

**THE APPROPRIATENESS OF VOLUNTARY COUNSELLING  
AND TESTING (VCT) CENTRES AS SOURCES OF  
INFORMATION FOR YOUTH: A STUDY OF NYERI DISTRICT,  
KENYA. )**

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**C/50/P/9245/01**

**A project submitted in partial fulfillment of the requirements for the  
award of the degree of Master of Arts in Sociology (Counselling).**

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**KENYA**



**FEBRUARY 2005**

## DECLARATION

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

  
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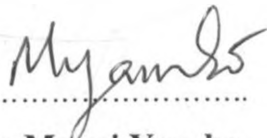
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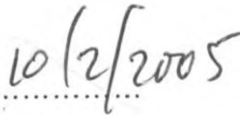
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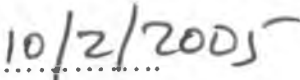
  
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## **DEDICATION**

This work is dedicated to my family members who have encouraged and stood by me throughout my life.

To my parents Stephen and Jane, who have always wanted the best for their children and have always been there for them. Their sacrifice to ensure that their children get the best is deeply appreciated.

To my brothers and sisters who have encouraged and assisted me in every way they could.

To my precious son Brian who had to bear long hours without me as I pursued my education, thank you very much for making my dream come true.

## ABSTRACT

HIV/AIDS is an impairment of the body's ability to fight disease. The disease is mainly spread through sexual intercourse. The youth are exposed to HIV/AIDS due to biological, socio-cultural and economic factors. Youth vulnerability to HIV/AIDS is made worse by the fact that parents, leaders and teachers have difficulties discussing matters related to sexuality with young people. This has created a vacuum of knowledge, making it difficult for the youth to handle HIV/AIDS effectively.

VCT is an essential component of an effective response to the AIDS epidemic. The aim of this study was to find out whether there existed a sufficiently strong empirical basis for introducing VCT services to secondary school students. The study therefore sought to find out whether the youth in secondary schools had access to accurate and reliable sources of HIV/AIDS information and counselling on a regular basis.

The study was carried out in Nyeri district, Central province, Kenya. The study was a survey using ex-post facto research design. Stratified random sampling and simple random sampling were used in both the selection of schools and in the selection of students. A total sample size of 118 students were selected and interviewed from the eight schools that were sampled. One teacher-counsellor from each of the eight selected schools and four VCT counsellors were also interviewed.

Different data collection instruments were used in the study. Two different interview schedules were developed to collect data from the students and the teacher-counsellors. An interview guide was used to collect data from the VCT counsellors. After data collection, SPSS was used to analyze the data. Descriptive and inferential statistics were used to present and interpret the data.

The study found that very limited HIV/AIDS counselling was being done in secondary schools. The majority of the students reported having insufficient information on HIV/AIDS. However, the same study observed that very few students approached their teacher-counsellors for HIV/AIDS counselling. Although the majority of the students and the teacher-counsellors reported that the students had fairly good access to HIV/AIDS information that was available in the schools, the teacher-counsellors

revealed that the HIV/AIDS audio and visual resources were very limited. In addition, all the teacher-counsellors who were interviewed had no training in HIV/AIDS counselling, and very few had any training in counselling.

The study found that although the majority of the youth were abstaining from sexual intercourse, a small percentage of them were still engaging and some of them had not taken any HIV/AIDS protective measures. This implies that the youth are still vulnerable to HIV/AIDS and therefore, more HIV/AIDS information and counselling is still needed to make them better equipped to face the HIV/AIDS pandemic.

Most of the students, the teacher-counsellors and half of the VCT counsellors recommended that VCT services be offered to students. In addition, more than three quarters of the students reported that they would like to find out their HIV status. However, very few students reported having ever visited a VCT site and very few clients at the VCT sites were reported to have been below 18 years. This implied that the VCT centers either have not made their services widely known to the youth or there is something about them that is not very appealing to the youth.

Results of the hypotheses tests showed that other factors other than teacher-counsellors teaching load, limited counselling skills, lack of well organized guidance and counselling programmes in schools and limited utilization of VCT sites by the youth contributed to students limited access to HIV/AIDS information and counselling. As a result the researcher recommends that further studies be done to establish how HIV/AIDS information and counselling can be made more accessible to the youth. In the meantime, basic counselling training including HIV/AIDS counselling training should be offered to all the teacher-counsellors to enable them to do their counselling job more effectively.

## ACKNOWLEDGEMENTS

I would like to thank the University of Nairobi for giving me the opportunity to pursue this course.

Special thanks go to my supervisors Professor Yambo and Mr Mutsotso who worked tirelessly and guided me through all the stages of this project.

I wish to acknowledge Rosa who assisted a lot in data analysis. Last but not least, I wish to thank everybody who contributed in any way towards my completion of this course.

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## **LIST OF ABBREVIATIONS**

<i>AIDS:</i>	ACQUIRED IMMUNE DEFICIENCY SYNDROME
<i>CBS:</i>	CENTRAL BUREAU OF STATISTICS
<i>CSA:</i>	CENTRE FOR THE STUDY OF ADOLESCENTS
<i>GOK:</i>	GOVERNMENT OF KENYA
<i>HIV:</i>	HUMAN IMMUNO-DEFICIENCY VIRUS
<i>MOH:</i>	MINISTRY OF HEALTH
<i>MOE:</i>	MINISTRY OF EDUCATION
<i>NASCOP:</i>	NATIONAL AIDS AND STD CONTROL PROGRAMME
<i>STD:</i>	SEXUALLY TRANSMITTED DISEASE
<i>STI:</i>	SEXUALLY TRANSMITTED INFECTION
<i>VCT:</i>	VOLUNTARY COUNSELLING AND TESTING

# CHAPTER ONE: INTRODUCTION

## 1.1 BACKGROUND

There is a growing understanding that the youth are sexually active. The Sessional Paper Number 4 (G O K, 1997:17), revealed that the high rates of teenage pregnancies, abortions and STD'S confirm that the youth are engaging in early sexual activities and are increasingly pre-disposed to HIV/AIDS. In Kenya, 10,000 girls drop out of school annually as a result of pregnancy (Forsythe, 1996:137). A Kenyan survey of 312 young people between the ages of 12-24 years, revealed that 64% of boys are sexually active with 30% of them reporting that they had already had more than five sexual partners. The same study revealed that nearly all young people knew about AIDS, predominantly through the radio ( Forsythe, 1996: 137). According to Tuju (1996:1), a 1995 fact sheet published by the Centre for the Study of Adolescents (CSA) revealed that about 35% of all reported HIV/AIDS cases in Kenya were teenagers aged between 15-19 years. A study conducted by CSA in Nyeri in 1993 ( Tuju, 1996:60), revealed a mean sexual initiation age of 13.5 for both boys and girls. This means that a good number of the youth engage in sex at an age when they cannot yet fully appreciate the consequences of their actions, which results in widespread unwanted pregnancies and Sexually Transmitted Diseases including HIV/AIDS. Youth vulnerability to HIV/AIDS is made worse by the fact that parents, leaders and teachers have difficulties discussing matters related to sexuality with young people. This has created a vacuum of knowledge, making it difficult for the youth to handle HIV/AIDS effectively (G O K, 1997:18).

According to Rivers and Aggleton (1992:2), young people often have less access to sexual information, services and resources than those who are older. Currently, out of the 219 Voluntary Counselling and Testing (VCT) centres operating in Kenya, only four are "Youth Drop- in VCT Centres." This makes it very hard for most adolescents to access the VCT services that are specifically designed to meet their needs (Chebet et al, 2003:4-16). In addition, parents and family members deny adolescents information on sex and reproduction, in the believe that they are protecting the young people from information which may lead to sexual experimentation. According to Erulker (1998:19), a study conducted in Nyeri revealed that most of the youth got their

reproductive health information from their friends and the media. In the three months before the study mentioned above, 47% of the youth sampled had discussed at least one reproductive health topic with a friend as compared to 38% who had discussed with a teacher and 20% who had discussed with a parent. Erulker argues that while teachers are potentially reliable, friends are most likely sources of misinformation.

In Kenya today, there is an ongoing debate as to who should educate the youth on sexual matters. The teachers feel that it should be done by the parents, while some parents feel that it should be done by the teachers. Unfortunately, as people dilly-dally wondering who to educate the youth on sexuality, many of the youth rely on their peers for information which is often inaccurate. According to Rivers and Aggleton (1991:1), teachers in many countries have reported being embarrassed to talk on the topic of sex with their students and they are also ill-prepared for teaching about sexual matters. This means that as much as there are guidance and counselling teachers in secondary schools, they cannot be wholly and fully relied on to adequately prepare the students on how to face the threat and challenges of HIV/AIDS. To make the situation worse, students do not feel free to discuss private sexual matters with their teachers. So, should the responsibility be left with the parents? No, because many of the parents are embarrassed to discuss sexual matters with their children and some do not even have the facts about HIV/AIDS. According to Erulker. (1998:31), "an even greater barrier than the parents' lack of knowledge seems to be the parents' embarrassment in discussing sexual topics." To avoid discussing sexual issues with the youth, adults have continued to insist that the youth must abstain from sex, giving little or no advice to those who continue to be sexually active.

At this juncture, Voluntary Counselling and Testing (VCT) services appear to be among the most qualified and suitable solution to the HIV/AIDS counselling problem for the adolescents. An exploratory study to identify opportunities for and barriers to providing VCT for youth which was conducted in Nairobi, Masaka and Kampala in May 2000 (Population Council, 2003:76), indicated that the youth would like access to HIV testing and counselling services if the services are confidential and inexpensive and if the results are reported honestly. In the study mentioned above, most of the

tested youth aged between 14-21 years in Kenya who were interviewed indicated that they intended to practise safer sex, while 77% of the untested youth indicated that they would like to be tested at some point in the future. Regardless of the result, the above study revealed that young people tested often change to less risky behavior. Unfortunately, none of the four Youth drop-in VCT centres in the country is in Nyeri district, and the only two VCT centres available in the district are located in Nyeri town (Chebet et al, 2003:6). As a result, for the youth in secondary schools to benefit from VCT services, it would be necessary to introduce mobile Outreach VCT services to the schools and ensure that adequate follow-up services are provided to counsel the students on sexual behavior and HIV/AIDS. According to the Orientation Package for VCT services in Kenya (NASCO, 2002:78), adolescents (under 18 years) can be encouraged to go for VCT if they are already sexually active.

## **1.2 PROBLEM STATEMENT**

About 35% of all reported HIV/AIDS cases in Kenya are teenagers aged between 15-19 years (Tuju,1996:1). According to Orege et al (2002:18), the great majority of HIV infections occur between the ages of 15-24 years with AIDS symptoms emerging three to ten years later. This is of great concern given the fact that 60% of the total Kenyan population is under 20 years of age. Kent (2002:8), argues that young people are vulnerable to HIV because they are more likely to engage in high- risk behavior e.g. unprotected sex with multiple partners, alcohol and drug abuse and also because they lack information about the risks of infection and how to protect themselves from it. A study conducted by CSA in Nyeri revealed that one out of every 25 teenagers engage in their first sexual intercourse before the age of ten years. Another study in the same district (Erulker, 1998:15), revealed that the proportion of young people reporting a boyfriend or girlfriend increases with age. In this study, 21% of boys aged 10-14 years reported having a girlfriend as compared to 71% of those aged between 15-19 years and 95% of those aged between 20-24 years. The girls followed a similar trend; 10% of 10-14 year old girls reported having a boyfriend as compared to 63% of those aged between 15-19, and 84% of those aged between 20-24 years.

Focus group discussions conducted in Kenya revealed that relationships that lasted more than a year, most likely involved penetrative sex. In the case discussed above,

respondents' most recent relationship had lasted 15 months for boys and 17 months for girls. The same study revealed that the time period between ages 14-20 seems to be the most critical stage, during which adolescents are most likely to first become sexually experienced. According to this study, 90% of boys and 64% of girls are sexually experienced by age 20 years, while 95% of boys and 77% of girls are sexually experienced by the time they are 24 years (Erulker, 1998:19). Reports from New York (Moore and Rosenthal, 1993:125), indicate that heterosexual transmissions of HIV virus is more widespread among adolescents than adults, and that among the 13-21 year old youth, the number of reported cases of AIDS is doubling every fourteen months. In Swaziland (Rikka, 1998:30), a national survey of secondary schools revealed that one half of the students were sexually active by the age of 15-16 years, and that HIV prevalence was 27% among students aged 15-19 years who were treated for sexually transmitted infections (STI'S). According to Rivers and Aggleton (1999:1), 50% of young men and 40% of young women recently surveyed in Uganda reported having had sex before 15 years of age. In Dar-es-salaam, 60% of 14 year old boys and 35% of girls reported being sexually active.

Looking at the above figures, and bearing in mind that the average age of secondary school students in Kenya is 13-19 years, one infers that a good number of secondary school youth are sexually active and therefore need HIV/AIDS counselling and health services as much as the adult population. If 35% of all reported cases of AIDS in Kenya are aged between 15-19 years, an age when they should be in secondary school, then adequate and accurate information on how to protect oneself from HIV/AIDS and how to live with AIDS if already infected would go a long way in reducing the spread of AIDS. According to the 1999 population census (CBS, 2003:214), 2.9 million out of the enumerated 28.7 million Kenyans are enrolled in secondary schools. The same population census revealed that 36% of all Kenyans fall between 15-24 years. A random sample of 1525 young people aged between 15-25 years in Nyeri in 1996 revealed that 54% of those aged 16 years and above had attained some years of secondary education (Erulker, 1998:9). This means that targetting the youth in secondary schools would ensure reaching a very good proportion of the population most at risk of contracting HIV/AIDS.

