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Research Paper

The Effectiveness of HIV/Aids Education in Promoting Interventions for A Supportive Environment To The Youth in Secondary Schools in Kenya

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ABSTRACT: *HIV/AIDS education is supposed to not only be a medium of creating awareness but also most importantly promote practices and skills to enable HIV prevention among youth in schools. This article reports on a study whose purpose was to assess the effectiveness of HIV/AIDS education in promoting interventions for a supportive environment in secondary schools. Specifically, the study sought to find out the extent to which interventions for a supportive environment for HIV/AIDS prevention were emphasized to youth; and explore the factors that influenced the promotion of the interventions. The study focused on youth involvement, parental involvement and HIV/AIDS prevention friendly school policies. The findings of the study established that the potential of the youth in enabling HIV/AIDS prevention among their fellow peers was not fully exploited. Parental involvement was low especially among the fathers. Parents rarely engaged in discussions on topics that dealt with sexuality. HIV/AIDS prevention friendly policies were ineffectively promoted in schools. Factors that influenced the promotion of the interventions were explored.*

Keywords: *HIV/AIDS education, HIV/AIDS prevention friendly school policies, schools, parental involvement, youth involvement*

I. INTRODUCTION

In Kenya, the youth who are over 10 million account for 36% of the total population[1]. Presently, 75% of the new HIV infections occur among the youth[2]. This is a 25% increase from the findings of the 2003 KDHS which reported that 50% of the new HIV infections constituted the youth[3].

Findings indicate that though 98% of youth in Kenya are aware of HIV/AIDS issues, 80% have at one time engaged in unprotected sexual intercourse and 60-70% are at risk of being infected[3, 4, 5]. This implies that knowledge is necessary but not sufficient to produce behaviour change. Studies confirm this by stating that perceptions, motivation, skills, and factors in the social environment also play important roles[6]. Some of the factors that. Interpersonal processes and primary groups including family, friends, peers, which provide social identity, support, and role definition should be actively involved successful preventive health programs should enforce are institutional factors like rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviours[6, 7]. This implies that to effectively prevent HIV/AIDS, the concerted efforts of parents, peers, teachers and the students themselves are crucial. Sound policies that are HIV/AIDS prevention friendly are also necessary. The study sought to find out if these stakeholders have been involved in the efforts to prevent HIV/AIDS.

The introduction of HIV/AIDS education in schools was meant to bring behaviour change among the youth given that to date the disease has no cure. Among the objectives of HIV/AIDS education were that the students were meant to be actively involved in school and out of school activities aimed at prevention and control of HIV and STDs infections; and to communicate effectively with peers and others, issues and concerns related to HIV/AIDS and STDs[8, 9]. Similarly, a review of 49 evaluation studies of sexuality and STD/HIV prevention programs in schools in the United States, found that some characteristic of those that significantly improved safe sexual behaviour were that they selected teachers or peer leaders who believed in the program and provided them with adequate training[10]. The studies are indicators of the important role peers could play in HIV/AIDS prevention initiatives.

Parents are an important subset of the community, and their acceptance and support are high valuables to school reproductive health programs. Schools need to involve parents in the design and delivery of programs, so as to respond to their concerns and to build a large critical mass that will support the program despite the

moral and religious disputes that circle around sex education debate[11]. This has become increasingly important in the present generation in which the traditional social networks have been eroded[12]. These studies imply that involving interest groups like parents can enhance the quality of school reproductive health programs.

Apart from the general right of youth to participate in discussions that affect them, programs are more likely to succeed when youth are allowed to articulate their own views and concerns regarding their difficult circumstances[13]. There is an assumption that most youth are actively making wrong choices that lead to adverse public health out comes like unwanted pregnancies, STIs, including HIV. Although these negative stereotypes exist, many youth serving organizations and professionals have realized the need to actively promote and incorporate the concept of youth involvement in program and policy development to help youth become part of the solution to problems many Youth Reproductive Health program implementers and policy advocates face[14]. The essence of youth involvement is forging effective youth-adult partnership.

Documentation report that program planners and International agencies such as WHO, UNESCO and UNICEF, recommend that the energy and creativity of young people be involved on many levels: needs assessment; identification of problem areas in services, design and planning; promotion of programs; implementation; teaching; counseling; organizing activities; disturbing information; assessing materials and evaluation. Participation of young people in the reproductive health programs' leadership and planning, for example, plays an important role in attending to the specific needs and concerns of the target population; ensuring these needs are met in a culturally and socially appropriate manner and can also foster commitment on the part of the adolescents to the programs success or ownership which enhances its sustainability. Youth can give invaluable information on how decisions are made, how information is spread and how behaviours are formed and transformed in their sub culture. More than operating as informants, youth can publicize, network, raise awareness and communicate important reproductive health messages to their peers[14, 15].

