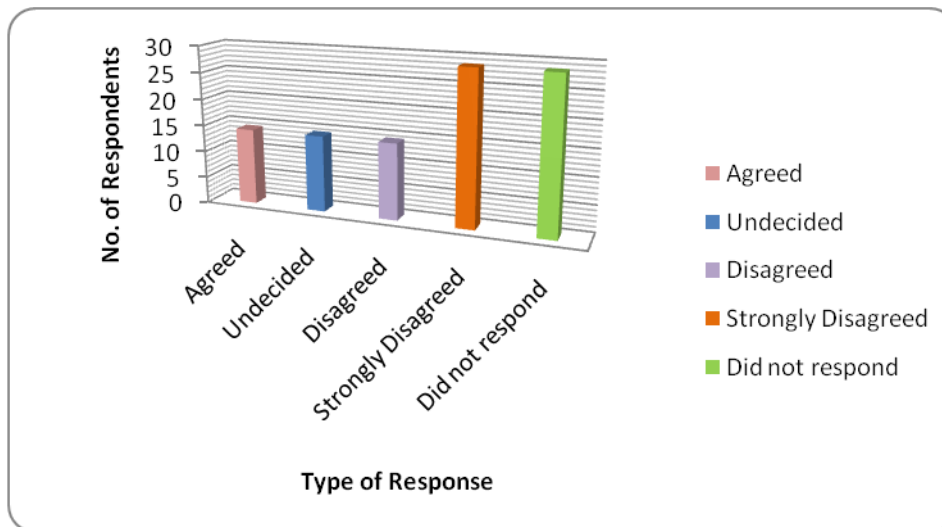
Contribution of the local community, government and other organizations: For the researcher to know if the capacity of the local community, the government, especially the ministry of education, and other organizations to deal with the problems of the challenged children in support of the Nyumbani Centre, the following responses represent what the majority of the workers said:

- .The government has provided free primary and secondary education.
- Monitoring and supervision of the centre activities through inspection by its staff.
- Providing learning teaching materials to enable the programme run smoothly.
- Make sure that the Nyumbani Centre learning activities are in conformity with the national goals of education.
- Training of the workers on how to deal with these children.
- In addition to these contributions, Nyumbani Children's Home network with other organizations such as churches and other church based organizations, Non-Governmental Organizations (NGOs) both local and international, Trade Unions, Parastatals and Societies.
- The organizations provided funds through the government to purchase items such as exercise books, food, clothing, pens and pencils. Others provide materials like chalks and chalkboards and other teaching aids.

Effect of seropositivity status on academic performance

The study also sought to find out the effect of children's health status on their academic performance. The workers were asked to state if children's academic performance is excellent and the result is as tabulated below.

Figure 4.17: Bar Graph Showing Response on Academic Excellence of Children



Source: Own, based on field research (2011).

In terms of the academic performance, majority (28.6%) strongly disagreed that the academic performance of the children is excellent. 28.6% did not respond to the question, 14.3% disagreed, 14.3% was undecided while the same number of respondents (14.3%) agreed with the statement that the academic performance of these children is excellent.

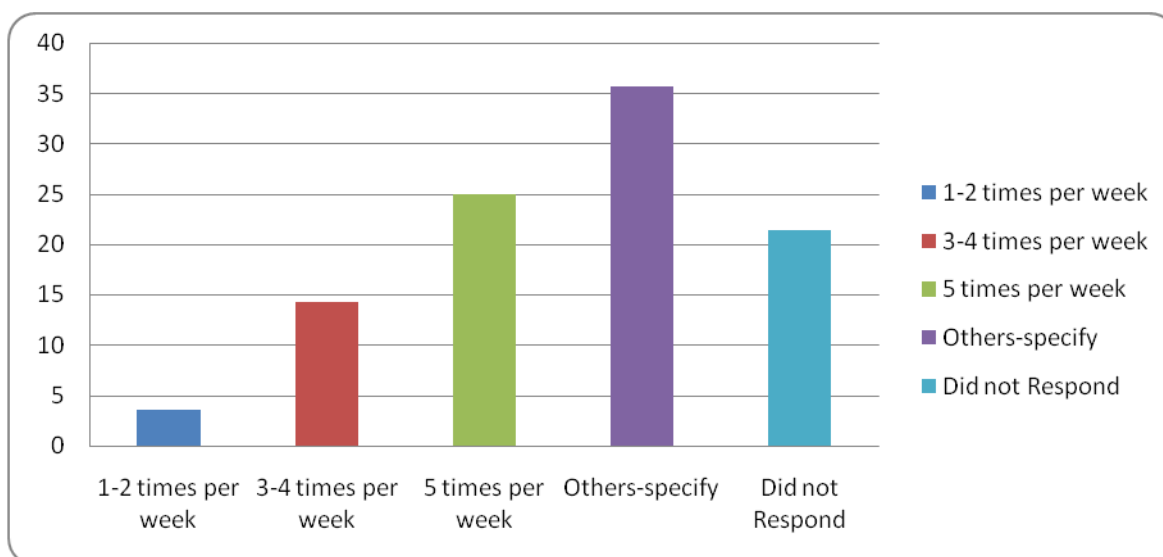
The children were asked whether they enjoy going to school without coercion or compulsion. The result is as tabulated below.