According to CSA fact sheet (Tuju, 1996:72), the rising levels of HIV/AIDS among adolescents is due to misinformation or lack of information on sexual behavior and HIV/AIDS. Many of the adolescents rely on their peers for information, which is often inaccurate or outright wrong. Others get their information from the media, which is often confusing. A Kenyan survey (Forsythe, 1996:137), revealed that nearly all youth knew about AIDS predominantly through the radio but that among the 64% sexually active youth, only 30% used condoms in a situation where 43% believed that they had a good to moderate chance of contracting AIDS. Assuming that nobody would wish to contract AIDS, why would these young people engage in unprotected sex? The only logical explanation is that they do not know any other way of protecting themselves from AIDS apart from abstinence, and probably are unwilling or unable to abstain or they do not have easy access to services and products that they can use to protect themselves. According to Mann et al (1992:579), personal vulnerability to HIV/AIDS increases with a lack of accurate, relevant and comprehensible information about HIV; when the individual is not concerned or sufficiently motivated regarding the dangers of HIV infection; and when the individual lacks access to needed services, supplies or equipment and the power or confidence to sustain or implement behavior changes. The ultimate prevention of HIV/AIDS, therefore, is individual empowerment- that is to say, empowering individuals to learn and to respond. At this juncture it is important to find out whether the youth have been empowered so as to reduce their vulnerability to HIV/AIDS.

According to Forsythe (1996:137), 10 000 girls drop out of school annually in Kenya as a result of pregnancy. This is a clear indication that the youth are actively engaging in unprotected sex, and the only way to save their lives in this era of AIDS is by giving them access to accurate information, services and resources which will help them to protect their health.

Worldwide experience during the past decade has demonstrated that successful HIV prevention requires three elements; information, health and social services, and a supportive social environment (Mann et al, 1992:579). It is in this spirit that this study



wished to find out whether the youth, especially in secondary schools had access to the three elements mentioned above, or the kind of information they have access to if any so that they could be able to protect themselves from the AIDS virus. In case they did not have adequate access, offering VCT services in their school setting, a place where they would feel comfortable to utilize them, would become a very timely solution to the problem. This is especially so because "health services are rarely designed specifically to meet the needs of the youth, and health workers only occasionally receive specialist training in issues pertinent to adolescent sexual health" (Rivers and Aggleton, 1999:2). Studies among boys and young men revealed that they would like to have access to confidential and affordable services provided at a time and location convenient to them. Most importantly, they want healthcare providers to be sensitive to their needs (Orege et al, 2002:6). According to the National Guidelines for VCT (NAS COP, 2001:17), all those involved in providing VCT to adolescents should be understanding, non-judgmental and respectful of the feelings and emotional turmoil that adolescents commonly experience. Currently, the country has only four youth- friendly VCT centres located in Nairobi (two centres), Mombasa (1) and Nakuru (1). These centres are too few considering that 17% of the Kenyan population are adolescents aged 15-19 years according to the 1999 population census (CBS, 2003:219).

### **1.3 OBJECTIVES**

The main objective of this study was to determine if there existed a sufficiently strong empirical basis for introducing VCT services to secondary schools by establishing whether VCT centres were appropriate sources of HIV/AIDS information for youth, and also whether the students were in need of the services. This study therefore sought to determine whether the youth in secondary schools had access to accurate and reliable sources of HIV/AIDS information and counselling on a regular basis.

To achieve the main objective, this study more specifically sought to find out:

1. Whether the students were offered intensive HIV/AIDS counselling on a regular basis
2. Whether the students were taking any measures (and if so, what measures they were taking) to protect themselves against HIV/AIDS infection

3. Whether the students were aware of VCT services and if they were willing to find out their HIV status

4. To what extent the VCT centres were considered as appropriate sources of HIV/AIDS information for youth.

#### **1.4 SCOPE AND LIMITATIONS**

Due to time and financial constraints, this study only covered Nyeri district, in the central province of Kenya. The study limited itself to the youth in secondary schools as they were easier to reach and would therefore save on time and money. Only students from randomly selected public schools were considered for the study because public schools are composed of youth from diverse backgrounds who better represented the general student population from the area. According to the Nyeri District Education Office (Statistics Section), Nyeri district has a total of 131 public secondary schools. These schools are stratified into: Boys Boarding Secondary Schools, Girls Boarding Secondary Schools, Mixed Boarding Secondary Schools and Mixed Day Schools.

## CHAPTER TWO: LITERATURE REVIEW

A selection of literature relevant to the research topic was reviewed in this chapter. The literature is discussed under various themes, namely: guidance and counselling in Kenyan schools, adolescents and HIV/AIDS, VCT in the fight against HIV/AIDS, what goes on at VCT sites, adolescents and VCT, and the theoretical framework.

### 2.1 GUIDANCE AND COUNSELLING IN KENYAN SCHOOLS

Counselling can be defined as a process whereby, a professional counsellor relates and responds to people with problems, with the aim of providing them with the opportunities to explore, to clarify, and to work towards living in a more satisfactory and resourceful way (Bond, 1993:15). On the other hand, guidance is usually given in educational institutions, especially when individuals are making career choices. Guidance implies "being available for an occasional chat to help a troubled person gain insight and better perspective with regard to his problems (Bond, 1993:21).

Guidance services for pupils have been recognized in most school systems as a function of the regular teaching staff. However, the growth of these services in high schools has created a demand for personnel especially trained to serve as counsellors (Adams, 1965:2). The Kenyan government encourages guidance and counselling in all schools. In fact, the Nation's Development Plan in 1977 called for a guidance and counselling programme in every Kenyan school by 1978 (G O K, 1977:1). The government has also been encouraging teachers to go for guidance and counselling training courses, to make them more effective as counsellors (G O K, 1977:6).

Guidance and counselling programmes in secondary schools were started in order to cater for all students with social, personal, psychological, educational and vocational problems (G O K, 1977:3). However, studies reveal that guidance and counselling programmes in most schools have not been effective because they are faced with numerous problems. A study carried out by Amukoa (1984:2), revealed that guidance and counselling in Kenyan schools has not been very successful because it faced problems like lack of enough trained personnel, lack of counselling facilities, negative

perception of teacher-counsellors by colleagues, students' indifference towards the service and lack of funds to employ full-time professional counsellors. Ligger (1968:150), argues that while guidance and counselling masters are mostly classroom teachers which leaves them with very little time for counselling, many of them have very little or no training at all as counsellors. This makes it very hard for the teacher-counsellor to counsel students who are faced with many social, emotional and psychological problems that can effectively be handled by professional counselling (Adams, 1965:2). The situation may be worse now, with the teacher-counsellor also expected to counsel the students on HIV/AIDS, an issue in which he/she may also be in need of counselling. According to Rivers and Aggleton (1991:1), teachers in many countries have reported being embarrassed to talk on the topic of sex with their students and they are also ill-prepared for teaching about sexual matters. This kind of information made the researcher wonder whether students were receiving the amount of counselling they deserved to help them face the threat of HIV/AIDS. A study carried out by Ngatia in Kiambu district (Ngatia, 2003:12), observed that there are very few schools with good and well-organized guidance and counselling programmes, while in most schools, counselling-teachers are only concerned with helping form four students fill out career forms. The researcher in this study wanted to find out whether too much classwork, limited counselling skills and lack of organized guidance and counselling programmes in schools had contributed to the students' inability to access regular and intensive HIV/AIDS counselling in the schools.

## **2.2 ADOLESCENTS AND HIV/AIDS**

HIV/AIDS is an impairment of the body's ability to fight disease. It leaves the affected individual vulnerable to illnesses that a healthy immune system might overcome. The disease is mainly spread through sexual intercourse (Victor, 1985: 1). The youth are exposed to AIDS due to biological, socio-cultural and economic factors. According to Kent (2002:8), an estimated 11.8 million people in the world, aged between 15-24 years were living with HIV/AIDS at the end of 2001. More than half of all new HIV infections occur among people aged below 25 years. This is because young people are more likely to engage in high risk-behavior e.g. unprotected sex with multiple partners, alcohol and drug abuse, and also because they lack information about the risks of

infection and how to protect themselves from it. In view of this, most of the HIV/AIDS programmes and services should focus on young people, if a significant reduction in the rate of spread of AIDS is to be realized in the near future, but do they?

Each day 14 000 people, 12 000 adults and 2 000 children in the world, become infected with HIV (Kent, 2002:3). At least 95% of these new infections occur in less developed countries, and more than 50% of them afflict women and young adults. In most cases, infections among young women are as a result of unprotected sex and reflect a power imbalance that limits women's ability to negotiate or control sexual interactions especially with older men. According to Orege et al (2002:5), some cultures around the world believe that having sex with a virgin will cure HIV/AIDS. While this is obviously untrue, increasing numbers of young girls are infected by older men as a result of this practice. On the other hand, boys and young men are expected to know about sex. This expectation from society stops many of them from seeking information about HIV/AIDS for fear of appearing ignorant about sexual matters, which in turn makes them vulnerable to HIV infection.

The HIV/AIDS pandemic in Kenya affects mainly the youth and people in early middle age. This means that HIV/AIDS preventive strategies would have a much bigger impact if they would succeed in people aged below 18 years. Yet, VCT services in the country mainly target people aged 18 years and above! Data from National AIDS Control Programme show that peak ages of AIDS occur at 20-25 years for females and 25-35 years for males. This is of great concern given the fact that 60% of the total Kenyan population is under twenty years of age and 36% of the population is aged between 14-24 years (G O K, 1997: 18). According to Steinberg (1985:347), the secrecy with which sex is treated during childhood makes it more difficult for individuals to deal with sexual feelings and desires when they reach adolescence. As a result, pre-marital sex has become a part of the average teenagers' social life. Consequently, society is now faced with a pressing need for earlier and more effective sex education, considering that sexual contact accounts for up to 90% of HIV infections in Kenya (Orege et al 2002:30).

First sexual intercourse commonly occurs during the adolescent years (Kent, 2002:8). Therefore, preventing HIV infection among adolescents is critical to slowing the epidemic because young people aged 10-19 years make up a large segment of the population. In fact, they make up more than one fifth of the total population in less developed countries and one seventh in more developed countries. A recent publication from UNICEF revealed that in every country where HIV transmission has been reduced, it has been among young people that the most spectacular reductions have occurred (Kent, 2002:22). In addition, Kent argues that prevention programmes are effective only if they can reach the people most at risk especially young adults.

Worldwide experience during the past decade has demonstrated that successful HIV prevention requires three elements; information, health and social services, and a supportive social environment (Mann et al, 1992:579). For individuals to change behavior they need basic knowledge of HIV and their risk of infection, they need to learn how to protect themselves and must have access to appropriate services and products. They must also perceive their environment as supportive of safe behaviors. This information makes one wonder whether the Kenyan adolescents are well equipped with information and access to services, which can help them to be better prepared to face the challenges of HIV/AIDS.

Gyepi-Garbrah (1985:26) argues that, despite the fact that adolescents are becoming an increasingly important segment of the sexually active population, their needs regarding information, healthcare and family planning are often overlooked principally because of how Kenyan society views it's youth. This argument can be supported by the fact that only four out of the 219 VCT sites currently operating in the country are basically structured to serve the youth while all the others are structured to serve those aged 18 years and above (Chebet et al, 2003:2). According to Orege et al (2002:18), the great majority of HIV infections occur between the ages of 15-24 years, with AIDS symptoms emerging three to ten years later. In view of this, the researcher wanted to find out whether limited access to information and health services on HIV/AIDS and limited access to VCT sites thus limited utilization of VCT sites as sources of

HIV/AIDS information for the youth had contributed to the increased youths' vulnerability to HIV/AIDS.

### 2.3 VCT IN THE FIGHT AGAINST HIV/AIDS

VCT (Voluntary Counselling and Testing) is a service that is offered to anyone who wishes to know his or her HIV status. A team of highly trained and experienced counsellors provide quality counselling and HIV testing for same day test results (Chebet et al, 2003:2). Voluntary confidential counselling and testing targets behavior change. According to the national guidelines for VCT (NASCOP, 2001:v), knowing one's HIV status empowers people to make informed decisions about their sexual lifestyle that would otherwise predispose individuals to HIV infection.

One of the Kenya government's major strategy is to make VCT services available, to target the majority of the population not yet infected and to identify early those who are infected for proper care services. According to Overall (1991:107), although there is at present no cure for AIDS, there are increasing numbers of drugs that can be effective in postponing the time period between the onset of seropositivity and active AIDS. Thus, there are more reasons why people should be tested for HIV so that those who are infected can get medication early enough.

VCT is an essential component of an effective response to the AIDS epidemic. According to Kent (2002:28), numerous research projects in Africa, including an important one in Kenya, have demonstrated that VCT and knowledge of serostatus encourages clients to reduce risky behavior. In view of this, VCT is important in any HIV prevention effort (NASCOP, 2001:1). According to Kent (2002:28), a study that included Kenya, Uganda and Trinidad documented a 43% reduction in unprotected sex among those who received VCT. Bearing this in mind, general information about VCT should be provided to groups in the course of general health education talks, to make them aware of the existence and the benefits of the service. VCT sites should make contacts with schools, and outreach to sites where youth are present should be made to explain the role and value of VCT. To avail VCT services to the youth, youth drop-in VCT centres should be established and mobile outreach VCT services should be offered to the youth in secondary schools (NASCOP, 2001:16). This, however, may

not be very easy because according to NASCOP (2001:viii), children under 15 years should be served at a VCT site only with parental consent, and counsellors need to judge very carefully before serving youth aged between 15-18 years. Yet, Tinker (1988:52), argues that until a vaccine is developed, preventing further spread of the HIV virus can be done only by preventing transmission, by ensuring that all including young people receive information on HIV and how it is spread, and making free confidential testing available. As such, the researcher was interested in finding out if secondary school students in Nyeri district were aware of the existence and benefits of VCT, and whether they had access to VCT services in their efforts to fight HIV/AIDS.

