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Ukimwi : HIV/AIDS in Kenya

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Ukimwi : HIV/AIDS in Kenya

Abstract

This manuscript points out the deficiencies school counseling programs in Kenya for children/adolescents affected/infected by HIV/AIDS. In addition, the paper is intended to inform, guide, and encourage policy makers, program developers, and school counselors as they develop school counseling interventions for the disease. The focus of the paper is limited to children/adolescents because they bear the greatest burden of HIV/ AIDS infections. The paper also provides evidence for planning and implementation of culturally and developmentally relevant, school-based counseling interventions. The paper explores the impact of HIV/AIDS on Kenyan children/adolescents infected/affected by HIV/AIDS and points out the factors that hinder prevention of the pandemic.

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UKIMWI : HIV/AIDS IN KENYA

A Research Paper

Presented to

The Department of Educational Leadership, Counseling,

and Postsecondary Education

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts in Education

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by

Virginia Wangui Gathua

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This Research Paper by: Virginia Wangui Gathua

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Abstract

This manuscript points out the deficiencies school counseling programs in Kenya for children/adolescents affected/infected by HIV/AIDS. In addition, the paper is intended to inform, guide, and encourage policy makers, program developers, and school counselors as they develop school counseling interventions for the disease. The focus of the paper is limited to children/adolescents because they bear the greatest burden of HIV/AIDS infections. The paper also provides evidence for planning and implementation of culturally and developmentally relevant, school-based counseling interventions. The paper explores the impact of HIV/AIDS on Kenyan children/adolescents infected/affected by HIV/AIDS and points out the factors that hinder prevention of the pandemic.

Ukimwi : HIV/AIDS in Kenya

The Human Immunodeficiency Virus (HIV) takes life or destroys the immune system cells (CD+ T cells) of the body s capacity to fight diseases, malignancies, and neurological disorders (Richards, 2004). HIV is transmitted through sexual intercourse with an infected person, sharing of contaminated needles or syringes, and transfusion of contaminated blood products (International Academy of Education (UNESCO), 2003). On the other hand, Acquired Immunodeficiency Syndrome (AIDS) is the later phase of HIV (Richards, 2004). AIDS is not transmissible; opportunistic diseases that ultimately take away the life of the individual assail a person suffering from AIDS.

AIDS is not a disease of individuals alone; it is a disease of families and communities. AIDS was first heard of in the early 1980 s and was first reported in New York City. It was first seen as a homosexual disease because only homosexual males seemed to have it. Later it was found to afflict intravenous drug users and people who received blood transfusions. Later it afflicted heterosexual men, women and finally children. For the most part, in Kenya counseling interventions for children/adolescents infected/affected by HIV/AIDS are general and most of them lack cultural or development relevance. Hence, it would be crucial to provide school counseling interventions for children/adolescents infected/affected by HIV/AIDS. These should be highly effective, culturally applicable, and developmentally suitable. Consequentially, it

would be significant to find out what counseling interventions are available in Kenya for children/adolescents infected/affected by HIV/AIDS and their degree of success.

The purpose of this paper is to show the lack of school counseling interventions in Kenya for children/adolescents affected/infected by HIV/AIDS, beginning with the history of the disease and the prevalence of the disease globally, in Africa and Kenya. In addition, the paper informs, guides, and encourages policy makers, program developers, and school counselors as they develop school counseling interventions for the disease. Factors promoting and hindering prevention/control/spread of the disease in Kenya will be discussed. The socio-economic implications/impact of the disease on the Kenyan society will be addressed. Information regarding treatment, prevention and school counseling interventions is also provided.

Deterioration of the Immune System-Symptoms and Signs of HIV/AIDS

AIDS results from a progressive destruction of T white cells by HIV (Anderson, 1997). T cells protect the body from infectious diseases and, when they reach critical low level, opportunistic infections or AIDS- related cancer can occur. Opportunistic infections are especially susceptive to pneumocystis carinii pneumonia (PCP), oral candidacies, herpes virus infection, toxoplasmosis, tuberculosis, and a wide range of common bacterial, viral or fungal infections, also the HIV virus causes meningitis in some children. Furthermore, the usual

childhood illnesses are intensified. These include ear infections, throat infections, sinusitis, and diarrhea syndromes. Because of the lack of immunity, chronic infections develop, and periodic illness is experienced on top of perpetual debilitative state (Anderson, 1997).