Both the physical and psychological environments of the school can have a powerful effect on reinforcing and contradicting health messages or practices in the school. School policies, programs and environments should advance relations between students and between students and school staff that are respectful, non discriminatory and non abusive. Schools should thus enforce policies that discourage discrimination, abuse and exploitation through school rules that reflect government policies in order to promote appropriate schools environment[13].

A review of laws and policies with a regard to reproductive health under the Kenya Youth Initiative project found that no single legislation deals exclusively with youth. Some of the laws date back to colonial times and are not consistent with the reality of youth sexual and reproductive health and give them a passive role in decision-making[16]. However with the ravaging effects of HIV/AIDS especially to the youth, the need for revision of policies that concern the welfare of the youth has become crucial. In Kenya, the Adolescent Reproductive Health policy and subsequently a plan of action to the policies was launched in the year 2003 and 2005 respectively. The policy gives the the youth a more proactive role in matters concerning their reproductive health[17, 18].

UNAIDS, postulates that the best preventive programs are those that work simultaneously at many levels by involving many stakeholders like parents, teachers and peers who can necessitate behaviour change, increased knowledge of HIV/AIDS and how to avoid it. Prevention also includes the creation of an environment where safer sexual practices and drug taking behaviours can be discussed and acted upon[19].

II. STUDY SITE

The study was carried out in Vihiga District in Western province, Kenya (The district has since been divided into two districts namely Vihiga and Emuhaya/Luanda). The major occupation in the area is subsistence farming. The population density was approximately 1091 persons per square kilometre with each family having an approximate land size of 1.5 acres. According to the 2003 KDHS, the total fertility rate in Western province, of which Vihiga district is part, is 5.8. This translates to an average of eight members per family. Hence, the land size of 1.5 acres cannot sustain the food consumption needs of the family. This has led to most male adults in the family to migrate to major cities and towns to look for jobs to subsidize the inadequate farm produce. Adult females in the households apart from fending for the family through farming also run small businesses to subsidize their farm produce and the income from their male counterparts[20, 3].

Findings by the health information systems in the district indicate that pneumonia, pulmonary tuberculosis and gonorrhea, diseases highly associated with populations that are at high risks of HIV/AIDS, are among the ten most common diseases in the area. The report also indicates that 20% of the patients who visited the health institutions and were suspected to be HIV positive in the year 2005 were found to be positive. The contributing factors to the present high rates of HIV include cultural practices especially wife inheritance and economic constraints due to high population density but low food security leading to exchange of sex for money[20, 21].

Studies by indicate that Western Kenya that constitutes Western and Nyanza provinces has been hardest hit by the HIV/AIDS pandemic. The sentinel surveillance sites in Western region indicate that there has been a steady decline in HIV prevalence since the year 2001 in all the sites apart from the Mbale site in Vihiga district. The prevalence in Mbale stagnated at 11% in the years 2001 and 2002, fell to 8% in 2003 then rose to 10% in 2004. This is an indicator that the gains in reducing HIV prevalence rate in Vihiga district are being lost at a time when youth are the most hard hit by HIV infections.[1] Hence, the reason for focusing the study on youth in Vihiga district.

III. METHODOLOGY

The study adopted the descriptive survey design. Data was collected using a students' questionnaire, focus group discussion guides targeting teachers and students and observation forms which reported on presence of modes of HIV/AIDS information dissemination outside the classroom. The students' questionnaire sought to find out: demographic information of the students that is their sex, grade level, type of school, residence when school was in session – boarder or day scholar and religious denomination; data on the extent of utilization of HIV/AIDS education programme tools (dissemination content, methods and forums).

The study focused on students and teachers in the 87 secondary schools in the district of which 9 are boys' schools, 15 girls' schools and 63 co-educational schools. The schools comprised a total of 13 983 female students and 12 530 male students thus a total of 26 513 students. The study also involved 706 teacher representatives from each of the eight departments in secondary schools. The departments were science, applied sciences, mathematics, humanities, guidance and counseling, games and carreers . A total of one third of the schools was involved in the study. The schools comprised 3 boys' schools, 5 girls' schools and 21 co-educational schools. A sample constituting 10% of the student population was used. The study adopted a stratified random sampling on the basis of type of school – girls', boys' and coeducational, gender and grade level. This added up to 2651 students. Of these, 1398 were female and 1253 male; 682 were in form one, 736 in form two, 646 in form three and 587 in form four; 655 were in girls' schools, 554 in boys' schools and 1 442 in coeducational schools; 944 were female boarders, 554 male boarders totaling to 1 498 while day scholars were 1 153 with 429 being female and 724 male; 498 were Catholics, 2028 Protestants, 40 Muslims and 85 did not subscribe to any religion.