Table 4.12: Response on whether the children liked going to school.

Response	F	%
YES	23	82.1
NO	4	14.3
Did not respond	1	3.6
Total	28	100

When the children were asked on whether they liked going to school. Majority, (82.1%) of the children agreed with the statement while 14.3% disagreed with the statement. And only 3.6% did not respond to the question. Thus this shows that the majority liked going to school, this is a positive attitude towards education.

Children were asked how frequently they attend school and the result is given below.

Figure 4.18: Bar Graph showing Duration of School Attendance by Children

Source: Own, derived from field research (2011).

The majority of the respondents 35.7% attended school on the specified days which mostly were six days. 25.0 % attended school five times per week. 14.3% attended school 3-4 times per week and 3.6% attended school 1-2 times per week.

The study also sought to find out if children are happy to be in the school they currently attend. This is because not liking the institution one attends will seriously impede one's realisation of academic dreams. The result is as portrayed below

Table 4.13: Table showing response on whether the children are happy to be in school they currently attend

Response	Frequency(F)	Percentage (%)
Strongly Agreed	13	46.4
Agreed	11	39.3
Disagreed	1	3.6
Strongly Disagreed	3	10.7
Total	28	100.0

When the children were asked on whether they are happy to be in their school 46.4% of the children strongly agreed with the statement, 39.3% agreed but 3.6% disagreed while only 10.7% strongly disagreed with the statement. They were also asked if they pass all the exams given in school and their views are as demonstrated in the table below:

Table 4.14: Response on whether the children pass all the exams given in school.

Response	Frequency(F)	Percentage (%)
Strongly Agreed	7	25.0
Agreed	6	21.4
Undecided	5	17.9
Disagree	8	28.6
Strongly Disagree	1	3.6
No Response	1	3.6
Total	28	100.0

On whether the children pass all the exams in school, the responses were as follows: 25.0% strongly agreed that the children pass all the exams given in school, and 21.4% agreed. 17.8% were undecided, while 28.6% disagreed with the statement. Only 3.6% strongly disagreed to this view that that the children pass all the exams given in school. 3.6% of the respondents did not respond to the question.

This subsection sought to find out if being HIV positive has an impact on academic performance and almost all the findings as depicted above seem to point toward this conclusion. Being seropositive is a health issue which may impact on one's productivity. As in the case of school going children, their academic activities are drastically curtailed as they spend most times being absent from school to attend to health issues. This consequently interferes with their smooth learning and thus poor performance. In an interview with the director, health issue was mentioned as one of the factors that hinder children from realising their academic goals.

Strategic and Measures adopted by Nyumbani to help children cope with their status

Given below are some of the mechanisms put in place by Nyumbani to help the children cope with awareness of their seropositivity status

- Seminars and peer counselling groups have helped to build self-awareness and self-esteem among the teenagers.

- The managing team continues to motivate the children, develop their personality through holistic development: socially, spiritually, psychologically, mentally and physically.

On the part of the contribution of the community towards the programme, the following responses were given by more than 80% of the workers, and managing team.

- The community members contributed by visiting the children, bringing some donations to the centre, and some take the children for outings.
- They mobilized the children to come to the learning centres and play a great role in sensitizing the parents about the importance of education to the future of the children and community.