Moreover, HIV is also carried to the brain. Brain damage at autopsy has been sound to be more severe in children than in adults (Anderson, 1997). This results in the destruction of the nervous system and other body organs. This leads to an array of clinical symptoms such as confusion, forgetfulness, memory loss, seizures, incontinence, and dementia. Children could also miss developmental milestones such as walking and other basic tasks. Children also suffer a lot of pain because of the nervous system is involved (Anderson, 1997).

Psychological Trauma

Orphans also suffer because of the way death, succession, and inheritances are handled. The extended family carries out expensive and elaborate funeral rites (Nyambedha, Wandibba, and Aagaard-Hansen, 2003). This uses up a lot of the resources that would otherwise be used to take care of the orphans. In addition, adult siblings deny grand-parents the opportunity to administer the property left behind by the dead person. At the same time, these siblings do not take care of the orphans and the old grandparents resort to asking for help from their peers. This kind of situation more often than not forces the orphans to take paid labour.

The orphans also experience child abuse from outside the home for most of these grandparents do not offer adequate care. In addition, the orphans suffer psychologically from the loss of parents.

When the orphans are in the hands of elderly care, they suffer because the grandparents are unable to provide the proper disciplinary measures. They are expected to contribute to subsistence work. The children brought up in towns prove to be more problematic in adjusting to rural life and discipline.

HIV/AIDS Statistical Trends

Global Prevalence of HIV/AIDS

The HIV/AIDS plague has been named one of the most challenging feats for humankind in the 20th century because its infection is fatal and research has not discovered a cure (Kiai & Nduati, 2004). AIDS was first observed in homosexual men in the USA in 1981 (Kiai & Nduati, 2004), and HIV was recognized in 1983. By 1994 over 17 million people are predicted to have contracted HIV/AIDS globally. The three major means of spreading of HIV are sexual relationships, getting in touch with blood products and mother-to-child communication (Kiai & Nduati, 2004).

Background of HIV/AIDS in Africa

Sub-Saharan African has been most affected by the HIV/AIDS pandemic. By the end of 2000 about 10.4 million children under 15 had lost their mother or both parents to AIDS (World Bank, 2000). The World Health Organizations (WHO)

estimates that the cumulative total of individuals with AIDS as of 2003 was 500,000 (World Bank, 2000) and that ten million individuals are HIV/AIDS positive worldwide. The fearsome reality for children infected/affected by HIV/AIDS and their families include psychosocial consequences in addition to medical complications.

Statistics paint a grim picture for the continent. Of the cumulative 40 million people infected with HIV/AIDS globally last year, 28.1 million came from sub-Saharan Africa. Young people are the centre of overcoming HIV/AIDS and more than two-thirds of newly infected 15-19-years-olds in sub-Saharan Africa are female.

HIV/AIDS in Kenya: History and Statistical trends

Kenya is one of the sub-Saharan African countries hit hard by AIDS. In Kenya, the scourge is said to be claiming the lives of 700 people daily while the same number of Kenyans infected are daily. Since the country discovered the first AIDS case in 1984, some 1.1 million Kenyans have died of the disease and about 2.2 million others are living with the virus.

Kenya is losing over 210 million shillings (about 2.6 million U.S. dollars) daily to HIV/AIDS. Certain socio-cultural practices are encouraging the continued spread of the diseases.

Three hundred thousand more Kenyans are expected to die to AIDS annually by 2005 (NASCOP, 1998, as cited as cited in Nyambedha, Wandibba, &

Aagaard-Hansen, 2003). AIDS prevalence has been high in western Kenya and the main highways (Republic of Kenya/UNDP, 1999, as cited as cited in Nyambedha, Wandibba, & Aagaard-Hansen, 2003). By the year 2000, thirteen million children had lost their mothers or both parents globally from AIDS and 10.4 of them were under 15 (UNICEF, 1999, as cited in Nyambedha, Wandibba, & Aagaard-Hansen, 2003). In addition, Kenya is one of the world s youngest countries. For example, 52 % of her population is adolescent. The other reason is that Kenya s adolescent fertility rate is among the worlds highest (Pratt, Obieng-Quidoo, Okigbo, & James, 2000).

Moreover, Kenya has a strategic position as the port of call to the trans-Africa Highway. This makes Kenya a reservoir, and a channel for the spread of HIV/AIDS, especially through cross regional truckers who cross from Mombasa through Zambia, Mozambique and to Zaire in the Western region (Pratt, et al, 2000). The geographical pattern of HIV/AIDS goes along the major track routes via truckers who patronize prostitutes and spread the HIV virus. This point leads to the question as to why Kenya s HIV/AIDS prevalence is so high.