The Focus Group Discussions (FDGs) were conducted in a sub sample of ten of the schools involved in the study. A sample of 80 teacher representatives from each of the eight departments in the ten secondary schools involved in the FGDs was included in the study. Sixty-eight focus group discussions with students and ten focus group discussions with teachers were conducted. The focused group discussions mainly sought to find out the factors that influenced the effective dissemination of HIV/AIDS education; The students' focused group discussions comprised: four in the one boys' school selected, eight in the two girls' schools selected and fifty six in the seven co educational schools selected. Each FGD consisted of eight students from the same grade level with all the four grade levels being represented therefore in the co educational schools, two FGDs were conducted in each class. Grouping on gender and class basis was to enhance free discussion of issues since homogeneity in class and gender could reduce intimidation among the students. Consent was got from the participants orally before the exercise. The researchers themselves conducted the focus group discussions and administered the questionnaire.

The research instruments were piloted in 9 schools which constituted 10% of the selected schools: one boy's, two girls' and six co-educational schools to check for validity and reliability before the actual study. Data analysis was done both quantitatively and qualitatively. Data for quantitative analysis was derived from the questionnaires and information from observation forms. These were described by use of percentages and reported in form of cross tabulations. Data for qualitative analysis was mainly derived from the focus group discussions. The tape recorded information from the focused group discussions was transcribed, categorized into emergent themes then reported in text form.

IV. RESULTS AND DISCUSSION

4.1 Youth Involvement

The study incorporated a five-point scale in the students' questionnaire to establish if HIV/AIDS education programme in schools encouraged activities that necessitated the youth in schools to actively participate in resolving issues that affected their sexuality. One statement sought to find out if the students actively participated in sharing with each other information on pregnancy, STIs, HIV/AIDS and other issues that affect the youth. In response to this statement, 20% of the respondents strongly agreed, 29.4% agreed, 26.2% were not sure, 16.5% disagreed and 7.9% strongly disagreed. Another statement sought to find out if students supported each other in cases where one of them had personal problems. In response to this statement, 27.9% of the respondents strongly agreed, 37.4% agreed, 25.3% were not sure, 5.6% disagreed and 3.8% strongly disagreed The findings from both the two statements indicate that the percentages of students who were in

agreement with the view that the HIV/AIDS education programme encouraged involvement of the youth in issues that affected the youth themselves were more than those who disagreed.

However, youth involvement was evidenced in this study from the forums used to disseminate knowledge on HIV/AIDS prevention that were used and which would most likely not be used without involving youth. These included drama and music whose use recorded 59.7% and 42.9% respectively. The rates are an indicator that the youth were used in dissemination forums though not maximally. Similarly, clubs were underutilized in HIV/AIDS prevention initiatives in schools. The most utilized clubs in HIV/AIDS prevention initiatives were straight talk, health and anti aids clubs had utilization rates of 24.7%, 15.3% and 7.1% respectively among the students.

The study further sought to ascertain the presence of youth involvement in schools by seeking to establish if peer education was practiced in schools. The researcher sought to find out if the schools provided peer education services and if referrals for peer education were made in cases of inadequacy. The study also sought to establish if the students were given the option of using the peer educators' services in school and or referrals. The findings were reported in form of cross tabulations in TABLE 1.

Table 1: Services on Peer Education that Students are Provided with and or Referred to Seek Elsewhere by the School in Percentages

	Categories of Responses									
Total Services response	Gender		School type			Grade level(Form)				
	Female	Male	Girls'	Boys'	Coed	1	2	3	4	
Present	63.1	56.1	69.0	67.6	52.4	46.6	63.2	61.4	68.9	59.7
Referred	8.0	9.1	4.8	4.2	11.9	5.7	9.5	8.4	10.8	8.5
Present & Referred	8.5	11.0	7.1	11.3	10.3	13.6	7.4	9.6	8.1	9.7