#### **2.4 WHAT GOES ON AT VCT SITES**

According to NASCOP(2001:14), individual pre-test counselling should be done to all those requesting for VCT. If demand at a VCT counsellorsite is very high, group pre-test counselling can be provided if; all clients consent to having pre-test counselling as a group, measures for privacy are adequate, no more than six people are placed in a group, and if efforts are made to compose groups of clients with similar ages and of the same sex. In addition, clients who request for counselling only and decline to be tested should be provided with this service without any pressure or coercion for testing (NASCOP 2001:20). This aspect of counselling may be particularly useful for adolescents who may not be sure of whether they would like to take the test or not. Issues that are discussed in the pre-test session include; basic facts about HIV infection and AIDS, meaning of a HIV test, reasons for requesting VCT.

Since the rapid tests used at the VCT centres give same-day results (NASCOP, 2001:14), the following issues are discussed while the test is developing: basic HIV prevention, personal risk assessment, client's readiness to learn serostatus, client's intentions after learning test results, exploration of what the client might do if the test is positive and the possible ways of coping with an HIV-positive result, exploration of what the client might do if the test is negative and possible ways of staying uninfected, exploration of behavior change, exploration of potential support from family and friends, condom use including condom demonstration, and any special needs discussed by the client.



Before disclosing the test results, the counsellor must ensure that the client is truly willing and ready to receive the results, and understands what both positive and negative results mean (NAS COP, 2001:15). Every post-test counselling session should include the development of a risk-reduction plan specific to the client's test results, and personal life situation. The counsellor should help the client to understand the importance of avoiding future risky exposure to HIV. VCT counsellors also inform the clients that they are available to talk to them in future.

According to Chebet et al (2003:2), services offered at VCT centres are on a voluntary and anonymous basis. VCT services observe confidentiality in carrying out HIV testing, disclosing results and keeping records. In most countries with VCT programmes, it has been found that more clients will request VCT when their names are not recorded and anonymity is practised. In general, HIV test results should be disclosed only to the client.

For special populations, such as pastoralists or in remote rural areas with limited health facilities, mobile VCT services should be considered (NAS COP, 2001:8). Agencies providing mobile VCT services should ensure that there are adequate follow-up services. The researcher in this study, felt that the youth in schools should be categorized as a special population, and should therefore be provided with mobile VCT services if need be.

According to Kent (2002:23), behavior change interventions e.g. VCT have succeeded in a variety of situations such as in North America, W. Europe, Australia etc. However, despite their recognized importance in AIDS control, VCT services tend to be of limited quality and coverage in less developed countries due to; lack of trained staff, concerns about confidentiality, stigma and discrimination, lack of resources, and clients' lack of knowledge about the existence and benefits of the services. The researcher wished to find out whether the youth were aware of the existence and benefits of VCT services.

## 2.5 ADOLESCENTS AND VCT

Traditional systems for teaching about sex are rapidly becoming inadequate for disseminating useful information, and so far, no other means of spreading this information has been devised (Gyepi-Garbrah, 1985:15). While the sex urge among young people seems to be increasing, parents have abdicated their responsibility in this area and no-one else is filling the gap. Parsons (1968:7) suggests that, when the home is unable to provide the necessary guidance, responsibility passes to the school. The researcher wanted to find out whether the schools were playing their part by ensuring proper HIV/AIDS counselling is offered to their students.

Unfortunately, very few schools in Kenya have good and well-organized guidance and counselling programmes (Ngatia, 2003:12). Parsons (1968:7), argues that, many tragedies have resulted from the combination of adolescents' deficient sense of responsibility, ignorance of sex life and the risks involved in unsuitable sexual relationships. However, according to the Orientation Package on VCT in Kenya (NAS COP/ MOH:79), the counselling part of VCT is especially suited for youth because they are very curious about sex and sexual feelings, and they often feel shy talking to their parents about sex. Therefore, counselling by the VCT personnel can help them establish healthy sexual behavior when they are still young. Unfortunately, according to the same Orientation Package (NAS COP/ MOH:78), adolescents (under 18 years) can only be encouraged to go for VCT if they are "mature minors" meaning: if they are already sexually active, already have a child, are about to enter into a relationship, have been a victim of rape or sexual exploitation, or have an STI or TB. The researcher felt that this condition was likely to limit the number of adolescents willing to go for VCT and thus intended to find out whether adolescents in secondary schools had actually been going for VCT, and which factors may be limiting them. According to NAS COP (2001:16), VCT providers should work to ensure that adequate youth-friendly services are available since adolescents are starting sexual activities early and can be guided into safer practices through counselling.

Children under 15 should be served at a VCT site only with parental consent, and only if there is a clear benefit to the child. At the same time, counsellors need to judge

carefully before serving the youth aged between 15-18 years (NASCO, 2001:viii). This age restriction may be necessary considering that an increased rate of suicide has been noted among AIDS patients, raising the issue of whether knowledge of HIV status increases suicidal behavior (Stanley and Sieber, 1992:148). However, inadequate research exists to determine the most ethical resolution of the conflict between the risks of increasing the chances of suicide if youths learn their HIV status, versus the risk of avoidable illness and death from AIDS if the youths are not tested and informed of their HIV status. A strong argument in favor of enabling youth to learn their HIV status is that, existing drugs can substantially alleviate symptoms and prolong the lives of HIV infected persons. To enable youths to benefit from these drugs, they must first get tested and be informed of their HIV status (Stanley and Sieber, (1992:148). Ethical procedures for HIV testing must therefore include adequate counselling and follow-up services to help people cope with test results, without bringing harm to themselves or to others.

An exploratory study conducted in Nairobi, Masaka and Kampala in May 2000 (Population Council, 2003:76), revealed that most of the HIV-tested youth aged between 14-21 years in Kenya who were interviewed indicated that they intended to practise safer sex, while 77% of the untested youth indicated that they would like to be tested at some point in the future. The researcher in this study was interested in finding out whether the youth in Nyeri district consider VCT a good weapon in the fight against HIV/AIDS and whether they were willing to find out their HIV status.

Gordon and Klouda (1989:156), observed that much AIDS education for the youth uses fear as the main motivation for changing behavior. While this is likely to have negative consequences for future relationships and to lead to denial, it also does not offer adolescents any safe way to express their sexuality, which, after all, is there and will not go away by will power alone. According to Tinker (1988:54), AIDS information which stirs up fears of contagion in the absence of supportive discussion and counselling can be worse than no information at all. This information makes it very necessary that HIV/AIDS counselling for youth be done by professional counsellors, and may be used to explain why regular classroom teachers may not be effective

HIV/AIDS counsellors to their students. According to GOK (1997:18), parents, leaders and teachers have difficulties discussing matters related to sexuality with young people which has created a vacuum of knowledge, making it difficult for the youth to handle HIV/AIDS effectively. The researcher wanted to find out whether the youth actually had limited access to HIV/AIDS information, services and resources, and whether VCT centres were appropriate sources of this information.

## **2.6 THEORETICAL FRAMEWORK**

A theory is a set of interrelated constructs, definitions and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena (Kerlinger, 1964:11). This study used the following behaviorist theories to try and explain how the youth could be assisted to adopt and maintain safe sexual behavior in order to protect themselves against HIV/AIDS.

### **2.6.1 COGNITIVE DISSONANCE THEORY**

This theory was proposed by Leon Festinger in 1955 (Newcomb et al, 1965:105). According to the theory, cognitive dissonance occurs whenever an individual holds two cognitions (ideas, attitudes, beliefs, opinions, feelings) that are psychologically inconsistent (Aronson, 1992:175).

HIV/AIDS issue has brought cognitive dissonance among many people. Among those who practiced extra-marital affairs, the fact that there is AIDS now means that, they have to think very carefully whether they still want to continue with the affairs and risk contracting HIV/AIDS. Alternatively, they can stick faithfully to their spouses and they will be safe from HIV/AIDS unless their spouses are already infected.

Among the youth, the situation is more difficult. Many of them have not yet settled for one permanent partner and some of them are unable or unwilling to abstain from sex. Due to the physiological and emotional changes taking place within the adolescents, their sexual drive is very strong and it is only natural for two young people who are becoming sexually mature to want to have sex (Kleinman, 1978:4). Unlike in the past, however, young people cannot freely engage in sex, they have AIDS- a life threatening

illness to think about. This brings about cognitive dissonance whereby, the youth are tempted to engage in sexual activities, while at the same time, they are scared of contracting HIV/AIDS in the process.

According to Newcomb et al (1965:105), the tension caused by cognitive dissonance has motivational force; the individual is prompted to reduce the dissonance, either by diminishing psychologically the importance of the dissonant elements or by changing one of the elements in order to restore consonance. In this respect, the youth might reduce the dissonance either by downplaying their chances of contracting HIV/AIDS, and thereby going on with sexual activities as if AIDS is non-existent. They can also engage in sex, but use a condom to reduce their chances of contracting the disease, or they can choose to abstain from sex in order to safeguard their health. Whatever option the young people take largely depends on what, and how much they know about the disease. Proper HIV/AIDS counselling among the youth at this stage, would help them to make the right decision on matters relating to their sexual behavior and HIV/AIDS. Professional HIV/AIDS counselling among young people can be used to reduce the cognitive dissonance in a way that guides them towards responsible sexual behavior. The question here was, 'are the young people being provided with adequate HIV/AIDS information, services and resources which make it easier for them to make the right choices on issues related to sexual behavior?'

### **2.6.2 PERSONAL CONSTRUCT THEORY**

This theory was developed by George Kelly in 1967. According to the theory, individuals actively interpret reality and guide their behavior according to the kind of reality they construe. HIV/AIDS is now a reality, and different people look at it from different perspectives. There are those who believe that having sex with a virgin can cure the disease (Orege et al, 2002: 5), there are those who see it as a curse, and there are those who have the facts about the disease and are therefore doing whatever they can to protect themselves from it.

Kelly argued that personal constructs are retained only as long as they are believed to be accurate. This implies that when individuals get new information on a particular

issue, they are likely to use that information to re-evaluate their constructs. Depending on the strength of the new information, individuals can retain their construct or revise it. Going by this theory therefore, it is possible to help the youth to adopt and maintain responsible sexual behavior by counselling them and ensuring adequate follow-up counselling services especially on HIV/AIDS. According to Steven (1973:18), personal constructs are ways in which predictions for the future are embodied in our psychological processes. This means that with adequate counselling from professional HIV/AIDS counsellors, responsible sexual behavior practices can be embodied in the minds of the youth which would in turn help them to form constructs that will help them to protect themselves from HIV/AIDS. The question here was, 'are the young people getting regular HIV/AIDS counselling in their schools to help them adopt and retain constructs that enable them to protect themselves against HIV/AIDS?'

## **2.7 HYPOTHESES**

Kerlinger (1964: 12) defines a hypothesis as a 'conjectural statement of the relationship between two or more variables. The purpose of hypothesis is to study explanation for certain facts and guide in the explanation of others. From the literature reviewed above, this study tested the following hypotheses:

1. Heavy teaching load and limited counselling skills has contributed to the teacher-counsellors' inability to offer regular and intensive HIV/AIDS counselling to the students
2. Lack of well-organized guidance and counselling programmes in most schools have contributed to the students inability to access unlimited HIV/AIDS information and counselling in their schools.
3. Limited HIV/AIDS counselling in the schools and limited utilization of VCT sites as sources of information for youth has contributed to the increased youths' vulnerability to HIV/AIDS.

## **CHAPTER THREE: METHODS**

This chapter addresses itself to the research design used in this study. Kerlinger (1964:275), defines a research design as “the plan, structure and strategy of investigation conceived so as to obtain answers to research questions and to control variance.” A research design guides the research in collecting, analyzing and interpreting observed facts. The chapter covers; site selection, target population, unit of analysis, sampling procedure, data collection procedures and data analysis techniques.

### **3.1 SITE SELECTION**

Nyeri district was selected for this study for several reasons. One, because having lived there, the researcher knows the area well and would therefore find it easier to locate the secondary schools. Another reason is that close interaction between the researcher and the teachers and students from the district revealed that most schools do not have regular HIV/AIDS counselling programmes for students taking place. In addition, Nyeri district has only two VCT sites, both of which are located in Nyeri town and none of which is a youth VCT site (Chebet et al, 2003:4). This made the researcher determined to find out whether the students in the district were actually disadvantaged by the shortage of these HIV/AIDS services, or whether other measures have been put in place to make sure the students have access to HIV/AIDS information and services.

### **3.2 TARGET POPULATION**

According to Borg and Gall (1983:241), “a target population refers to all the members of a real or hypothetical set of people, events or objects to which we wish to generalize the results of our research.” The target population of this study is made up of public secondary school students and guidance and counselling teachers from Nyeri District, Central Province, Kenya. Nyeri District has a total of 131 public secondary schools, with a student population of 31,377 (Nyeri District Education Office, statistics section). According to the Nyeri District Development Plan (G O K 1996:16), the district covers an area of 3 266 square kilometers and 26.97% of it's total population fall between ages 10-19 years.

### **3.3 UNIT OF ANALYSIS**

In this study, the unit of analysis was the secondary school student. The students, guidance and counselling teachers, and the VCT personnel were the respondents. The data was collected directly from the field with the use of questionnaires administered to the students, and interview guides administered to the guidance and counselling teachers and the VCT counsellors.

### **3.4 SAMPLING PROCEDURE**

In this study, stratified random sampling method and simple random sampling method were used in both the selection of schools, and in the selection of students in the selected schools. Simple random sampling ensures that every item in the population has an equal chance of being included in the sample, and as Singleton (1988:147) argues, "in addition to increasing efficiency, stratified random sampling may be used to guarantee that variable categories with small proportions of cases in the population are adequately represented in the sample."