Interventions and lessons that can be replicated

Also enumerated below are some interventions and lessons that can be replicated in similar programmes elsewhere

- Training of the workers on how to deal with these children.
- Income Generating Activities (IGAs) ought to be explored and aggressively pursued in order to become self sustaining in order to avoid overdependence on donors.
- Seminars and peer counselling groups have helped to build self-awareness and self-esteem among the teenagers.
- The managing team continues to motivate the children, develop their personality through holistic development: socially, spiritually, psychologically, mentally and physically.

Education for all is a goal that has been reaffirmed by states of the world over many times in the last decade. It is meant to be achieved by 2030 by all children in Kenya. But the response from the respondents clearly shows that the Kenyan government has not paid special attention to the educational needs of children living with HIV/AIDS in the country. Quality education is not reaching the world's most vulnerable unless this has to be done, vision 2030 won't be achieved.

Chapter Summary

This chapter dealt with the presentation and discussion of findings. It described the demographic characteristics of the respondents, their gender, age groups, information on Nyumbani, implementation and the attitudes of the respondents towards the home in form of figures and tables among other findings.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The purpose of this study was to find out factors affecting education of children living with HIV and AIDS with special reference to Nyumbani Children's home based in Karen suburb of Nairobi, Kenya. This was in order to offer suggestions for improvement.

In this chapter a summary of the study and its findings is given. After this the researcher draws conclusion of the entire study which eventually forms the basis for recommendations and suggestions for further studies.

5.2 Summary

Data for this study was collected from respondents based at Nyumbani children's home which consisted of 2 senior members of the management team, that's the Executive Director and the General Manager, 7 workers and 28 children. This comes to a total of 37 respondents. However, previously a sample population of 42 respondents was targeted. This target was not realized because some student respondents were absent, away in boarding schools, during the data collection exercise. Student respondents who took part in this exercise were from class six, seven and eight. Due to the sensitive nature of this study, only a select group of workers took part in the exercise. Face to face interview was carried out with the executive director of the home despite her busy and hectic schedule. The study established that nyumbani children's home has put in place strong intervention mechanisms to ensure that the children under its care are well taken care of psycho-

socially and spiritually and as well as receive quality education despite their seropositivity status. Through face to face interview with the executive director, the children are made aware of their HIV positive and guided to face the situation in a positive manner. They are continually counselled so that they do not relapse to negative withdrawal which affect them psychologically and thus affecting their academic performance.

Among the factors that the study established to be detrimental to the educational progression of children living with HIV/AIDS were:

- Gender based violence especially meted out on young girls
- Financial constraints
- Home environment or ambience
- Educational level of caregivers since they act as role models
- Nutrition- good nutrition is of paramount importance
- Health status-this brings about absenteeism, irregular classroom attendance
- Discrimination
- Educational level of caregivers

The biggest threat to these children's furtherance of education was established to be stigmatization emanating from their seropositivity status. This was established to be a very negative societal response to the issues of HIV and AIDS. A case in point is that of a high school student who has just done her KCSE and emerged with mean grade A-, a sterling performance despite her HIV positive status (The Standard, Thursday 27th July, 2011pg3). Her wonderful performance demonstrates that HIV positive children can perform well and reach higher echelon of academic ladder if accorded equal opportunities

devoid of pestering stigmatization. Recounting her story to the education stakeholders during head teachers' conference in Mombasa, the student, who acquired the disease through mother-to-child transmission, narrated that stigmatization and discrimination was rife in schools, both primary and secondary. She posited thus:

“I lost my parents when I was only six years old, but I have lived to tell my story. Once in primary school, a teacher told other pupils to stop sharing cups with me because of my status for fear that I could infect them.” (The Standard, July 27, 2011 pg3).

She reported that many school children living with HIV and AIDS suffer silently from stigma and faced dreadful experience despite this scourge being around for 25 years since its advent in the country.

“It is unacceptable that stigma and discrimination remains one of the biggest hurdles that HIV infected face in our schools. The discrimination practices they are subjected to are too hard to bear.” She told the conference delegates (The Standard, July 27, 2011 pg3).

To circumvent the occurrence of the above scenario as narrated by the student, Nyumbani management, having been in the same situation before when it took the government to court and won the case as a result of discrimination, decided to totally avoid government schools and take their children to select private schools where only very few select teachers are kept in the know about the sero positivity of these children. This is according to one of the sources the researcher talked to. The source revealed to the researcher that the children are picked first and dropped last at the home when the school transport is doing rounds dropping students to their respective picking/dropping zones at the beginning and end of school day. This kind of discreet arrangement, in the view of the researcher, is not very healthy for the overall psychosocial development of the HIV

positive children and their integration into the mainstream society. What happens if the children's cover is finally blown? And discovered that they are HIV positive?