The findings in TABLE 1 indicate that 59.7% of the students were aware of the presence of peer education services in their schools. Presence of referrals for peer education services was rated at 8.5%. Among the student respondents, 9.7% felt that schools provided the services in school and also provided referrals. These findings are an indicator that a considerable number of students were not aware of peer education in their schools. One probable reason could be that such approaches did not exist in some schools yet the study established that some students preferred peer educators as alternative counselors to their counseling teachers. Peers educators recorded a total response of 47.6% preferred counselors to teachers. They were the next most preferred after mothers and doctors who recorded total responses of 71.2% and 56.5% respectively. This is despite the fact that the HIV/AIDS syllabus stipulates one of its objectives as being that the youth in this programme should be actively involved in issues aimed at HIV/STD prevention and that they should be able to communicate effectively with peers and others issues and concerns related to HIV/AIDS and STDs[9].

There were higher response rates on the presence of peer education in institutions among the female students and girls' schools as compared to the male students, boys' schools and coeducational schools. This could be due to the perception that the female students were at a high risk to HIV as compared to the male students. Boarders had higher responses on the presence of peer education services as compared to the day scholars. This could be because the boarders by virtue of staying in school had more time to interact with the service providers. The male students, boys' schools and day scholars used the referral services more than the female students, girls' schools and co educational schools and the boarders respectively. The male students, boys' schools and day scholars had more access to the option of using peer education services in school and the referrals.

4.1.1 Factors Influencing Youth Involvement

One factor that influenced youth involvement especially as peer educators was lack of adequate training to enable them gain sufficient information, knowledge and skills on how best they could sensitize their peers on issues related to HIV/AIDS prevention. During the teachers and students FGDs it was revealed that the teachers selected the peer educators. The students had very little input in deciding who was best suited for the

responsibility. These peer educators were chosen on the basis that the teachers perceived them to be good role models. After selection, the peer educators were given a few talks on how they ought to carry out the duty. Frequent forums that could provide them with knowledge and skills on how they ought to carry out their duty as peer educators were few if any.

The teachers' FGDs revealed that lack of moral and financial support was a factor that influenced youth involvement. Since the exercise of enhancing HIV/AIDS prevention did not contribute to academic excellence in the school, very few teachers and even school administrators took a lot of interest in it. In turn, the youth in schools did not take activities geared at HIV/AIDS prevention seriously. Activities related to HIV/AIDS prevention like trainings for the youth, organizing music and drama concerts and involving guest speakers require financial support from the administration. However, financial support was rarely offered. The administrators claimed that there was no financial allocation for HIV/AIDS prevention activities. This finding is in agreement with findings that HIV/AIDS initiatives in institutions lacked moral and financial support and coordination from school officials[23].

Another factor that influenced youth involvement was high turn over among youth in schools. This implied that trainings had to be replicated each year to enlighten the youth who had just joined the school. This high turn over especially due to secondary school level completion, affected the sustainability of the programmes. This finding is in agreement with findings that high turn over due to attrition affected youth involvement in HIV/AIDS initiatives[14]. The teachers' FGDs reported that even when some non-governmental organizations sponsored some youth for trainings on issues related to HIV/AIDS prevention, the high turnover affected sustainability of their efforts since these trained manpower would move to other levels and create a gap.

Another factor that influenced youth involvement was insufficient time afforded the youth to participate in HIV/AIDS prevention initiatives. During the teachers and students FGDs it was noted that covering the syllabus of examinable subjects was given priority. Therefore, since the curriculum was already overloaded, the teachers and students strived to cover and master the contents of this syllabus. This syllabus coverage was done at the expense of other activities including those geared at HIV/AIDS prevention. Teachers said that in their efforts to cover the syllabus, there were times that out of school youth troupes had to be turned down when they wanted to perform to the students various presentations on HIV/AIDS prevention issues. This finding is in agreement with findings that the youth lacked sufficient time to get involved in HIV/AIDS initiatives since were not full time peer educators but did it on voluntary basis in addition to some other duties like employment or education[14].

Double standards among the youth charged with the responsibility of being peer educators influenced youth involvement. During both the teachers' and students' FGDs, it was revealed that the credibility of some of the students appointed as peer educators was wanting since some of them engaged in behaviours that they were supposed to be championing against. The most noted behaviour was engaging in boy-girl relationships. Some were even suspected of engaging in sexual relationship yet they were supposed to be promoting abstinence. Since it has been instilled in the students that such relationships were not meant for the youth, the students adopted a judgmental attitude towards such peer educators. These judgmental attitudes affected the peer educators' ability to efficiently and effectively discharge their duties.