The secondary schools in the district were first stratified into: Boys Boarding Schools, Girls Boarding Schools, Mixed Boarding Schools and Mixed Day Schools. Simple random sampling was then done to select two schools from each category. A table of random numbers was used in this case. To select the sample of students, students in the selected schools were stratified into: Form 1 students, Form 2 students, Form 3 students and Form 4 students. Systematic random sampling was then used to select students from each form/ category. A class list was used as the sampling frame. The total number of students in each class/form was used to work out the number to whom questionnaires would be administered since it differed from school to school thus entailing variations. Using proportionate stratified random sampling, the researcher interviewed a total sample size of 118 students.

The key informants were the guidance and counselling teachers in each of the selected schools, to give a total of 8 guidance and counselling teachers. Since there are only two VCT centres in Nyeri district (Chebet et al, 2003:4), both of them were visited and key informants interviewed to find out the extent to which the youth have been utilizing the



VCT services and their appropriateness as sources of HIV/AIDS information for the youth.

### **3.5 THE RESEARCH INSTRUMENTS**

Students were given questionnaires which they filled in by themselves under the supervision and guidance of the researcher in order to collect data on their level of awareness of HIV/AIDS and VCT services, their main sources of information, and what they are doing to protect themselves from HIV/AIDS. The researcher also made use of an interview guide that was administered to four VCT counsellors separately and an interview schedule that was administered to each of the eight teacher-counsellors.

### **3.6 DATA COLLECTION PROCEDURE**

The researcher personally interviewed the key informants in the study. The respondents were asked to fill in the questionnaires individually under the guidance and supervision of the researcher.

All the respondents and key informants were assured that strict confidentiality would be maintained when dealing with their responses.

### **3.7 PROBLEMS ENCOUNTERED IN THE FIELD**

A few problems were encountered as data were being collected in the field. The major problem was that at the time of data collection, most schools had their students sitting for mid-term examinations. As a result, the researcher had to wait until late afternoon to interview the students, and was only given a few minutes. In addition to prolonging the time period initially planned for data collection, this made it difficult for the researcher to interview individual students personally and instead resulted in the students' being given the interview schedules to fill in by themselves under the supervision and guidance of the researcher. This may be one of the factors that contributed to missing responses in some parts of the study by some students, although usually it was a very small number.

Another problem was that some of the sampled schools were very far apart, making it very expensive for the researcher in terms of time and money. This was made worse

where some schools were far from the main-road and the researcher had to walk long distances.

Getting to interview some key informants, namely the VCT personnel, had also proved difficult at first, but permission was later granted after the researcher got a letter from the area District Education Officer requesting the people concerned to assist. However, some VCT counsellors were still hesitant to give their personal opinions on some issues despite having been assured of confidentiality.

### **3.8 DATA ANALYSIS**

Raw data were cleaned, coded and then entered into a computer using the Statistical Package for Social Sciences (SPSS). Descriptive and inferential statistics were then used to present and interpret the data. In this study, data has been described using percentages, frequency distributions, tables and pie charts.

### **3.9 OPERATIONAL DEFINITION OF VARIABLES (INDEPENDENT AND DEPENDENT VARIABLES)**

#### **Dependent variable**

The dependent variable is the one that the researcher is interested in explaining and Predicting (Singleton. 1988:72).

#### **Independent variable**

This is the variable that explains / predicts changes in the dependent variable(s).

The dependent and independent variables in each hypothesis have been operationalized into several observable variable indicators to make them measurable and thus testable. Identification of variable indicators was necessary because it enabled the researcher to identify the most appropriate units of observation and the best research instrument to be used when collecting the data needed for the study. The research instruments used, that is, the interview schedule for the students and the teacher-counsellors, and the interview

guide for the VCT counsellors have been developed with reference to the observable variable indicators shown in the table below.

**Table 1: Study variables and measurement of indicators**

<i>Hypothesis</i>	<i>Type of variable</i>	<i>Variable Name</i>	<i>Variable indicators or measurements</i>
Hypothesis 1	Dependent	Ability to offer regular and intensive HIV/AIDS counselling	<ul style="list-style-type: none"> <li>-presence of teacher- or not</li> <li>-number of HIV AIDS counselling hours per \week</li> <li>-percentage number of students coming for HIV/AIDS counselling per term</li> <li>-presence or absence of counselling room with facilities</li> <li>-well kept counselling records</li> <li>-presence of HIV/AIDS counselling programme</li> <li>-HIV/AIDS counselling programme strictly followed</li> </ul>
	Independent	Teaching load  Counselling skills	<ul style="list-style-type: none"> <li>-Number of lessons per week compared to the optimal load as per ministry standards and also compared to the other teachers in the school</li> <li>-counselling training or not</li> <li>-level of counselling training eg certificate, diploma, degree etc</li> <li>-number of years of counselling practice</li> </ul>

Hypothesis 2	Dependent	Access to HIV/ AIDS information and counselling	<ul style="list-style-type: none"> <li>-presence or absence of counselling programme</li> <li>-number of HIV/AIDS counselling sessions per term</li> <li>-percentage number of students attending HIV/AIDS counselling sessions per term</li> <li>-presence or absence of counselling room with facilities</li> </ul>
	Independent	Organized guidance and counselling programme	<ul style="list-style-type: none"> <li>-presence or absence of teacher</li> <li>-presence or absence of counselling programme</li> <li>-counselling programme followed strictly and according to the timetable</li> <li>-presence or absence of updated counselling records.</li> </ul>
Hypothesis 3	Dependent	Youths' vulnerability to HIV/AIDS	<ul style="list-style-type: none"> <li>-sexual activity or not</li> <li>-protected or unprotected sex</li> <li>-protective measures used</li> <li>-level of awareness of the risks of contracting HIV/AIDS</li> <li>-access to HIV/AIDS counselling and services</li> </ul>

	Independent	HIV/AIDS counselling	<ul style="list-style-type: none"> <li>-presence or absence of HIV/AIDS counselling programme</li> <li>-HIV/AIDS programme followed strictly as per the time-table</li> <li>-presence or absence of teacher</li> <li>-presence or absence of counselling room with facilities</li> <li>-allocation of HIV/AIDS counselling budget</li> </ul>
		Utilization of VCT services	<ul style="list-style-type: none"> <li>-percentage number of students aware of VCT services</li> <li>-percentage number of students who have ever visited a VCT center</li> <li>-frequency with which individual students visit VCT sites</li> <li>-percentage number of VCT clients who fall below 18 years per week</li> </ul>

**Table 1** affected the design of the research instruments in that it enabled the researcher to identify the most appropriate units of observation for the various study variables. This enabled the researcher to identify the most appropriate research instruments to be used for effective collection of data on all the observable variable indicators. For example, an interview schedule was developed for the students and the teacher-counsellors because they were required to answer many questions that needed straightforward answers with few explanations, while an interview guide was selected for the VCT counsellors because data needed from them could be better collected through in-depth discussions and clarifications.

The table is related to the hypotheses in that it shows how each hypothesis has been broken down into its dependent and independent variables and how each variable has been operationalized into observable variable indicators to make it measurable and thus testable. The research instruments were then developed with reference to the observable variable indicators as shown in the table to make sure that as much data as possible were collected in the field to enable the researcher test the hypotheses.

## CHAPTER 4: DESCRIPTIVE ANALYSIS OF FIELD DATA

This chapter presents and descriptively analyses the data gathered from the field. The data are presented in the form of tables, pie charts, frequencies and percentages where applicable.

### 4.1 AGE DISTRIBUTION OF STUDENTS

The study sample consisted of 118 students, 4 VCT counsellors, and 8 teacher-counsellors. The student sample consisted of 69 boys (58.5% of total), and 49 girls (41.5%). Their ages ranged from 14 to 21 years. They were selected from form 1 to form 4. **Table 2** below shows the distribution of their ages. From, the table, it can be concluded that majority of the secondary school students in the district are aged between 17-19 years.

**TABLE 2: AGE DISTRIBUTION OF STUDENTS**

AGE IN YEARS	FREQUENCY	PERCENTAGE	CUMULATIVE PERCENTAGE
14-16	27	22.9	22.9
17-19	80	67.8	91.7
20-22	6	5.1	96.8
NO RESPONSE	5	4.2	100
TOTAL	118	100	

source: field data, 2004

## 4.2 HIV/AIDS COUNSELLING IN SCHOOLS

The researcher observed that very little HIV/AIDS counselling was going on in the secondary schools. **Table 3** shows the responses of students when asked whether their schools had an HIV/AIDS counselling programme.

**Table 3: PRESENCE OF HIV/AIDS COUNSELLING IN SCHOOLS**  
(Student responses)

	Frequency	Percent
No HIV/AIDS Programme	113	95.8%
Presence of HIV/AIDS programme	0	0%
Total	113	95.8%

Source: field data, 2004

From **Table 3**, 95.8% of the students revealed that their schools did not have an HIV/AIDS counselling programme. All the key informants (teacher-counsellors) confirmed that their schools did not have a programme specifically for HIV/AIDS counselling but added that the HIV/AIDS issue always came up during their normal counselling sessions. In this study, an HIV/AIDS counselling programme was defined by having time set aside specifically for HIV/AIDS counselling. Since none of the schools had set up the HIV/AIDS programme, it implies that emphasis is not given to HIV/AIDS counselling in most schools despite having a guidance and counselling department in those schools. The study also revealed that only 25% of the teacher-counsellors kept updated counselling records of their student clients as shown in **Table 4**. In some of the schools the researcher visited, the teacher-counsellors were not even aware they are supposed to keep records of their counselling clients while in others, the records were kept in the students' file with the administrators. This showed that the

teacher-counsellors do not take their counselling profession seriously or they are not well trained in that profession so they do not know what they are expected to do.

**TABLE 4: AVAILABILITY OF COUNSELLING RECORDS**  
(Responses from teacher-counsellors)

	Frequency	Percent	Valid Percent	Cumulative Percent
YES	2	25.0	25.0	25.0
NO	6	75.0	75.0	100.0
Total	8	100.0	100.0	

Source: field data, 2004

#### 4.3: AVAILABILITY OF THE COUNSELLING TEACHER

All the schools that the researcher visited had a teacher-counsellor. When the students were asked whether the teacher-counsellor was available whenever they needed counselling, Table 5 shows their responses.

**Table 5: Availability of the counselling teacher when needed by students**

(Student responses)

	Frequency	Percent
Unavailable	17	14.4%
Available	98	83.1%
Total	115	97.5%

Source: field data, 2004



**Table 5** shows that the majority of the students find their teacher-counsellors readily available whenever they need them. This is important because the teachers are expected to play the role of parents when the children are in school. It is therefore reassuring to find that the majority of the students felt that the teacher-counsellors were always there for them.

#### 4.4 AVAILABILITY OF GUIDANCE AND COUNSELLING PROGRAMME

To determine how the students viewed their school's guidance and counselling system, they were asked whether their school had a guidance and counselling programme, how organized they felt it was, and whether the programme was strictly adhered to. **Table 6**, **Figure 1** and **Table 7** shows the responses of students to each of the above questions respectively.

**Table 6: Availability of guidance and counselling programme (Student responses)**

	Frequency	Percent
Unavailable	53	44.9%
Available	60	50.8%
Total	113	95.8%

Source: field data, 2004

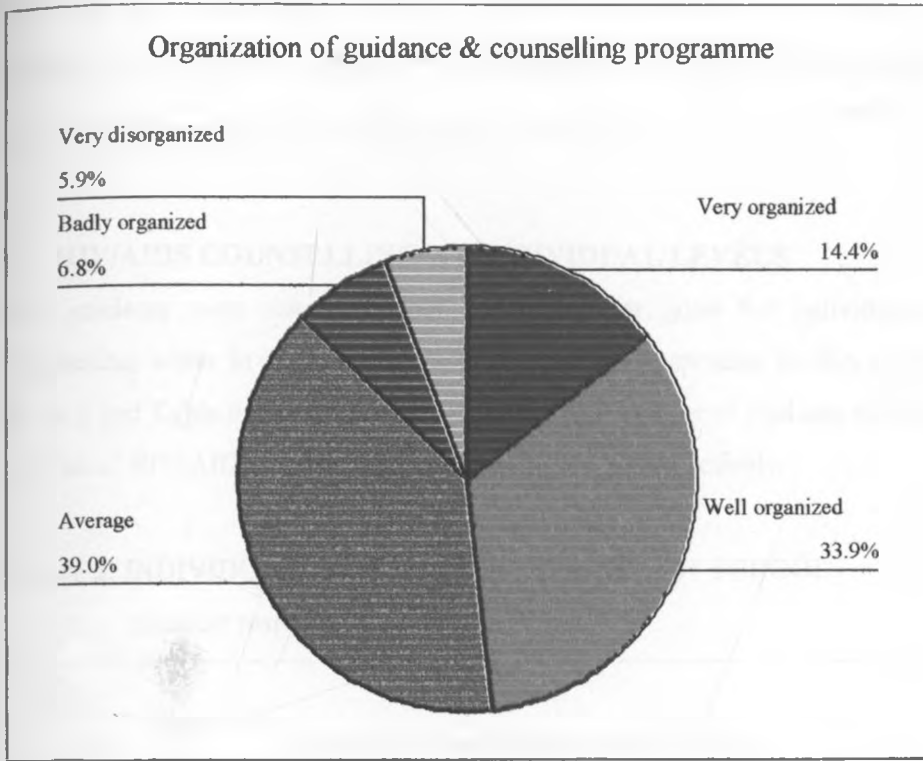
**Table 6** shows that 44.9% of the students felt that their schools did not have a guidance and counselling programme. A few students (4.2%), did not respond to the question probably because they did not know whether to call what was in their school a programme or not. However, according to the researcher's personal observation, only two schools out of the eight that were visited had a good programme on paper though

the teacher-counsellors admitted that sometimes it was not possible to strictly adhere to it.