No one knows how many street children live in Nairobi, but their numbers are increasing exponentially. By city council estimates there were roughly 60,000 four years ago; now social workers speak of 200,000 all between the ages of 1-18. Most are believed to be AIDS orphans or victims of Kenya s unrelenting economic decline, cast out by parents no longer able to feed them, stalk and attack

pedestrians, steal mobile phones, look after parked cars or run drugs (Santoro, 2002).

Social Economic Implications/Impact on HIV/AIDS Infected/Affected Children/Adolescents in Kenya

In most rural communities in Kenya one out of three children below 18 years of age has lost at least one biological parent — and one out of nine has lost both parents (Nyambedha, Wandibba, & Aagaard-Hansen, 2003). This leads to a host of other problems, such as lack of school fees, food, and medical care.

School Systems

HIV/AIDS is a threat to the education sector in Kenya through death and incapacitation (Africa News Service (ANS), June, 2003). The HIV/AIDS pandemic is threatening the education sector in Kenya, according to the Teachers Service Commission (TSC). In one district alone, 450 students died every year from HIV/AIDS (ANS, 2004). This has led to harmful influences on educational planning and administration. In addition, HIV/AIDS has strained the resources available for funding the delivery of basic education. Although, there has been free primary education since 2003, it is difficult for AIDS children to acquire school requirements, such us, books and writing tools. In addition, these children have no food, which lowers their learning ability, leading to school dropout for some and paid labour, while others start their own households and if any of them ever return to school they are dogged by frequent absenteeism. Furthermore,

AIDS orphans and those infected with HIV are denied entrance to public schools (ANS, April, 2004). And even when admitted they suffer from stigmatization and discrimination.

Social Welfare Systems and Family System

In Kenya where the extended family is the only Social Security, AIDS has claimed the productive population. Abandoned children have been left alone, or their grandparents try to take care of them (Nyambedha, Wandibba, & Aagaard-Hansen, 2003). The pandemic is happening at a time when it is difficult to practice traditional African principles of sharing reciprocal assistance because of numerous famine, drought, poverty, migrations of families, and changing of lifestyles. These changes maybe attributed to the integration of Kenya to a global economy. The rising number of orphans has strained the traditional mechanism of taking care of them, which are based on patrilineal kinship ties. This crisis has led to some orphans being looked after by culturally inappropriate categories, such as, matrilineal kin and strangers. Moreover, many of these caretakers are ill themselves, old, or poor.

Impact of the Societies Mistaken Beliefs Regarding Transmission, Prevention, and HIV/AIDS Treatment

Cultural Beliefs and Practices

Cultural beliefs and practices surrounding HIV/AIDS are stumbling blocks in the fight against AIDS. Scientists, health officials, and workers in Kenya agree on

one thing: cultural beliefs practices contribute immensely to the spread of HIV/AIDS in Kenya. For instance, wife inheritance (Levirate marriage: a practice in which a widow becomes the property of clan members after the husband s death) is a widespread phenomenon in some communities, and efforts to stop it become divisive national issues. Even when local HIV/AIDS counselors or health officials visit communities to educate people about this disease, their messages are not persuasive (Ngome, 2003).

Other cultural factors that help in promoting HIV/AIDS include wife sharing, polygamy, acceptance concubines, sexual involvement of young girls with older men, forced early marriages for girls, female circumcision, and lower social status of women (Mugo, 2002).

Access to Information

Kenya still lags behind on information due to the nation s high level of illiteracy. A majority of Kenyans live in rural areas where they cannot get the newspapers that are read by more educated people and few own transistor radios.

And women rarely own or listen to radios so they often rely on information relayed from third parties (Ngome, 2003). Kenyan secondary school adolescents appear to have a broad knowledge base of HIV/AIDS. But the adolescents do not seem to differentiate between HIV and AIDS. This is in line with much of Kenya s public HIV/AIDS education, which does not differentiate the two. Some Kenyan adolescents also seem to think that mosquitoes can transmit HIV/AIDS.

About 40% of adolescents also seem to think that mosquitoes can transmit HIV/AIDS. Forty per cent of Kenyan adolescents feel they are at the risk of acquiring AIDS, but this does not always translate into appreciation of risk. Studies (Patullo & Malonza, 1994) show incongruity between apparent risk of HIV infection and their failure to use condoms. Adolescents also feel invincible by HIV/AIDS. One should remember that this is a characteristic of this stage of development (Vernon, 2002). Awareness of condoms is universal, but negative perceptions of condoms persist, as does shame about Sexually Transmitted Diseases/Sexually Transmitted Infections (STD/STIs) and reluctance to seek treatment.