4.2 Parental Involvement

The study also incorporated a five point scale in the students' questionnaire to establish if HIV/AIDS education programme in schools encouraged the school fraternity to facilitate parent-student communication. The findings reported that 32.1% of the respondents strongly agreed, 33.8% agreed, 22.7% were not sure, 6.8% disagreed and 4.7% strongly disagreed. These findings indicate that the percentages of students who were in agreement with the view that the HIV/AIDS education programme encouraged parent-students communication were more than those who disagreed.

To establish the extent to which parents or guardians were involved in promoting HIV/AIDS prevention among their children, the study sought to establish from the students the topics related to HIV/AIDS parents had discussed with them. The guardian was considered an alternative parent in cases where the respondent's parent was deceased. The findings were reported in TABLE 2.

Table 2: Rate of Discussion of Topics Associated with HIV/AIDS Prevention with Parents/Guardians in Percentages

Topic Discussed	Categories of Responses: Gender		School type			Grade level(Form)				Total response
	Female	Male	Girls'	Boys'	Coed	1	2	3	4	
The female menstrual cycle:										
With both parents	1.2	3.6	1.4	1.1	2.6	2.1	2.4	1.4	1.8	2.3
With female parent	2.4	84.5	1.4	28.6	50.0	34.7	43.4	29.7	36.8	68.8
With male parent	1.2	1.2	1.4	1.1	1.6	2.1	0.0	0.0	1.2	1.2
With none	75.0	10.7	73.2	60.0	37.5	53.7	44.6	55.4	50.6	27.8
How pregnancy occurs:										
With both parents 1.8	7.1	1.4	3.2	4.2	2.1	8.4	2.7	3.8	5.7	
With female parent	6.1	61.9	5.6	27.6	39.6	26.3	38.6	27.0	31.5	55.1
With male parent 4.3	1.2	5.6	1.6	2.8	3.2	0.0	0.0	2.4	0.6	
With none	67.7	29.8	64.8	58.4	45.3	61.1	43.4	56.8	52.6	38.6
Sexually transmitted infections:										
With both parents 21.3	39.3	15.5	26.5	26.6	26.3	27.7	25.7	27.4	33.0	
With female parent	1.8	31.0	0.0	13.0	17.7	13.7	19.3	12.2	14.7	26.7
With male parent 15.8	1.2	15.5	8.6	6.8	5.3	3.6	13.6	8.2	1.1	
With none	40.9	28.6	46.5	42.7	40.6	47.4	39.8	35.1	40.0	39.2
How to say no to sex:										
With both parents 23.8	33.3	23.9	24.3	28.6	26.3	28.9	20.3	26.5	29.0	
With female parent	6.1	42.9	5.6	22.2	29.2	28.4	27.7	20.3	23.8	40.3
With male parent 15.2	1.2	14.1	9.1	6.3	7.4	7.2	6.8	8.5	2.3	
With none	34.8	22.6	33.8	34.6	27.6	30.5	26.5	39.2	31.5	28.4
Contraceptives e.g condoms:										
With both parents 6.1	2.4	2.8	5.4	2.6	2.1	2.4	5.4	4.1	2.3	
With female parent	0.6	7.1	0.0	1.6	3.1	1.1	6.0	4.1	2.6	4.5
With male parent 1.8	1.2	1.9	2.7	1.6	4.2	1.2	0.0	2.1	2.3	
With none	71.3	89.3	73.2	81.1	84.4	85.3	80.7	77.0	81.5	90.9

Table 2: Rate of Discussion of Topics Associated with HIV/AIDS Prevention with Parents/Guardians in Percentages (Continued)