#### **4.5: Organization of the guidance and counselling programme in schools?**

As shown in figure 1, only 5.9% of the students reported that their schools' guidance and counselling programmes were very disorganized, compared to 14.4% who felt that their schools' programmes were very organized. The organization of guidance and counselling programme in this study was judged by how well the guidance and counselling activities were outlined on paper, which activities were included in the programme, how much time was allocated to guidance and counselling according to the programme, and how strictly the programme was adhered to. According to the researchers personal observation, very few schools had well-organized guidance and counselling programmes. In some schools that had a guidance and counselling programme, the programme simply involved having one or two hours per week set aside on the time-table and meant for guidance and counselling, while in reality students and teachers used this time to do other things. However, in some others, the guidance and counselling programme included a 'Family Day' once a year where students, parents and teachers met, shared experiences and were addressed by guest speakers on selected topics of interest.

**FIGURE 1: Organization of guidance and counselling programme  
(Responses from students)**



Source: field data, 2004

#### 4.6 ADHERENCE TO COUNSELLING TIME TABLE

**TABLE 7: ADHERENCE TO COUNSELLING TIME-TABLE (student responses).**

	Frequency	Percent
<b>Not adhered to</b>	79	66.9%
<b>Adhered to</b>	38	32.2%
<b>Total</b>	117	99.2

Source: field data, 2004

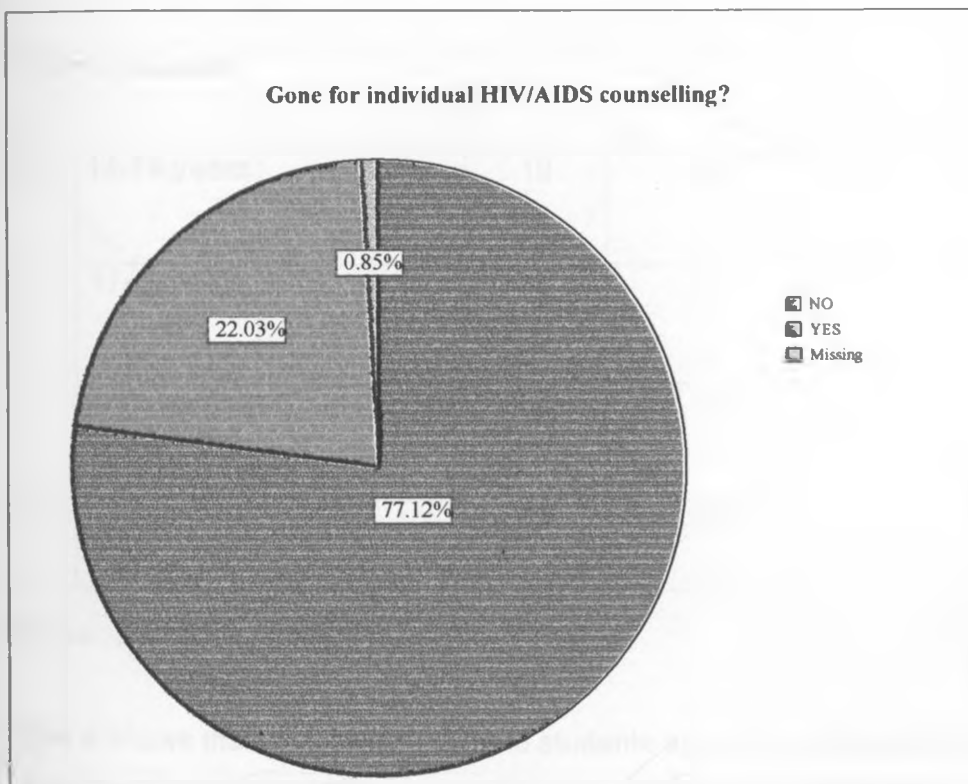
Table 7 shows that only 32.2% of the students felt that their schools adhered to the counselling time-table. From the key informants, the researcher found that it was

difficult to adhere to the counselling programme because in some cases, other school activities were organized to coincide with this counselling time because neither the students nor the teachers seemed to take guidance and counselling very seriously, and also because unexpected events sometimes came up.

#### 4.7 HIV/AIDS COUNSELLING AT INDIVIDUAL LEVELS

The students were asked whether they had ever gone for individual HIV/AIDS counselling while in school. Figure 2 shows their responses to this question, while Table 8 and Table 9 show cross-tabulations of the number of students who had gone for individual HIV/AIDS counselling by age and gender respectively.

**Figure 2: INDIVIDUAL HIV/AIDS COUNSELLING AT SCHOOL**  
(student responses)



Source: field data, 2004

**Figure 2** shows that 77.12% of the students have never gone for individual HIV/AIDS counselling by their teacher-counsellors or other teachers in the school despite their schools not having any HIV/AIDS counselling programme. Surprisingly, the study also revealed that the majority of the youth had insufficient HIV/AIDS information and desired to have more as will be discussed later on in this study. This implies that the majority of the students are not willing to approach their teachers for HIV/AIDS information and counselling. As illustrated later in this study, most students argued that they would prefer a professional counsellor if they badly needed HIV/AIDS counselling.

**TABLE 8: Distribution of students who have gone for individual HIV/AIDS counselling at school by age (student responses)**

		Individual HIV/AIDS counselling		
		Yes	No	Total
Age	0-13years	-	-	-
	14-16 years	6	19	25
	17-19years	14	61	75
	20years and above	4	1	5
Total		24	81	105

**Source: field data, 2004**

**Table 8** shows that 4 (80%) out of the 5 students aged 20 years and above went for individual HIV/AIDS counselling in their schools as compared to 14 (17.72%) out of 75 aged 17-19 years, and 6 (24%) out of 25 students aged 14-16 years.

**TABLE 9: Distribution of students who have gone for individual HIV/AIDS counselling at school by gender (student responses)**

Gender	Individual HIV/AIDS counseling		
	yes	No	Total
Male	13	53	66
Female	11	37	48
<b>Total</b>	<b>24</b>	<b>90</b>	<b>114</b>

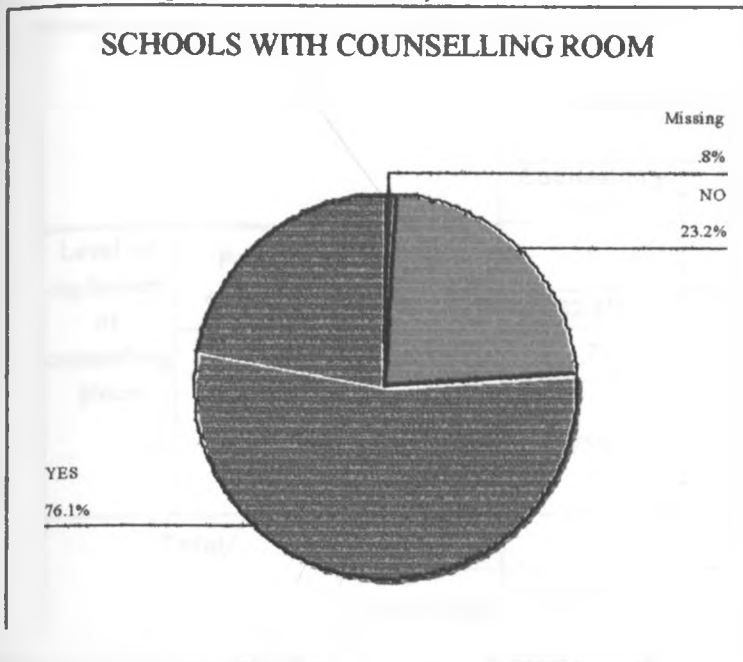
Source: field data, 2004

From **Table 9**, it can be concluded that 13 (19.9%) out of 66 male students and 11 (22.4%) out of 49 female students had gone for individual HIV/AIDS counselling in their schools. From **Table 8** and **9**, a higher percentage of the girls had gone for individual HIV/AIDS counselling than the boys, but the age of the students does not seem to be a factor in this case.

#### **4.8 PRESENCE OF COUNSELLING ROOM**

From the study, 76.1% of the students reported that their schools had a room set aside for counselling purposes as shown in **Figure 3**. However, all the key informants (teacher-counsellors) reported that their schools had a counselling room as shown in **Table 10**. From the key informants, the researcher found out that in some of the schools, the room was hardly ever used for counselling because the counselling teachers preferred to counsel the students elsewhere especially in open air, staff-room or wherever the students approached the teacher-counsellor. This may probably explain why some students thought that their schools did not have a counselling room. **Table 11** shows the responses of key informants when they were asked whether their counselling rooms were well equipped or not. Well equipped in this case was defined by the presence of lockable cabinets, comfortable seats, curtains, a decent table, shelves etc.

**Figure 3: PRESENCE OF COUNSELLING ROOM  
(Response from students)**



Source: field data, 2004

**TABLE 10: PRESENCE OF COUNSELLING ROOM (Responses from teacher-counsellors)**

	Frequency	Percent	Valid Percent	Cumulative Percent
Presence of counselling room	8	100.0	100.0	100.0
Absence of counselling room	0	0	0	100.0

Source: field data, 2004

**Table 11: Level of equipment of counselling place  
(Response from teacher-counsellors)**

			Place of counselling		Total
			Counselling room	Other	
Level of equipment of counselling place	Poorly equipped	Count	5	1	6
		% of Total	62.5%	12.5%	75.0%
	Well equipped	Count	2	-	2
		% of Total	25%	-	25.0%
Total		Count	7	1	8
		% of Total	87.5%	12.5%	100.0%

Source: field data, 2004

Table 11 shows the responses of teacher-counsellors as to whether their counselling rooms or whichever place they preferred to perform their counselling role was well equipped or not. Two of the teacher-counsellors reported that their rooms were fairly well equipped while the rest felt that theirs were poorly equipped. One of the teacher-counsellors (12.5%), preferred to counsel the students somewhere in the open especially in the field. Under ideal situations, a counselling room should be furnished well enough to be comfortable. In most of the schools that the researcher visited, the counselling rooms only had two chairs and an old table with many teaching aids meant for class-room teaching.

#### 4.9 MEASURES TO PROTECT SELF AGAINST HIV/AIDS.

The study revealed that approximately 23% of the students had engaged in sexual intercourse at some point in their lives as shown in Table 12. However, only 08% of them had engaged in sexual-intercourse in the year of this study. It should be noted however that, 23% is quite a large number and youths' vulnerability to HIV/AIDS cannot be ignored considering that 8% of them had engaged in sexual intercourse



during the first six months of the year of this study. According to the study findings, majority of the students who had ever engaged in sexual intercourse had their first encounter before they were 6 years old as shown in **Table 13**. This is not only surprising but shocking because at that age, the children are too young to know what they are doing.

**TABLE 12: Distribution of students who had ever engaged in sexual intercourse (students' responses)**

	Frequency	Percent	Valid Percent	Cumulative Percent
<b>YES</b>	27	22.7	22.9	22.9
<b>NO</b>	88	73.9	74.6	97.5
<b>TOTAL</b>	115	96.6	100.0	

Source: field data, 2004

**TABLE 13: Students' age at first sexual encounter (students' responses)**

AGE IN YEARS	Frequency	Percent	Valid Percent	Cumulative Percent
<b>0-5</b>	14	11.8	11.9	11.9
<b>6-10</b>	7	5.9	5.9	17.8
<b>11-15</b>	5	4.2	4.2	22.0
<b>16-20</b>	1	.8	.8	22.8
<b>21 and above</b>	0	0	0	22.8
<b>Total</b>	27	22.7	22.8	

Source: field data, 2004

Table 12 and 13 above reveal that almost a quarter of the student population, have ever had a sexual encounter at some point in their lives. All the 21% who have ever engaged had their first sexual encounter before they were 21 years of age. This implies that reproductive education should be offered to the young people from as early in their lives as possible. The students were also asked whether they were taking any measures

to protect themselves from HIV/AIDS and what measures they were taking if any.

Table 14 shows a cross tabulation of the student responses to the above question.

**Table 14: HIV/AIDS PROTECTIVE MEASURES TAKEN BY STUDENTS  
(Responses from students)**

PROTECTING SELF	MEASURES TO PROTECT				TOTAL
	ABSTINENCE	CONDOM USE	FAITHFULNESS	OTHER	
YES	99	4	10	1	114
TOTAL					114

Source: field data, 2004

It was observed that 114 (97.4%) out of the 118 students were protecting themselves against HIV/AIDS. Out of these, 99 (85.2%) were abstaining, 4 (2.6%) used condoms and 10 (8.7%) remained faithful. The findings were a good indicator that the youth had thought of HIV/AIDS and that they were taking measures to protect themselves.

#### 4.10: YOUTH'S AWARENESS OF VCT SERVICES.

**TABLE 15: Youth's awareness of VCT services (Students' responses)**

	NUMBER OF STUDENTS	PERCENTAGE	CUMULATIVE PERCENTAGE
AWARE OF VCT SERVICES AND CENTRES	76	64	64
AWARE OF VCT CENTRES BUT NOT SERVICES	28	24	88
NO IDEA	14	12	100
TOTAL	118	100	

Source: field data, 2004

As shown in **Table 15**, 64% of the youth have heard of VCT centres and are aware of VCT services. Another 24% have heard of VCT centres but are not aware of the services offered at VCT centres. The remaining 12% had no idea of the centres or the services. Despite the fact that a number of the students do not know much about the services offered at the VCT centres, majority of the students, teacher-counsellors and VCT counsellors recommended VCT for youth as will be illustrated later. As shown in **Table 16**, 50% of VCT counsellors supported and recommended VCT for youth. On the same issue, 87.5% of teacher-counsellors supported VCT for youth as shown in **Table 17**. However, 12.5% of teacher-counsellors supported VCT counselling for youth but not HIV testing unless the students really insisted. The remaining 12.5% did not know much about VCT but would recommend anything that would help students to fight HIV/AIDS. In addition, 50% of VCT-counsellors reported that in their personal opinion, VCT is the most appropriate source of HIV/AIDS information and counselling for youth because that is the one place the youth can get all information in confidence.