5.3 Conclusion

Nyumbani has been touted as a successful hospice for the HIV positive children and is well known all over the country as the referral centre. During the interview session, the researcher learnt that these children end up here as a result of abandonment, some are brought by the police, hospitals, cruelty at home by the extended families and some extended families could not cope with taking care of these children due to limited resources. The children at the home come from all the corners of the country hence showing a nationalistic face. Nyumbani tries as much as its capacity can enable not to turn away HIV positive child. Its guiding philosophy is passion for Christ, service to humanity especially to neglected HIV positive children. It is a home that has given children who otherwise had no hope to have a second chance to experience life. Though one of the avenues that Nyumbani uses to accord this second chance is education as attested to by the children who are currently pursuing college and university courses, it experiences a myriad of challenges in according these children education. The key challenges that these children face in their quest for education is the twin problem of stigma and discrimination.

5.4 Contribution from the Study

The study was able to unmask some of the challenges that children living with HIV and AIDS in their quest for furthering their education. It is hoped that the government and

other education stakeholders will use the findings emanating from this study to come up with relevant policies and other intervention programs towards easing acquisition of education by the children living with HIV and AIDS.

5.5 Recommendations

Based on the findings of the study, the researcher recommends that:

- There is need to improve teachers' skills on the issue of HIV/AIDS and how to handle HIV positive children. The understanding of HIV/AIDS.
- A serious HIV/AIDS awareness campaign should be mounted in all schools both public and private and both primary and secondary so as to create awareness on the rights of HIV positive children.
- That the HIV positive children whose statuses are already publicly known be given all the necessary support such as medical, psychosocial nutritional and financial for his/her healthy well-being to enable him/her learn unperturbed.
- That legislation outlawing stigmatization and discrimination be strictly enforced, that any teacher caught promoting discrimination on the basis of HIV positive status be severely punished through interdiction and jail.
- That the HIV positive children themselves should be encouraged to come out and speak openly about their status. This way, hearing from the infected, HIV and AIDS will be greatly de-stigmatized. The clue can be derived from the girl already mentioned above and also from the example of Ryan White pictured below.
- Nyumbani as an institution should be in the forefront fighting for the rights of HIV positive children in the country. This is because it is an already well established and

known hospice in the country which catering for the needs of HIV positive children for more than a decade now. They should emulate the example of Ryan White and his mother who travelled USA giving speaking engagements and educating the public on the rights of HIV positive children to attend school and, by extension, spoke for the voiceless people afflicted by HIV/AIDS. Their efforts resulted in United States government enacting legislation outlawing discrimination against persons living with HIV/AIDS and as well coming up healthcare program known as Ryan White CARE program, the biggest HIV health care program geared helping HIV positive people across United States. The figures below demonstrate the positive contribution of Ryan White's campaign towards empowering HIV positive people. Nyumbani too can champion the rights of HIV infected persons in Kenya by letting some of their children to do speaking engagements and educate the public. This way, the government can be assisted in coming up with more policies favouring education and overall care of children living with HIV/AIDS.

5.6 Suggestions for Further Research

- A study should be carried out on the viability of replicating more institutions like Nyumbani in several parts of the country
- There is need to carry out a study on why there is still negative attitude towards HIV positive pupils and students in schools despite the massive awareness campaign that have been mounted in the country over the years.

- Statistical survey need to be carried to get the correct demography of the children living with HIV/AIDS in Kenya ranging from ages 0-15 showing gender distribution.
- Study should be carried out on the effects of relying on donor funding to educate children living with HIV/AIDS. Are there other revenue streams that can be exploited to bridge the gap in maintaining and educating the HIV positive children, so as to avoid the see-saw of donor funding?
- A study ought to be carried out to find out if parents of healthy children are also a contributing factor in discriminating against children living with HIV/AIDS in schools.
- A further research is required to investigate the various forms of discrimination and ostracisation that are meted out on the HIV positive children and the measures that can be put in place to deter them.
- Study should be carried out to establish if guidance and counselling is really effective in helping children living with HIV/AIDS accept their situation.
- An in-depth study should be carried out to find out the attitudes of teachers towards educating HIV positive children.
- A study should also be carried out on how to properly carry out research involving traumatised children.