Topic Discussed	Categories of Responses: Gender		School type			Grade level(Form)				Total response
	Female	Male	Girls'	Boys'	Coed	1	2	3	4	
HIV/AIDS prevention:										
With both parents	47.2	28.7	48.8	22.5	39.5	43.2	35.8	39.8	33.8	38.2
With female parent	3.7	23.9	29.8	4.2	10.8	12.5	14.7	15.7	13.5	14.1
With male parent	4.5	13.4	1.2	11.3	11.4	11.4	10.5	4.8	8.1	8.8
With none	24.4	34.1	20.2	39.4	29.2	23.9	31.6	30.1	31.1	29.1
Using safe sex practices:										
With both parents	1.1	3.0	2.4	1.4	2.2	1.1	2.1	3.6	1.4	2.1
With female parent	5.1	3.0	7.1	1.4	3.8	2.3	3.2	8.4	2.7	4.1
With male parent	1.7	4.9	0.0	1.4	5.4	5.7	2.1	4.8	0.0	3.2
With none	92.0	68.9	90.5	73.3	79.5	81.8	85.3	73.5	82.4	80.9
Leisure time management:										
With both parents	59.1	35.4	77.4	35.2	38.9	48.9	47.4	47.0	47.3	47.6
With female parent	14.8	6.1	11.9	5.6	11.9	11.4	11.6	9.6	9.5	10.6
With male parent	6.8	18.3	3.6	18.3	14.1	12.5	9.5	14.5	13.5	12.4
With none	19.4	19.5	7.2	18.3	25.4	18.2	23.2	19.3	16.2	19.4
Drug misuse:										
With both parents	40.3	33.5	53.6	28.3	33.0	26.1	37.9	41.0	44.6	37.1
With female parents	13.1	4.9	17.9	4.2	7.0	10.2	12.6	8.4	4.1	9.1
With male parent	11.4	14.0	9.5	12.7	14.1	18.2	8.4	13.3	10.8	12.6
With none	35.3	27.4	17.9	32.4	36.8	36.4	33.7	26.5	27.0	31.2
Where to get VCT services:										
With both parents	18.8	12.2	16.7	5.6	18.9	15.9	14.7	15.7	16.2	15.6
With female parent	5.7	4.9	7.1	2.8	5.4	8.0	3.2	6.0	4.1	5.3
With male parent	2.8	4.3	1.2	2.8	4.9	4.5	4.2	3.6	1.4	3.5
With none	72.2	58.5	73.8	66.2	61.2	62.5	69.5	65.1	64.9	65.6
Do not discuss:										
With both parents	9.1	4.9	1.5	8.5	9.2	4.5	8.4	4.8	10.8	7.1
With female parent	1.1	15.9	0.0	15.5	9.2	10.2	7.4	6.0	9.5	8.2
With male parent	10.8	3.0	9.5	4.2	7.0	3.4	11.6	7.2	5.4	7.1
With none	79.0	75.6	89.3	71.8	74.1	81.8	72.7	80.7	74.3	77.3

TABLE 2 indicates that 77.3% of the respondents had had some form of discussion with their parents/guardian. This was derived from the percentage of students who had never discussed with any parent. Three topics namely HIV/AIDS prevention; Leisure time management and Drug misuse recorded higher response rates on the presence of discussions with either or both parents. The other topics had higher responses on lack of discussion. The topics on safe sex practices and contraceptives recorded the least instances of discussions. This could be because the topics involved discussions on condoms yet most parents would not want to believe that their children were sexually active. Female parents/guardians participated more in discussing with their children the enumerated topics.

4.2.1 Factors Influencing Parental Involvement

Whether or not the students resided with their parents influenced parental involvement in discussion with their children on issues regarding HIV/AIDS. The study established that approximately half of the students – 56.2% stayed with both parents while 19.1% stayed with their mothers and 2.6% stayed with their fathers. These rates imply that mothers were more in contact with their children as compared to fathers and could be the reason why they had more discussions with their children as reported in Table 2.

Another factor that influenced parental involvement was absence of the parents due to death. The study established that 17.4% of the students had lost their fathers, 8.2% had lost their mothers and 5.8% had lost both parents. Being orphaned meant that these students were not able to interact with their parents.

Geographical separation among parents and or separation between parents and their children also influenced parental involvement. Separation could be due to marital disagreement between the parents and or the parents having to move to other areas especially urban areas in search of employment. The study established that 95.3% of fathers and 74.7% of mothers had some form of employment. This caused the children to contend with staying with one parent most times or left the children in the care of other relatives. Even in cases where the students stayed with their parents, the parents lacked sufficient time to discuss issues on reproductive health and HIV/AIDS with their children due to their hectic schedules.

Traditional practices also influenced parental involvement. Traditionally, there were mediums that were used to enlighten the youth on issues related with their sexuality. It was unacceptable for parents especially those of the opposite gender to discuss sexuality issues freely with their children. However, modernization and the search for employment far from ancestral homes has caused a breakdown of these traditional mediums yet, a considerable number of parents are still reluctant to discuss issues on sexuality with their children. Issues on reproductive health and HIV/AIDS involve discussions on sexuality hence parents felt less inclined to freely discuss them.