Treatment Interventions

Peer Education/Counseling

Kenya s Girl Guide Association (KGGA) movement is one of the organizations spearheading a relentless war against HIV/AIDS). It has trained 25,000 HIV/AIDS peer educators and targets a million by 2004 in an ambitious programme to fight the scourge. The KGGA education-of-girls-by girls programme teaches brownies (7-10), guides (10-14 years) and rangers and cadets (14-18 and 18-25 years respectively) to educate their guide and non-guide peers about AIDS. Guide leaders (often teachers) are trained as the curriculum s facilitators. They in turn train patrol leaders (guides in charge of 6-8 peers) who are expected to integrate the curriculum in their respective school clubs. The aim

is to induce behaviour change, provide facts about human sexuality, social pressure and HIV/AIDS in the 15-24-year-old age —bracket, which accounts for half of all sexually transmitted infections according to United Nations. The majority contracts the diseases before they are 20 (Mugo, 2002).

The curriculum has eight talking points for HIV/AIDS prevention — personal family and community values; gender roles and equality; sexuality; adolescence; relationship; preventing pregnancy; STIs, HIV and AIDS; and self-esteem and communication. The peer program involves young people in decision-making. Girls and young women are twice more likely to be infected than male age mates because they are less able to negotiate safer sex, their reproductive and immune system are immature and they often have inadequate access to reproductive health services (Mugo, 2002).

Mass Media/Communication

There are three broad categories of HIV/AIDS communication interventions targeting adolescents; these aim at behavioural modification. An example of culturally relevant and appropriate communication interventions in Kenya is the use of theatre. This is done in form of music, drama, dance, and poetry (Nduati & Kiai, 2004). This can have a positive and negative effect on impacting the pandemic. There is still need to comprehend the numerous cultures and how maneuver them to hold up customs, which lessen the threat of HIV/AIDS illness.

Prevention

School counselors should get involved in the current HIV/AIDS curriculum. They should encourage students to complete the curriculum. They should also make sure the teachers are trained in order to have a concerted effort in schools to fight the scourge (Marseille, Dandona, Saba, McConnel, Rollins, Gaist, Lundberg, Over, Bertozzi, & Kahn, 2004). In order achieve this, school counselors should complete training in the HIV/AIDS prevention curriculum. Counselors would then provide prevention education to students through classroom guidance to ensure they acquire basic knowledge about HIV/AIDS on which to base personal decisions and actions. In addition, counselors should continuously assess the impact of the education on the students knowledge of HIV/AIDS, understanding of personal risk, their ability to refuse or negotiate safer sex, and proper use of condoms.

Voluntary Counseling and Testing (VCT)

School counselors can facilitate voluntary counseling and testing for children/adolescents (all and HIV+). This should be both pre- and post-testing counseling (Marseille et al, 2004). Viewing of videotapes could teach the students about AIDS among the youth and how to avoid it. HIV/AIDS youth are not a pleasant sight and they suffer a great deal. They are miserable, hurting often, just lying in hospital beds or at home waiting to die. No one would wish to be HIV/AIDS-antibody positive after realizing how the odds are stacked against

her/him. Those who view a videocassette about youth HIV/AIDS would want to be tested. The students could view a videotape with such experts as District Hospitals doctors counseling them about HIV/AIDS. After viewing the tape they could be required to fill out a questionnaire asking if they would be willing to take the test, offered in a convenient location, free, and confidential.

Community-Based HIV/AIDS Care, Support, and Prevention Programs

Community-based programs aim at providing inexpensive, efficient community-based counseling programs. Examples of such programs are the reduction of maternal —infant transmission intervention programs in Kenya (Nduati & Kiai, 2004). Development of school counseling HIV/AIDS counseling interventions would be part of new course and new energy to an extended recharged response to the scourge. The use of school counseling interventions should be complemented by the use of the media. This because studies (Pratt, 2000) show that the mass media is the source of choice for HIV/AIDS information. It is important that mass media includes ora-media . This includes drums, horns, gongs, plays, theatres, market places and *barazas* . This would reflect Kenyan cultural appropriateness.