Figure 5.1 Ryan White



Ryan White and his mom courageously fought AIDS-related discrimination and helped educate the Nation about his disease.

Ryan White was diagnosed with AIDS at age 13. He and his mother Jeanne White Ginder fought for his right to attend school, gaining international attention as a voice of reason about HIV/AIDS. At the age of 18, Ryan White died on April 8, 1990, just months before Congress passed the AIDS bill that bears his name – the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. The legislation has been reauthorized four times since – in 1996, 2000, 2006, and 2009 – and is now called the Ryan White HIV/AIDS Program.

Source: HRSA (2011)

Figure 5.2 Ryan and his mother



Ryan was one of the first children with hemophilia to be diagnosed with AIDS. The two are the champions for rights of persons living with HIV/AIDS.

Source: Adapted from HRSA (2011).

Figure 5.3 Signing of Ryan White act by President Bill Clinton



President Bill Clinton signing Ryan White CARE act into law. Looking on is Ryan White's mother and other officials.

Source: Adapted from HRSA (2011)



Figure 5.4 President poses with Ryan's mother

President Barack Obama poses with Jeanne White Ginder, Ryan White's mother.

Source: Crowley (2009)



President Barack Obama, surrounded by Members of Congress and other officials, signs the Ryan White HIV/AIDS Treatment Extension Act of 2009 in the Diplomatic Reception Room of the White House



Jeanne White Ginder, Ryan White's mother, displays the signed reauthorization.

Source: Crowley (2009).

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APPENDIX A: Introductory Letter to Respondent

Dear Respondent,

My name is Victor Odandi. I am a student of Kenyatta University doing a master degree in education (special education). I am currently carrying out a research seeking to establish the problems faced by children living with HIV and AIDS in pursuing their education. I kindly request you to answer the questions below as honestly as you can. All the information given will be treated with utmost confidentiality.

Thank you in advance and God bless you.

Victor Odandi

Researcher

APPENDIX B: Questionnaires for Children

Section A: Background Information

Instructions

Please tick one in the bracket in front of the most appropriate items; where an explanation is required use the spaces provided

1. I am Male [] Female []
2. How old are you? ____ I amyears old
3. Where is your home area? District _____
 Province _____ Town _____

Section B: Information on Education

4. What is your class? _____
5. What would you like to become in future? (e.g. a doctor, teacher etc) _____
6. Do you like going to school? _____
7. Why do you like going to school?
8. Or Why don't you like going to
 school? _____
9. How regularly do you attend school?
 1-2 times per week []
 3-4 times per week []
 5 times per week []
 Others (specify).....
10. What do you like most about being at Nyumbani Children's home?

11. What do you like least about being at Nyumbani Children's home?

12. Where do you do your homework? At school or at home

13. Who helps you with your homework?

Nobody, I do it alone

Teacher

Home care

others, specify; _____

14. Please mention some problems you face in school that prevents you from learning well

15. What suggestions can you make to solve the problems you mentioned above?

Section C:

16. Please tick only one box after sentence below. Follow the following key

Key: Strongly Agree (SA) Agree (A) Undecided (U) Disagree (D) Strongly Disagree (SD)

ITEMS	SA	A	U	D	SD
I like the centre					
The workers in this centre are good					
The teachers in my school are friendly					
The children in the centre are learning well					
The teachers are teaching well					
Food in school where I attend is good					
I am very happy to be in my school					
Our centre is well equipped with resources to enable us learn well					
I finish my assignment on time					
I pass all the exams am given in school very well					

APPENDIX C: Questionnaire for Nyumbani Workers.**Section A: Background information**

1. Please indicate your gender Male [] Female []

2. What is your age bracket?

Under 20 years []

21-25 []

26-30 []

31-35 []

36-40 []

41-45 []

46-50 []

51-55 []

55-60 []

Over 60 []

3. What is your level of education?

PhD []

M.A []

M.Ed []

B.Ed []

B.A []

B.Sc []

Diploma []

Others, please specify _____

4. What is your job designation? What do you do at Nyumbani?

5. Are you an in house or non-resident worker? _____

6. How long have you been working here? _____

Section B: Information about the centre

7. In your interaction with the children, what are their aspirations in life?

8. How often do you interact with the children?

- Everyday []
- Once a week []
- Once a month []
- Not at all []

9. What problems do these children face that hinders realization of their academic goals?

10. What can be done to solve the problems you mentioned?

Section C: The attitude towards the centre

11. In this section there are five levels of which you can grade your attitude towards the centre. For each item please place a tick under the level that best represent your attitude.