Another factor that influenced parental involvement was lack of proper coordination between parents and the school fraternity. This led to the assumption that teachers covered all issues related to the students' sexuality in schools while the schools assumed that parents were also playing their role in guiding their children on sexuality issues. During parents and teachers meetings issues related to the youths' reproductive health, were not comprehensively discussed. The best that was done was to mention youth reproductive health issues in passing then dwell more on exploring strategies for academic excellence.

Lack of sufficient knowledge and skills was another factor that influenced parental involvement. Some students claimed that their parents were not well versed on issues related to reproductive health and HIV/AIDS. The study noted that the main reason for this was not most likely to be illiteracy. Findings from the students' questionnaire revealed that only 0.6% of fathers and 0.3% of mothers lacked some form of formal education. The majority of fathers were university graduates while most mothers possessed secondary school education. The most probable reasons for insufficient knowledge and skills among the parents could be that the parents lacked commitment, interest and time to seek information on issues related to HIV/AIDS.

4.3 HIV/AIDS Prevention Friendly School Policies

Since school rules are an important tool for gauging the policies a school has for its students, the study sought to establish if there were any school rules that promoted HIV/AIDS prevention in schools. During the study, the researcher enumerated various areas and asked the students to acknowledge the presence of school rules addressing these areas. These findings are reported in TABLE 3. The researcher also included an open question in the students' questionnaire in which the students were asked to specify the rules on issues they had responded to affirmatively in the preceding question, as being governed by school rules. These findings are also reported in TABLE 3.

Table 3: Rate of Awareness of School Rules Addressing Issues Related to HIV/AIDS Prevention in Percentages

School rules	Categories of Responses									Total response
	Gender		School type			Grade level(Form)				
	Female	Male	Girls'	Boys'	Coed	1	2	3	4	
Acknowledgement of presence of school rules addressing the mentioned issues:										
Love relationships	60.8	40.2	69.0	9.9	58.4	50.0	49.5	49.4	55.4	50.9
Pregnancy	46.0	28.7	45.2	2.8	47.6	34.1	41.1	36.1	39.2	37.6
Sexual abuse/coercion	26.7	22.6	15.5	12.7	33.5	21.6	17.9	30.1	31.1	24.7
Sexual relationships	48.3	29.9	53.6	14.1	42.7	35.2	38.9	43.3	40.5	39.4
Contraceptives	6.3	7.3	2.4	5.6	9.2	6.8	4.2	8.4	8.1	6.8
Condoms	6.8	10.4	2.4	7.0	11.9	8.0	10.5	8.4	6.8	8.5
Drugs	62.5	73.8	54.8	76.1	70.8	56.8	70.5	72.3	73.0	67.9
Alcohol	58.0	65.2	61.9	73.2	56.8	53.4	66.3	60.2	66.2	61.5
HIV/AIDS	15.9	23.2	7.1	16.9	25.9	22.7	16.8	16.9	21.6	19.4
School rules enumerated by students prohibited the following:										
Boy-girl relationships	34.1	28.0	25.0	2.8	44.9	27.3	34.7	28.9	33.8	31.2
Pregnancy in school	29.0	14.6	28.6	0.0	27.6	17.0	21.1	27.7	23.0	22.1
Coercive sex/rape	0.0	0.6	0.0	1.4	0.0	0.0	0.0	0.0	1.4	0.3
Same sex intimate relationships	25.6	0.0	53.6	0.0	0.0	12.5	15.8	12.0	12.2	13.2
Intimacy with staff members	4.0	1.2	6.0	0.0	2.2	2.3	0.0	3.6	5.4	2.6
Possession of condoms	6.3	3.0	3.6	2.8	5.9	3.4	8.4	2.4	4.1	4.7
Possession of contraceptives	3.4	0.6	2.4	1.4	2.2	0.0	3.2	1.2	4.1	2.1
Possession of alcohol	35.2	36.0	45.2	35.2	31.4	30.7	37.9	33.7	40.5	35.6
Possession of drugs	48.3	51.2	47.6	47.9	51.4	39.8	53.7	48.2	58.1	49.7
Discriminating against HIV/AIDS Infected/affected	1.7	1.2	3.6	1.4	0.5	1.1	2.1	1.2	1.4	1.5

The findings indicate that most schools were reluctant to deal with issues on contraceptives and condoms. This is evident in the low rates of acknowledgement of the presence of school rules on these two issues that stood at 6.8% and 8.5% respectively. The issues on contraceptives and condoms were tackled with reluctance probably because most schools promoted abstinence. Though there were rules prohibiting sexual relationships, schools did not seem to appreciate that some of these sexual relationships could be due to coercion or rape hence the low response rate when the students were asked to enumerate the rules present in schools on sexual relationships. Many students seemed not to be sensitized on the issue of discriminating against those affected or infected hence they could not enumerate rules to this effect. This was a threat to the efforts being made to destigmatize HIV/AIDS.