School Counseling Interventions

Studies (Ndovu & Sihlangu, 1992, as cited in Pratt, C. B. et al, 2000) show that school counselors are not among children/adolescents main source of information. Their chosen sources of information, in order, are doctors, mass media, health

workers, and teachers. School counselors should find their niche in their order. This means school counselors should establish their function in relation to helping the children/adolescents affected/infected by HIV/AIDS. The school counselor s support should not be at variance with promotion of health (Stein, Steinburg, Zyl, Allwood, Karstaedt, & Brourd, 1995). This would be achieved through developing and using culturally and developmentally appropriate interventions that have been tried and succeeded elsewhere. A case in point is Uganda. By late 1980s Uganda was the core of the AIDS epidemic in the world but strong preventive interventions and committed leadership has turned the epidemic round.

Traditional African Counseling Instruments

When developing HIV/AIDS counseling interventions, it is important to incorporate Traditional African counseling in form of traditional specialists to ensure a holistic community response to the HIV/AIDS pandemic. This includes traditional priests, medicine men, seers, herbalists, and elders. This is because Kenyans, especially in rural areas, will consult these traditional specialists before going to the modern doctor, clinic, or hospital (Christian Children s Fund, (CCF) 2003).

For instance, traditional counselors and other specialists can be present in modern day counselor workshops to learn westernized editions of interventions for children/adolescents affected/infected by HIV/AIDS and train the school counselors in the traditional methods of counseling and healing. This kind of

approach should be nurtured and research carried out to find out the effectiveness of the mixed approach.

Community-Based HIV/AIDS Care, Support, and Prevention Programs

Kenyan non-profit organizations dedicated to providing HIVAIDS services within the community, should work closely with the education sector to ensure that Kenyan adolescents have access to HIV/AIDS prevention education, voluntary and confidential counseling and testing, and comprehensive sexual and reproductive health services.

Kenyan school counselors planning HIV/AIDS interventions need to interact closely with representatives from the communities involved, the media, volunteers, and other stakeholders. Community based programs aim at providing inexpensive, effective, and efficient community-based counseling programs. Examples of such programs are the reduction of maternal-infant transmission intervention programs in Kenya (Population Council, 2001).

Empowering Young people

School counseling interventions should take into consideration that boys and girls are different in how they respond to knowledge about HIV/AIDS. This is because most African girls rarely use any knowledge to free themselves or to transform their lives (Morell, Unterhalter, Moletsane, & Epstein, 2001). This is because of their personal histories, widespread sexual assaults, and the patriarchal communities. The boys too have no control over their destinies in their social

world. But in relationships with girls and other boys they express their power and rights by expressing their sexuality violently and carelessly. Therefore, school counseling interventions should address these gender differences.

School counselors can increase the sense of self-worth of the youth, to make them feel good about themselves, so that they will be more likely to take ownership of wise suggestions designed to reduce high-risk behaviors. Various culturally appropriate interventions can be used to help youth increase their sense of self-worth: involvement in Kenyan sports, and in the arts, including Kenyan dance music, Kenyan painting, and Kenyan craftwork.

Another technique that can be used to promote interactive communication involves role-playing, Kenyan mural painting, and essay writing. For example: counselors can have actors come into schools and present a complex situation involving an older male student who does a favor for a younger female student, expecting that she will reward him in a way that involves high-risk sexual behavior. He tells her to meet him after school hours in a school storeroom. Students role-play (act this out) and the actors freeze the skit at the moment when the girl needs to make the critical decision. At this point, actors ask the student audience to suggest different solutions, reflecting different types of behavior. After a participatory discussion, the students decide on a few safe solutions, such as the girl deciding to take a friend with her to the storeroom, or to not meet the male student at all. Then the muralists (artist) sketch these options out on the wall.

Over the next two weeks, the students cooperate in painting the mural. In practice, they discuss the issues raised by the mural and the previous presentation. Following the completion of the mural there is an essay-writing competition, where the students submit essays on a range of subjects connected to the mural and associated discussions. Through this kind of participatory discussion and activity, including drama, arts, and creative writing, Kenyan young people are stimulated to consider and implement safe responses to potentially dangerous situations.

Focus on Prevention

Through classroom guidance school counselors should reach learners in primary schools before they begin sexual activity. This is because trying to reach them in high school maybe too late (Taylor, Dlamini, Kagoro, Jinabhai, & Vries, 2003). School counselors should encourage learners in primary school to delay sexual activity. In addition, school counselors should impart information and skills at an early age for this would decrease high-risk behaviour, such us alcohol consumption and other substances, which would reduce susceptibility. The programs should provide adolescents with knowledge, attitudes, and skills needed to abstain from sex and to use condoms effectively if they choose to have intercourse.