**TABLE 16: VCT COUNSELLORS SUPPORTING VCT FOR YOUTH**

(Responses from VCT-counsellors)

	Frequency	Percent	Valid Percent	Cumulative Percent
<b>Supporting</b>	2	50.0	50.0	50.0
<b>Not supporting</b>	2	50.0	50.0	100.0
<b>Total</b>	4	100.0	100.0	

Source: field data, 2004

**TABLE 17: Teacher-counsellors supporting VCT for youth**

(Responses from teacher-counsellors)

	Frequency	Percent	Valid Percent	Cumulative Percent
<b>Supporting</b>	7	87.5	87.5	87.5
<b>Not supporting</b>	1	12.5	12.5	100.0
<b>Total</b>	8	100.0	100.0	

Source: field data, 2004

To assess whether young people were utilizing VCT services, the VCT counsellors were asked to rank their common clients in terms of age and marital status. Table 18 shows that very few clients aged below 18 years visited VCT centres, while Table 19 shows that the most common clients were single people aged between 20-30 years.

**TABLE 18: VCT clients below 18 years**

(Responses from VCT counsellors)

	Frequency	Percent	Valid Percent	Cumulative Percent
<b>Many</b>	0	0	0	0
<b>Few</b>	0	0	0	0
<b>Very few</b>	4	100.0	100.0	100.0

Source: field data, 2004

**TABLE 19: Distribution of responses from VCT counsellors showing the most common clients at VCT centers by age and marital status**  
(Responses from VCT counsellors)

		marital status of common clients		Total
		single	Married	
Age of Common clients	19 years and below	0	0	0
	Between 20-30 years	4	0	4
	Above 30 years	0	0	0
<b>Total</b>		4	0	4

Source: field data, 2004

#### 4.11: YOUTH'S VULNERABILITY TO HIV/AIDS

To help assess the youth's awareness of their risk of contracting HIV/AIDS, Table 20 shows whom the youth thought were the most vulnerable groups to HIV/AIDS. As shown in the table, 64% of the students were aware that those who engage in unprotected sex are the group most at risk of contracting HIV/AIDS while the rest are not. Several of them (32%), felt that simply being young puts one at the highest risk, while 3% felt that socializing with HIV/AIDS infected persons puts one at the highest risk of contracting the disease. The information above shows that a good number of the youth are still not well informed about the disease and something therefore, needs to be done about it so that they can get more information on HIV/AIDS.

**TABLE 20: VULNERABILITY TO HIV/AIDS (Students' responses)**

	FREQUENCY	PERCENTAGE	CUMULATIVE PERCENTAGE
ENGAGING IN UNPROTECTED SEX	75	64	64
YOUNG PEOPLE	38	32	96
SOCIALIZING WITH HIV+ PEOPLE	4	3	99
MARRIED PEOPLE	1	1	100

Source: field data, 2004

#### 4.12 WILLINGNESS OF THE YOUTH TO FIND OUT THEIR HIV STATUS

The table below shows responses of students when they were asked whether they would like to know their HIV status.

**TABLE 21: PERCENTAGE OF YOUTHS WILLING TO FIND OUT THEIR HIV STATUS (Student responses)**

		Frequency	Percent
	NOT WILLING	14	11.9%
	Willing	99	83.9%
	No idea	5	4.2%
<b>Total</b>		<b>118</b>	<b>100.0%</b>

Source: field data, 2004

As shown in **Table 21**, 83.9% of the youth were willing to find out their HIV/AIDS status. 11.9% are not for the idea while the remaining 4.2% are not decided. Other results showed that only 11.9% of the youth had ever visited a VCT centre as shown in **Table 23**, as compared to 94% who recommended that VCT services be offered to students as shown in **Table 22**.

**TABLE 22: In support of VCT for students (Student responses)**

	Frequency	Percent	Valid Percent	Cumulative Percent
<b>Supporting</b>	112	94.8	94	94
<b>Not supporting</b>	5	4.2	3.5	97.5
<b>Total</b>	<b>117</b>	<b>99.15</b>	<b>99.5</b>	

Source: field data, 2004

From **Tables 21 and 22**, it can be concluded that students would like to find out their HIV status and they would also like VCT services offered to students. However, from **Table 23**, only 11.9% of the students had ever visited a VCT site. This implied that more students would like to access the VCT services but there may be factors that hinder them from going there.

**TABLE 23: YOUTH WHO HAVE EVER VISITED A VCT CENTRE**  
(Students' responses)

	FREQUENCY	PERCENT
Never visited	103	88.1%
Ever visited	14	11.9%
Total	118	100.0

Source: field data, 2004

#### 4.13: YOUTHS' PREFERENCE TO COUNSELLORS

Figure 16 shows the youths' preference when it comes to seeking HIV/AIDS counselling services. If in desperate need for HIV/AIDS counselling, 72% of the students reported that they would prefer a professional counsellor as compared to other people. 12% would prefer counselling from their parents, 9% from their guidance and counselling teachers while the rest would prefer friends and other peers.

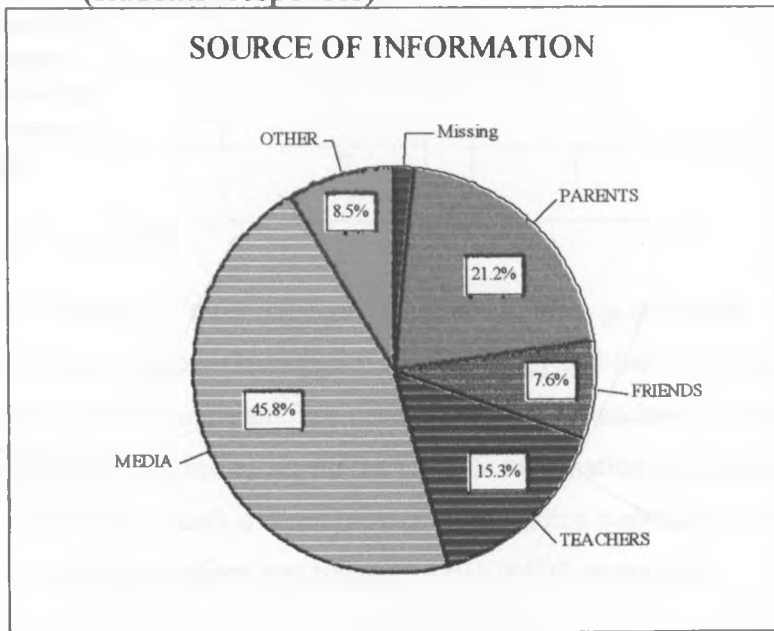
**TABLE 24: PREFERRED HIV/AIDS COUNSELLOR**  
(students' responses)

	FREQUENCY	PERCENTAGE	CUMULATIVE PERCENTAGE
PROFESSIONAL HIV/AIDS COUNSELLOR	85	72	72
PARENTS	14	12	84
TEACHER-COUNSELLOR	11	9	93
FRIENDS	6	5	98
OTHERS	1	1	99
TOTAL	117	99	

Source: field data, 2004

Despite the fact that the majority of the students preferred professional HIV/AIDS counsellors by majority of the students, 45.8% of them still got most of their HIV/AIDS information from the media, and only 15.3% got most of their HIV/AIDS information from their teacher-counsellors as shown in figure 4

**Figure 4: SOURCES OF INFORMATION ON HIV/AIDS**  
(students' responses)



Source: field data, 2004

In 7 (87.5%) out of the 8 schools visited by the researcher, the teacher-counsellors reported that no students had ever approached them for individual HIV/AIDS counselling despite having no HIV/AIDS counselling programmes in their schools. However, as shown in Table 25, 100% of the schools organized group counselling sessions once or twice per year where guest speakers were asked to say something on HIV/AIDS and teachers reported using every opportunity to talk on HIV/AIDS.



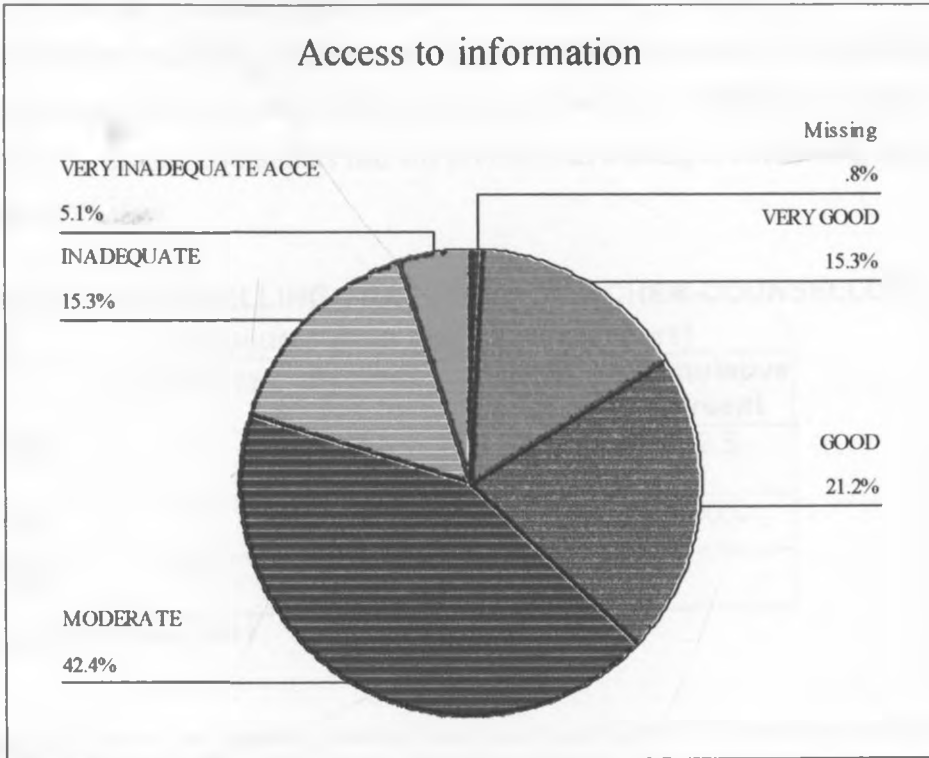
**TABLE 26:** Presence of guidance and counselling sessions with guest speakers by the number of Guidance and counselling sessions by guests per year (responses from teacher-counsellors)

		Number of guidance and counselling sessions by guest speakers per year		Total
		Once	twice	
Presence of guidance and counselling sessions with guest speakers	yes	7	1	8
Total		7	1	8

Source: field data, 2004

As shown in **figure 5**, most students reported a fairly good access to HIV/AIDS information in their schools although 78% still felt they had insufficient information on the issue (**TABLE 26**) and therefore needed more. The teacher-counsellors reported giving students good access to all the HIV/AIDS information that they had, but also complained that their schools did not have enough reading materials on HIV/AIDS and none of the teacher-counsellors was trained on HIV/AIDS counselling.

**FIGURE 5: ACCESS TO HIV/AIDS INFORMATION (Students' responses)**



Source: field data, 2004

**TABLE 26: DISTRIBUTION OF STUDENT RESPONSES ON WHETHER THEY HAVE ENOUGH INFORMATION ON HIV/AIDS**

		Frequency	Percent
VALID	NO	92	78.0%
	YES	23	19.5%
	Total	115	97.5%
Total		118	100.0%

Source: field data, 2004

As shown in the above table, more than three quarters of the students felt that they had insufficient information on HIV/AIDS despite having reported good access to the information. This could be because the schools themselves do not have sufficient materials on the disease or because some factors hinder the students from seeking the information.

Many of the teacher-counsellors felt that their teaching load was too heavy to leave them with enough time and energy for student counselling. However, a few of them argued that their teaching load had no effect on counselling because students hardly ever approached them on counselling issues unless they were referred. In addition, only 12.5% of the teacher-counsellors had any professional training in counselling as shown in Table 27 below.

**TABLE 27: COUNSELLING TRAINING OF TEACHER-COUNSELLORS**  
(Responses from teacher-counsellors)

	Frequency	Percent	Valid Percent	Cumulative Percent
<b>YES</b>	1	12.5	12.5	12.5
<b>NO</b>	7	87.5	87.5	100.0
<b>Total</b>	8	100.0	100.0	

Source: field data, 2004

Figure 28 shows the teaching load of teacher-counsellors. The teaching load has been classified as being light, fair or heavy whereby between 19-21 lessons per week was seen to be light, 22-24 was seen to be fair and 25-27 was seen to be heavy. The optimum teaching load according to the Ministry of Education is 28 lessons per week.

As shown in Table 29 below, only one out of the eight teacher-counsellors (12.5%) had their teaching load reduced by virtue of being counsellors. All the others had their teaching load equal to the other teachers in their respective schools.

**TABLE 28: Teaching load of teacher counselors**  
(Responses from teacher-counsellors)

	Frequency	Percent	Valid Percent	Cumulative Percent
<b>heavy</b>	2	25.0	25.0	25.0
<b>fair</b>	5	62.5	62.5	87.5
<b>light</b>	1	12.5	12.5	100.0
<b>Total</b>	8	100.0	100.0	

Source: field data, 2004

**TABLE 29: Teaching load reduced for being counsellor**  
(Responses from teacher-counsellors)

	Frequency	Percent	Valid Percent	Cumulative Percent
yes	1	12.5	12.5	12.5
No	7	87.5	87.5	100.0
<b>Total</b>	8	100.0	100.0	

Source: field data, 2004

Despite having limited or no training in counselling, the study found out that most of the teacher-counsellors have been counselling for many years as shown on Table 30 below. It is no wonder, therefore, that many of them felt that with adequate information, they would have no problem counselling the students on HIV/AIDS as shown on Table 31.