The highest responses on acknowledgement of presence of school rules in Table 3 were on drugs and alcohol - 67.9%and 61.5% respectively. The most enumerated rules were also those on drugs and alcohol – 49.7% and 35.6% respectively. This is probably because schools felt that these issues were safer to address as compared to those dealing with the sexuality of the students. A student percentage of 22.1% still felt that pregnancy was prohibited in schools yet this policy has been revised to give girls who got pregnant a chance to pursue their education instead of them dropping out of school completely. This is because dropping out is seen as wastage of education resources and potential and pregnancy has been one major cause of dropping out

Generally the total response rates on this issue of HIV/AIDS friendly school policies were low especially when the students were told to enumerate the rules. This could probably be because some students seemed not to be well versed with the school rules. This was evident during further probing during the FGDs.

4.3.1Factors Influencing HIV Prevention Friendly School Policies

One factor that influenced HIV/AIDS prevention friendly policies in the learning institutions was lack of revision of school rules. Most school rules had not been revised for as far back as over ten years. This is an indication that the school rules do not conform to the changing trends and policies in our society. This could be evidenced by the fact that most students still held to the rule that pregnancy in school led to expulsion. The student FGDs confirmed that expulsion of pregnant students was still being practiced in schools yet the present education policies advocate for giving the expectant students a chance to continue with their education.

Another factor that affected HIV/AIDS prevention friendly school policies was poor orientation of the students on school policies. When the students were admitted to the schools most of them were given a copy of

school rules to read. There after there was no intensive follow up to ascertain if the students fully understood the rules and their implications. Even in schools where there were orientation meetings, the rules were not elaborately explained. Instead, most of the speakers during students' orientation meetings, emphasized on academic excellence. Furthermore, these orientation meetings were meant for students who were new admissions and those who had joined form one. Time was rarely allocated for the continuing students to be reminded and refreshed on the school rules. School rules were also issued once during a students' life span in the school and the likelihood that the students lost them before they left the learning institutions were very high. Emphasis on academics implied that schools do not appreciate that these rules could improve behaviour and to some extend enhance academic performance.

Lack of commitment and support from the school governing bodies like the board of governors, the parents' teachers association and school religious sponsors in encouraging the formulation of school rules and policies that would favour HIV/AIDS prevention influenced the promotion of HIV/AIDS prevention friendly policies in schools. Most churches were opposed to schools giving students comprehensive information on HIV/AIDS prevention and insisted on abstinence only. This viewpoint of the churches would definitely be championed by their affiliates - the religious school sponsors. The board of governors and parents teachers association upheld the religious school sponsors' view because they did not want to be viewed as opposing the religious views. Additionally, the board of governors and parents teachers association being the bodies charged with the responsibility of allocating and or approving budgetary allocations and even some school activity schedules in institutions of learning, they did not give consideration to activities and policies that would enhance HIV/AIDS prevention.

V. CONCLUSION

Findings from this study are an indicator that the students in secondary schools were not accorded a supportive environment for HIV/AIDS prevention. Peers who are a major influence to the youth and who are members of an important culture that the youth belong to are not actively involved in HIV/AIDS prevention initiatives despite the secondary school syllabus recommendations and stipulations in its content and objectives. Parents are an important subset of the community therefore their active involvement in issues that concern HIV/AIDS prevention initiatives for their children is likely to enable enhanced community approval. This includes issues that seem to contravene community values like contraception. However, their reluctance in discussing topics on sexual issues with their children creates an environment that does not support HIV/AIDS prevention especially to the youth who are sexually active. Findings in this study indicate that schools do not have the commitment to adopt revised policies that are in tandem with the prevailing needs and challenges of the youth especially in their HIV/AIDS prevention efforts.

This article therefore recommends the following:

i. More efforts should be put in creating a supportive environment for HIV/AIDS prevention initiatives by stepping up youth involvement, parental involvement and promotion of HIV/AIDS prevention friendly policies.
ii. Schools should follow guidelines on recommendations of initiatives they need to include in HIV/AIDS prevention education.
iii. School policies need to be revised so that they are in tandem with policies that have been formulated to enable HIV/AIDS prevention among the youth – notably the Adolescent Reproductive Health Policies of 2003.

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