School counselors can reconcile the idea of abstinence and the practice of safe sex by teaching safety and well-being, as it relates to adolescent sexuality, which

is much more than teaching how to properly acquire, maintain and apply a condom. The fundamentals of decision making, identifying unhealthy and healthy relationships, refusal skills, defining risky behaviors, and goal setting are far more important and need to be emphasized. Topics such as STD's, adolescent pregnancy, condom effectiveness (not condom application), fetal development, and human physiology should also be taught, but in a manner that stresses the benefits of sexual abstinence until marriage.

It should be explained that sharing needles might put a person at the risk of contact with the blood of an infected person. Students should know that it is important for pregnant women to know their HIV status so that they can make informed decisions. HIV- positive pregnant women can reduce transmission to unborn babies through the use of antiretroviral treatment during pregnancy and labour and during the infant stage (American Academy of Pediatrics Committee on Pediatric AIDS, (AAPCP) 1998).

Schools need to develop comprehensive HIV/AIDS counseling programs based on current information calculated to enlighten students about the disease, methods of transformation, and effective prevention techniques. The school counselors should base the guidance curriculum on the up-and-coming wealth of information on what constitutes HIV/AIDS education. The program should impart correct information; hands on methods; discussions; skill modeling and practice, such as decision-making and refusal negotiation skills and self-esteem matters

(AAPCP, 1998). The program should be developmentally appropriate and grade-specific and culturally suitable. When the curriculum is being developed, the cooperation of the community members such as health care professionals should be sought.

Correct information means that counselors should give classroom guidance on human sexuality, AIDS as a sexually and blood transmitted infection, and standard infectious disease precautions, issues of ethics, testing, and counseling, modes of transmission by injection drug use and an understanding of the interaction of substance abuse (including alcohol and non-injection drug use) with high-risk behaviors such as unprotected sexual intercourse.

Counselors can use puppets to transmit information on human sexuality. Counselors should design and construct puppets, which reflect symbols or figures recognized in the Kenyan culture. A show can be put on during classroom guidance and the puppets tell a story. The counselor tells the class that at their signal, he/she will interrupt the puppets so that the class can direct questions and comments to the puppets. It often happens that the class will talk to the puppets, and tell the puppets things that they would be shy to tell a human or the school counselor face to face. Another variant of this is that the puppet show will be deliberately stopped at certain points and then the counselor standing at one side will ask the class to suggest solutions to a problem raised by the puppets, which

will then be implemented by the puppets. The class is then asked to further comment by the counselor.

Primary school HIV/AIDS guidance should highlight general concepts of health and disease, hygiene, role of germs in disease, and prevention of infection. The content should define HIV infection and effects separating myths from fiction (AAPCP, 1998). In addition, the curriculum should include the relationship between substance abuse and transmission, psychosocial, emotional, discrimination and legal issues of the disease.

Child-to-Child Education

School counselors can also use child-to-Child intervention. This is a culturally relevant intervention in the African society. The younger children always look up to the older ones and the older ones in turn look after the younger ones in the absence of their elders. This would encourage children to participate in developing solutions through group as well as individual activities.

Moreover, these interventions should not be rigid so that they can lend themselves to local adaptation and cultural adjustment. Child-to-child interventions would be integrated with other ongoing programs and institutions and institutions operating within the school and community for example youth groups. Materials and resources for child-to-child interventions include, for example, child-to-child books, which describe how an older child can help a younger child, and child-to-child readers. These books are health books that

provide HIV/AIDS messages while teaching how to read and activity sheets that would reflect basic concepts of child-to-child approach. The books provide activity-based learning in different content areas: development, safety, prevention, and living with AIDS (The Consultative Group on Early Childhood Care and Development, 1999)

Conclusion

It appears that HIV/AIDS is a threat to the education sector in Kenya through death and incapacitation. HIV/AIDS takes away children and the future of Kenya.

This paper has shown the lack of school counseling interventions in Kenya for children/adolescents affected/infected by HIV/AIDS. Cultural beliefs and practices surrounding HIV/AIDS are also stumbling blocks in the fight against AIDS. Kenyan secondary school adolescents appear to have a broad knowledge base of HIV/AIDS but the adolescents do not seem to differentiate between HIV and AIDS. Adolescents also feel invincible by HIV/AIDS.

The school counselors should get involved in the current HIV/AIDS curriculum. School counselors should establish their function in relation to helping the children/adolescents affected/infected by HIV/AIDS by adopting an active role in curriculum development and by being proactive with a systematic vision of change.

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