**TABLE 30: COUNSELLING EXPERIENCE OF TEACHER-COUNSELLORS**  
(Responses from teacher-counsellors)

	Frequency	Percent	Valid Percent	Cumulative Percent
<b>0-3 YEARS</b>	1	12.5	12.5	12.5
<b>4-7 YEARS</b>	1	12.5	12.5	25.0
<b>8 YEARS AND ABOVE</b>	6	75.0	75.0	100.0
<b>Total</b>	8	100.0	100.0	

source: field data, 2004

**TABLE 31: TEACHER-COUNSELLORS' HIV/AIDS COUNSELLING ABILITY**  
(Responses from teacher-counsellors)

	Frequency	Percent	Valid Percent	Cumulative Percent
<b>WELL</b>	2	25.0	25.0	25.0
<b>FAIR</b>	6	75.0	75.0	100.0
<b>Total</b>	8	100.0	100.0	

Source: field data, 2004

#### 4.14: SUMMARY OF CHAPTER FOUR

From the findings of this study, it was clear that very limited HIV/AIDS counselling was going on in secondary schools. This is despite the fact that the schools had a guidance and counselling teacher, a counselling room and the students were in need of HIV/AIDS information.

The study revealed that the majority of the students had insufficient information on HIV/AIDS and would like to have more. However, the same study revealed a situation where the teacher-counsellors complained of having very few students approaching them on HIV/AIDS issues. Although the majority of the students and the teacher-counsellors reported that the students had fairly good access to HIV/AIDS information that was available in the school, the teacher-counsellors revealed that the information was very limited. In addition, all the teacher-counsellors who were interviewed had no training in HIV/AIDS counselling and very few had any training at all in counselling. This may probably explain why the students did not approach their teacher-counsellors for HIV/AIDS counselling. It is no wonder, therefore, that almost half of the students reported having got most of their HIV/AIDS information from the media, and also why the majority reported that they would prefer HIV/AIDS counselling from professional counsellors.

The study found that although the majority of the youth were abstaining from sexual intercourse, a small percentage of them were still engaging and some of them were not taking any protective measures. This implied that the youth were still vulnerable to HIV/AIDS. Therefore, more HIV/AIDS information and counselling is still needed to make them better equipped to face the threat of HIV/AIDS.

Most of the students, the teacher-counsellors, and half of the VCT counsellors recommended that VCT be offered to students. In addition, more than three-quarters of the students reported that they would like to find out their HIV status. However, very few students had ever visited a VCT site. This implied that either the VCT centres have not made their activities widely known to the youth, or there is something about them that is not very appealing to the youth.

## CHAPTER FIVE: INFERENCE ANALYSIS OF DATA

This chapter deals with inferential analysis of field data in order to determine whether relationships exist between variables. Regression analysis has been used to test hypothesis one while ANOVA has been used to test hypotheses two and three.

### 5.1: HYPOTHESIS I:

**H<sub>0</sub>:** Heavy teaching load and limited counselling skills have no effect on teacher-counsellors' ability to offer regular and intensive HIV/AIDS counselling to the students.

**H<sub>1</sub>:** Heavy teaching load and limited counselling skills have contributed to the teacher-counsellors' inability to offer regular and intensive HIV/AIDS counselling to the students.

Hypothesis 1 was tested using the multiple regression analysis. This test is useful when data includes three or more variables where the dependent variable (usually labelled Y), is related to and dependent on two or more independent variables (usually labelled X<sub>1</sub>, X<sub>2</sub>, X<sub>3</sub>, ...).

The general formula for multiple regression is represented by:

$$Y_P = b_1X_1 + b_2X_2 + b_3X_3 + \dots + b_kX_k + C$$

Where b<sub>1</sub>, b<sub>2</sub>, b<sub>3</sub>... b<sub>k</sub> are coefficients that give weight to the independent variables according to their relative contributions to the prediction of Y. The number of predictor, or independent variables is represented by k, and C is a constant (Vincent, 1995:105-106).

When coded variable data was fed into the SPSS computer programme to test the above hypothesis, results shown in the table below were observed.

**TABLE 32: Variables in the Equation**

	<b>B</b>	<b>S.E.</b>	<b>Wald</b>	<b>Df</b>	<b>Sig.</b>	<b>Exp(B)</b>
<b>Training</b>	23.819	486.118	.002	1	.961	22096413835.556
<b>Experience</b>	.000	192.212	.000	1	1.000	1.000
<b>Teaching load</b>	11.616	192.217	.004	1	.952	110834.605
<b>Constant</b>	-59.253	1339.776	.002	1	.965	.000

Since the computed value of all the variables was more than the 0.05 significance level, the null hypothesis was accepted and it was concluded that heavy teaching load and limited counselling skills have no significant contribution to the teacher-counsellors' inability to offer regular and intensive HIV/AIDS counselling to the students.

## 5.2: HYPOTHESIS II:

**H<sub>0</sub>:** Lack of well-organized guidance and counselling programmes in most schools has no effect on students' ability to access unlimited HIV/AIDS information and counselling in their schools.

**H<sub>1</sub>:** Lack of well-organized guidance and counselling programmes in most schools have contributed to the students' inability to access unlimited HIV/AIDS information and counselling in their schools.

The dependent variable indicators for this test are presence or absence of HIV/AIDS counselling programme, number of HIV/AIDS counselling sessions per term percentage number of students attending HIV/AIDS counselling sessions per term and presence or absence of counselling room with facilities. These variables are compared against the independent variables, which are: presence or absence of teacher, presence or absence of counselling programme, counselling programme followed strictly and according to the presence or absence of updated counselling records.

Hypothesis 2 was tested using the one-way ANOVA. Analysis of variance (ANOVA), is a parametric statistical technique used to determine whether significant differences exist among means of three or more sets of data. The ratio value,  $F = \text{average variance}$

between groups divided by average variance within groups. When at least one sample mean is significantly different from any other, F is significant and the null hypothesis is rejected.

The results in the table below were computed when *access to HIV/AIDS information and counselling* variable data were tested against *organized guidance and counselling programme* variable data using the ANOVA.

**TABLE 33: Results of ANOVA testing of Access to HIV/AIDS information by Organized guidance and counselling programme**

		<b>Sum of Squares</b>	<b>Df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
<b>HIV/AIDS counselling programme</b>	Between Groups	9.564	4	2.391	.983	.420
	Within Groups	274.750	113	2.431		
	Total	284.314	118			
<b>HIV/AIDS counselling hours per week</b>	Between Groups	44.144	4	11.036	.941	.443
	Within Groups	1325.627	113	11.731		
	Total	1369.771	118			
<b>individual counselling</b>	Between Groups	6.463	4	1.616	1.433	.228
	Within Groups	127.402	113	1.127		
	Total	133.864	118			
<b>Counselling room</b>	Between Groups	3.031	4	.758	3.060	.020
	Within Groups	27.986	113	.248		
	Total	31.017	118			

The results in the table 33 above show that most of the computed variables had a value higher than the 0.05 significance level. Thus the null hypothesis was accepted. This led to the conclusion that lack of well-organized guidance and counselling programmes in



schools has no significant contribution to the students inability to access unlimited HIV/AIDS information and counselling in their schools. This means that there must be other factors that hinder students access to HIV/AIDS counselling.

### 5.3: HYPOTHESIS III:

**H<sub>0</sub>** Limited HIV/AIDS counselling in the schools and limited utilization of VCT sites as sources of information for youth has no contribution to the increased youths' vulnerability to HIV/AIDS.

**H<sub>1</sub>** Limited HIV/AIDS counselling in the schools and limited utilization of VCT sites as sources of information for youth has contributed to the increased youths' vulnerability to HIV/AIDS.

In this case, vulnerability was defined by sexual activity, self-protection measures, level of awareness and access to HIV/AIDS counselling services. Counselling was identified by presence or absence of HIV/AIDS counselling programmes, equipped rooms and presence of an HIV/AIDS . Percentage number of students aware of VCT services identified utilization of VCT services. Others include; percentage number of students who have ever visited a VCT site, frequency with which individual students visit VCT sites and percentage number of VCT clients who fall below 18 years.

Hypothesis 3 was also tested using the ANOVA and the following results were observed. The table below gives computed results when youths' vulnerability to HIV/AIDS variables were tested against HIV/AIDS counselling variables.

**TABLE 34: Results of ANOVA testing of Youths' vulnerability to HIV/AIDS by HIV/AIDS counselling**

		Sum of Squares	Df	Mean Square	F	Sig.
Sexual activity or not	Between Groups	6.496	2	3.248	2.922	.058
	Within Groups	127.818	115	1.111		
	Total	134.314	118			
Protected sex or not	Between Groups	2.774	2	1.387	.187	.830
	Within Groups	852.718	115	7.415		
	Total	855.492	118			
Protective measures taken	Between Groups	.313	2	.157	.081	.922
	Within Groups	223.110	115	1.940		
	Total	223.424	118			
Any protective measures	Between Groups	.010	2	.005	.151	.860
	Within Groups	3.854	115	.034		
	Total	3.864	118			
HIV/AIDS vulnerability	Between Groups	6.039	2	3.020	3.528	.033
	Within Groups	98.436	115	.856		
	Total	104.475	118			

As shown in the table, most of the computed values were higher than the 0.05 significance level thus the null hypothesis was accepted and the alternative hypothesis rejected. This means that youths' vulnerability to HIV/AIDS has no significant relationship with limited HIV/AIDS counselling in their schools.

The following table gives computed results when *Youths' vulnerability to HIV/AIDS* was tested against *utilization of VCT services* using the ANOVA.

**TABLE 35: Results of ANOVA testing of Youths' vulnerability to HIV/AIDS by utilization of VCT services**

		<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
<b>Sexual activity or not</b>	Between Groups	2.241	1	2.241	1.968	.163
	Within Groups	132.072	116	1.139		
	Total	134.314	118			
<b>Protected sex or not</b>	Between Groups	9.466	1	9.466	1.298	.257
	Within Groups	846.025	116	7.293		
	Total	855.492	118			
<b>Protective measures or not</b>	Between Groups	.033	1	.033	.988	.322
	Within Groups	3.832	116	.033		
	Total	3.864	118			
<b>protective measures taken</b>	Between Groups	.266	1	.266	.139	.710
	Within Groups	223.157	116	1.924		
	Total	223.424	118			
<b>Vulnerability to HIV/AIDS</b>	Between Groups	3.209	1	3.209	3.676	.058
	Within Groups	101.266	116	.873		
	Total	104.475	118			
<b>Access to HIV/AIDS information</b>	Between Groups	.049	1	.049	.032	.858
	Within Groups	176.502	116	1.522		
	Total	176.551	118			

As shown in Table 35, all the computed values were higher than the 0.05 significance level thus the null hypothesis was accepted and the conclusion is that limited utilization of VCT sites by the youth has no significant effect on the youth's vulnerability to HIV/AIDS.

The results of the ANOVA test on hypothesis 3 show that other factors other than limited HIV/AIDS counselling in the schools, and limited utilization of VCT sites by the youth has contributed to the youth's vulnerability to HIV/AIDS.

#### **5.4: SUMMARY OF CHAPTER 5**

After the three hypotheses were tested statistically, all of them were rejected on the ground that no significant relationship was observed between the variables of interest.

Statistical testing of hypothesis 1 revealed that heavy teaching load and limited counselling skills have no significant contribution to the teacher-counsellors' inability to offer regular and intensive HIV/AIDS counselling to the students. Since very little HIV/AIDS counselling was found to be going on in most of the schools, it can only be concluded that factors other than the teacher-counsellors' teaching load and counselling skills contributed to the teacher-counsellors' inability to offer regular and intensive HIV/AIDS counselling to the students. Such factors may include the students' unwillingness to go to the teacher-counsellors for HIV/AIDS counselling, shortage of counselling time due to other school activities, and lack of a conducive environment (room) for HIV/AIDS counselling.

After testing hypothesis 2, it was concluded that lack of well organized guidance and counselling programmes in schools has no significant contribution to the students' inability to access unlimited HIV/AIDS information and counselling in their schools. This implies that although the guidance and counselling programmes in most schools may not be very well organized, they cannot be largely blamed for students' inability to access unlimited HIV/AIDS counselling in those schools. Other factors, for example, the students' lack of interest in HIV/AIDS counselling from their teachers, lack of adequate HIV/AIDS materials in the schools and failure to sensitize the students on the importance of HIV/AIDS counselling may have contributed.

Testing hypothesis 3 led to the conclusion that limited HIV/AIDS counselling in the schools, and limited utilization of VCT sites as sources of HIV/AIDS information for the youth has no significant effect on the youths' vulnerability to HIV/AIDS. This

study revealed that most of the youth are taking measures to protect themselves against HIV/AIDS despite limited HIV/AIDS counselling in schools and limited utilization of VCT sites. Since many students reported that they got most of their HIV/AIDS information from the media and they seem to be making good use of that information, then more HIV/AIDS counselling in schools and other settings could improve their ability to protect themselves. However, cultural factors, economic factors and negligence could also contribute to youths' vulnerability to HIV/AIDS.

## CHAPTER SIX: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

### 6.1: SUMMARY

Many studies have shown that the majority of HIV infections occur between 15-24 years of age with HIV/AIDS symptoms emerging years later. This means that the majority of HIV/AIDS patients get infected when they are either in secondary schools or colleges. As such, it is important to pay attention to the youth on matters of sexuality, especially at this time when HIV/AIDS is claiming millions of lives and many continue to be infected every day.