Key: Strongly Agree (SA) Agree (A) Undecided (U) Disagree (D) Strongly Disagree (SD)

ITEMS	SA	A	U	D	SD
I like the centre					
Programs run at the centre are relevant to the needs of the children					
Educating these children is rewarding					

The children in the centre are learning well					
The needs of these children are being solved through the centre					
Those who have passed through and completed through the centre are successful in life					
I am happy to be part and parcel of implementing programs at the centre for the benefit of the children					
Our centre is well equipped with resources to enable the children learn well					
The time used to nurture the children at the centre is adequate					
The centre model should be replicated country wide					
Children from this centre are not discriminated against in schools where they attend					
Academic performance of these children are excellent					

APPENDIX D: Questionnaire for the Management of the Home

Section A: Background information

1) Please indicate your gender Male [] Female []

2. What is your age bracket?

26-30 []

31-35 []

36-40 []

41-45 []

46-50 []

51-55 []

55-60 []

Over 60 []

Others please specify _____

3. What is your highest academic qualification?

PhD []

M.A []

M.Sc []

B.ed []

B.A []

B.Sc []

Others, please specify _____

4. Are you a resident or non-resident worker? (Stay within the home)

5. How long have you been here? _____

Section B: Information about the Centre

6. What is the total number of children you have at the centre?

7. What is the age range of these children?

8. How many are boys?.....Girls?.....

9. What criteria do you use to admit these into this centre?

10. How many children are in Kindergarten?.....

Primary school?.....

Secondary School?.....

Collges/ Universities?.....

Working?.....

11. Do you have adequate facilities and resources to run the centre?.....If not, explain

12. As far as educating the children in this home is concerned, what challenges do you face in educating them?

13. What challenges hinders the children in realizing their educational aspirations?

14. Overall, what other challenges do you face in running the home?

15. What measures do you put in place to mitigate against some of these challenges?

16. What is the government of Kenya's contributions towards the education of these children?

17. What are the contributions of other organizations towards the centre?

18. What are the community's contributions towards the centre?

Section C: The attitude towards the centre

1. In this section there are five levels of which you can grade your attitude towards the centre. For each item please place a tick under the level that best represent your attitude.

Key: Strongly Agree (SA) Agree (A) Undecided (U) Disagree (D) Strongly Disagree (SD)

ITEMS	SA	A	U	D	SD
I like the centre					
Programs run at the centre are relevant to the needs of the children					
Educating these children is rewarding					
The children in the centre are learning well					
The needs of these children are being solved through the centre					

Those who have passed through and completed through the centre are successful in life					
I am happy to be part and parcel of implementing programs at the centre for the benefit of the children					
Our centre is well equipped with resources to enable the children learn well					
The time used to nurture the children at the centre is adequate					
The centre model should be replicated country wide					
Children from this centre are not discriminated against in schools where they attend					
Academic performance of these children are excellent					

Section D: Suggestions for the improvement of the centre

2. In your opinion what should be done to sustain the education of the children in this centre?

3. What do you think should be done to improve the standard of education of children living with HIV and AIDS in Kenya?

APPENDIX E: Interview Guide with Nyumbani Management (Director)

1. Briefly tell me about Nyumbani's guiding philosophy?
2. How do the children end up here? Are they brought by their parents, referred by other institutions (hospitals, other children's homes among others) or are they brought by other individuals?
3. Do they go to school?
4. Basically, what problems or challenges does your institution face in helping them acquire formal education?
5. How do they cope with the knowledge that they are HIV positive? Does this affect their studies?
6. How do you help them cope with this knowledge?
7. What innovations have you put in place to alleviate some of the challenges you face?
8. Does the Kenya government offer you help in any way to educate these children?
9. In your opinion, what are the shortcomings of the Kenya government in the education of these children?
10. What recommendation/suggestions would you make to the Kenya government as far as education of children living with HIV/AIDS is concerned?
11. Any other comments?

APPENDIX F: Map of Karen Suburb Section of Nairobi Showing Location of Nyumbani Children's Home