This study was designed to find out whether the youth have access to HIV/AIDS information and counselling that they require. Although the study only sampled eight schools to represent the whole Nyeri District secondary school population, the researcher found that none of the schools in the sample had started an HIV/AIDS counselling programme, and none of the teacher-counsellors had any training in HIV/AIDS. However, the teacher-counsellors revealed that they would not shy away from counselling their students on HIV/AIDS if only they had the necessary skills and if the students approached them.

The students on the other hand reported that they would prefer professional HIV/AIDS counsellors if they needed HIV/AIDS counselling. It is no wonder, therefore, that despite many students reporting that they have good access to HIV/AIDS information in their schools, an overwhelming majority reported that they would like more HIV/AIDS information. This could simply mean that even though the students know that their teachers are willing to counsel them on HIV/AIDS, they are uncomfortable with the situation and therefore search for most of the information from the media as shown in this study.

Most of the respondents and key informants felt that VCT's are good sources of HIV/AIDS information and counselling. However, as shown in this study, the majority of the school-going youth have not utilized the service and some were not even aware of its existence. It is important to note here that even some teacher-counsellors admitted

to not knowing much about these centres. In addition, some VCT counsellors would not recommend the centres to the youth for fear of what they might do if they found themselves HIV positive. In view of this, it is important for all stakeholders to come together and come up with a generally acceptable mode of providing HIV/AIDS information and counselling to the youth.

## **6.2: CONCLUSIONS**

This study found that the teaching load of the teacher-counsellors and their limited counselling training did not affect HIV/AIDS counselling in their schools. The study found that even though most of the teacher-counsellors had no counselling training, most of them had been counselling for more than three years which boosted their counselling skills. However, very little HIV/AIDS counselling seemed to be going in those schools and some students still seemed to be quite ignorant about some basic facts of the disease. This implied that, other factors not tested in this study must have contributed to having very little HIV/AIDS counselling being done in those schools.

Most of the schools did not have a well-organized guidance and counselling programme; and even for those which had, many did not adhere to it. According to the findings of this study, the lack of well-organized guidance and counselling programmes had not contributed to students' lack of access to unlimited HIV/AIDS information and counselling. From the study findings, students reported fairly good access to HIV/AIDS information and counselling in their schools although very few of them reported having gone for this counselling. The teacher-counsellors also reported making the students aware that they could access as much HIV/AIDS information as was available in the schools. However, these teacher-counsellors complained that they had no HIV/AIDS counselling training and the schools had very few resources on HIV/AIDS. This implied that as much as the students reported fairly good access to HIV/AIDS information in their schools, very little information was actually available in those schools.

From the findings, it is clear that the youth are still vulnerable to HIV/AIDS. This is because, a few students reported having engaged in unprotected sex in the year of this

study. Vulnerability was also defined by asking the students what they thought made somebody most vulnerable to HIV/AIDS and then judging from the answers they gave. From their answers, it was clear that a number of them did not know that unprotected sexual intercourse put one at the highest risk of contracting HIV/AIDS. However, from hypotheses testing, neither limited HIV/AIDS counselling in the schools nor limited utilization of VCT centres as sources of HIV/AIDS information for youth had any significant contribution to youth's vulnerability to HIV/AIDS. This meant that other factors that were not tested in this study must have contributed to the youth's vulnerability to HIV/AIDS.

### **6.3: RECOMMENDATIONS**

From the findings of this study, the teacher-counsellors who have been given the difficult task of guiding and counselling students do not have adequate counselling training. Even though most of them have been teacher-counsellors for more than six years, only one out of the sample interviewed could produce a professional certificate in counselling and none of them had any training on HIV/AIDS counselling. In view of this, the researcher recommends that the Ministry of Education should take up this issue and ensure that the teacher-counsellors receive some professional training in counselling to enhance their counselling skills.

HIV/AIDS pandemic has become an issue of national concern and was even declared a national disaster. However, none of the schools the researcher visited had any HIV/AIDS counselling programme. The only time the students benefited from professional HIV/AIDS counselling in their schools was once or twice a year when the schools invited guest speakers to talk to the students and only if, one of those guests happened to be a professional HIV/AIDS counsellors. In this respect the researcher recommends that HIV/AIDS counselling be taken more seriously in the schools. This can be done by ensuring that all the teacher-counsellors get some basic training on HIV/AIDS counselling and also ensuring that HIV/AIDS counselling sessions are held more frequently in the schools in order to make the HIV/AIDS information actually available. The schools should ensure that more reading materials and audio-visual resources on HIV/AIDS are available for students and teachers in their schools.



Although the organization of guidance and counselling programmes were not found to have a significant effect on access to HIV/AIDS information, it could be because the students have not been sensitized enough to go for this HIV/AIDS counselling. As such, there is need to sensitize the students on the importance of approaching their teacher-counsellors whenever they had any HIV/AIDS issues instead of searching for the information from the media. This means that the guidance and counselling programmes in the schools must be structured well enough to make the students view them as confidential sources of counselling.

From the study findings, very few students had approached their teacher-counsellors on HIV/AIDS counselling, and very few had visited a VCT site for counselling. However, as the study findings show, students continue to be vulnerable to HIV/AIDS through unprotected sexual intercourse. Since the students reported being in need of more HIV/AIDS information, there must be certain factors that hinder the students from seeking HIV/AIDS counselling from their teacher-counsellors and the VCT counsellors. The researcher, therefore, recommends that further studies be done to find out why students who claim to be in need of HIV/AIDS information are not seeking for it from their teacher-counsellors or the VCT counsellors.

#### AREAS OF FURTHER RESEARCH

-Since this study only covered public schools in Nyeri District, there is need for another study to cover all schools in the district and if possible to cover schools in the whole country in order to determine the situation at the national level.

-Studies should be done to find out why students are not seeking HIV/AIDS counselling services from either their teacher-counsellors or the VCT counsellors

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Appendix 1

THUKU W PAULINE  
P O BOX 74472  
NAIROBI

.....June 2004

Dear sir/madam,

**REF: LETTER OF INTRODUCTION**

I am a Master of Arts (Counselling) student at the University of Nairobi, Sociology Department. I am carrying out a research study to establish whether the youth in secondary schools are getting adequate counselling on HIV/AIDS and whether VCT Centres are appropriate sources of HIV/AIDS information for the youth. Your institution is among the institutions selected for this study. I would like to assure you that all the information collected will be treated with utmost confidentiality and will only be used for purposes of this study. Your co-operation and contribution will be highly appreciated.

Thank you in advance.

Yours faithfully,

.....



7. How many hours per week do you set aside for HIV/AIDS counselling per week?
8. What percentage of students under your care came for individual HIV/AIDS counselling during the last full school term?
9. How many HIV/AIDS group counselling sessions do you organize per term? Is it voluntary or compulsory for students to attend? How well do the students respond to the sessions both in attendance and participation? Who usually counsels the group eg teacher-, external HIV/AIDS counsellors, other teachers, student peers etc
10. What is the maximum teaching load as per the ministry standards? What is the teaching load of the teacher- and the teaching load of most teachers in the school?
11. How does the teaching load impact on the teacher-'s ability to offer regular and intensive HIV/AIDS counselling to students?
12. Does the teacher- have any training in counselling? What level? How many years of practical counselling?



13. To what extent does the teacher- feel able to counsel students on HIV/AIDS? Does he/she feel that the students are getting adequate HIV/AIDS counselling in the school or does more need to be done?

14. How much access do the students under your care have to the HIV/AIDS information and counselling that they require at school?

15. What problems does the teacher- face as a student ? Any extra problems when counselling on HIV/AIDS?

16. Is the school administration doing enough to support HIV/AIDS counselling for students eg budget allocation, moral support?

17. How does the teacher- feel about VCT for youth?

### Appendix 3

#### INTERVIEW GUIDE FOR VCT

1. Who are your most common clients eg married people, those planning to marry, youth etc
2. About how many clients do you serve per day? Of these, what percentage are below 18 years?
3. According to you, which is the most appropriate source of HIV/AIDS information and counselling for youth? Why? Do you think that this source is doing everything they can to counsel the youth on HIV/AIDS?
4. How do you feel about VCT for youth? Do you think they are appropriate sources of HIV/AIDS information for youth or not? Why?
5. Have any efforts been made to make the youth aware of the existence of VCT services? Should VCT services be made more accessible or less accessible to youth below 18 years? Why?

#### Appendix 4

### INTERVIEW SCHEDULE FOR STUDENTS

#### SECTION A: PERSONAL DETAILS

1. NAME OF SCHOOL.....
2. SCHOOL CATEGORY: (tick only one as appropriate)
  - A. BOYS' BOARDING.....
  - B. GIRLS' BOARDING.....
  - C. MIXED BOARDING.....
  - D. MIXED DAY SCHOOL.....
3. CLASS: (tick only one)     A. FORM 1.....     B. FORM 2 .....
- C. FORM 3 .....     D. FORM 4.....
4. SEX: (tick as appropriate) A. MALE .....     B. FEMALE.....
5. AGE (at last birthday) .....YEARS

#### SECTION B

(Tick the most appropriate answer where choices have been given. Where a space has been left, please write the correct answer.)

6. Do you have a guidance and counselling teacher?  
A. Yes.....     B. No.....
7. Is the teacher always available when students need counselling?  
A. Yes .....     B. No.....,...
8. Is there time set aside specifically for guidance and counselling in the school?  
A. Yes.....     B. No.....
9. If so, how many hours per week have been set aside for guidance and counselling according to the school time-table? .....hours
10. Is the guidance and counselling time-table strictly adhered to?  
A. Yes .....     B. No.....
11. Is there an HIV/AIDS counselling programme in the school?

- A. Yes..... B. No.....
12. If so, how many hours per week have been set aside specifically for HIV/AIDS counselling? ..... Hours.
13. Have you ever gone for individual HIV/AIDS counselling in the school?  
A. Yes ..... B. No.....
14. If so, whom did you approach to counsel you? (tick all appropriate)
- A.Guidance and counselling teacher.....  
B. Other teachers.....  
C. friends.....  
D.Any other (specify).....
15. How frequently did you go for guidance and counselling during the last full school term? .....times per week .....times during the whole term
16. How frequently did you go for HIV/AIDS counselling during the last full school term? .....times per week .....times the whole term
17. If you seriously needed HIV/AIDS counselling, whom among the following would you prefer to go to and why? (choose only one)
- A. Parents.....  
.....  
.....
- B. guidance and counselling teacher.....  
.....
- C. friends.....  
.....  
.....
- D. professional HIV/AIDS .....  
.....
- E. other teachers.....  
.....
18. Does the school organize HIV/AIDS counselling for all students as a group (group counselling)?  
A. Yes ..... B. No.....
19. If so , how many such sessions are there per term? (choose only one)

- A. One.....
  - B. Two.....
  - C. Three.....
  - D. more than three (record actual number).....
20. Who mostly offers HIV/AIDS counselling in your school? (choose only one)
- A. other students.....
  - B. guidance and counselling teacher.....
  - C. s from outside the school.....
  - D. other teachers.....
  - E. other (specify).....
21. Do you think you now have all the information you need on HIV/AIDS?
- A. Yes.....
  - B. No.....
22. If your answer above is NO, would you like to get more information?
- A. Yes.....
  - B. No.....
23. Does your school have a room specifically for counselling?
- A. Yes.....
  - B. No.....
24. How organized is the overall guidance and counselling programme in your school?  
(choose one)
- A. Very well-organized.....
  - B. Well-organized.....
  - C. 50 50 (average).....
  - D. Badly organized.....
  - E. Very badly organized.....
25. To what extent does your school give you access to all the HIV/AIDS information and counselling that you need? (choose one)
- A. very good access.....
  - B. Good access.....
  - C. Moderate access.....
  - D. Inadequate access.....
  - E. Very inadequate access.....
26. Where do you get most of the information you have on HIV/AIDS? (choose only one)

- A. parents.....
  - B. friends.....
  - C. teachers.....
  - D. the media.....
  - E. other (specify).....
27. Have you ever engaged in sexual intercourse?
- A. Yes.....
  - B. No.....
28. If so, how old were you during that first encounter? .....years
29. Have you engaged in sexual intercourse this year?
- A. Yes .....
  - B. No.....
30. If so, did you use a condom?
- A. Yes .....
  - B. No.....
31. From the groups of people listed below, whom do you think is most at risk of contracting HIV/AIDS? (choose one)
- A. married people.....
  - B. anybody who engages in unprotected sexual intercourse.....
  - C. young people.....
  - D. those who socialize with HIV/AIDS infected people.....
32. Are you taking any measures to protect yourself from HIV/AIDS infection?
- A. Yes.....
  - B. No.....
33. If Yes, what measures are you taking?
- A. Abstaining from sex.....
  - B. Using a condom.....
  - C. Remaining faithful to one partner.....
  - D. Others (specify).....
34. If No, why not.....
- .....
35. Have you ever heard of VCT (Voluntary Counselling and Testing) Centres?
- A. Yes.....
  - B. No.....
36. Do you know what services are offered in VCT centres?
- A. Yes.....
  - B. No.....
37. Have you ever visited a VCT centre for counselling?

A. Yes..... B. No.....

38. If so, how many times have you visited a VCT centre this year (choose one)

A. none..... B. once..... C. twice .....  
D. more than twice (indicate exact number).....

39. Do you think HIV Voluntary Counselling and Testing services should be offered to students?

A. Yes ..... B. No.....

If Yes, why?.....

.....

If No, why not?.....

.....

40. Would you like to know your HIV status?

A. Yes..... B. No.....

41. In your opinion, what are the advantages and disadvantages of knowing one's HIV status?

Advantages.....

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Disadvantages.....

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42. Suggest what you think should be done to improve HIV/AIDS counselling in your school to make the students better prepared to face and protect themselves against HIV/AIDS.