

**ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
AND PERFORMANCE OF PUPILS/STUDENTS
IN BUSIA DISTRICT, KENYA.**

A RESEARCH REPORT PRESENTED TO THE INSTITUTE OF
OPEN AND DISTANCE LEARNING IN PARTIAL
FULFILMENT OF THE REQUIREMENTS FOR
THE BACHELORS DEGREE IN SCIENCE
EDUCATION / GUIDANCE
AND COUNSELLING



KAMPALA INTERNATIONAL UNIVERSITY

BY

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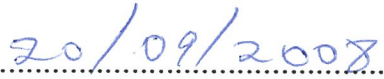
NOVEMBER, 2008.

DECLARATION

I declare that, to the best of my knowledge, the material in this booklet has not been presented elsewhere for any academic qualification.

Signed: 


ASIBA OUMA LINUS

Date: 

APPROVAL

This research is submitted for examination with my approval as the supervisor

Signed: 
.....
MR. MAKI PETER

Date: 
.....

ACKNOWLEDGEMENTS

I would like to extend my sincere appreciation to the following for the support they gave during this research.

1. Mr. Maki Peter, GC Lecturer, Kampala International University, for the guidance he gave during my proposal writing.
2. School Heads and Students for their co-operation.
3. My wife Audrey Nambanga and Children, for propping me up to finish the research on time.
4. Blantine Asuka who worked at odd hours on typesetting and all friends of good will.
5. DR. Martin Odendo, Researcher, Kenya Agricultural Research Institute (KARI), lecturer, Moi University for his critical advice on research methodology and formatting.

DEDICATION

I dedicate this work to my father ASIBA ADEYA. A peaceful man who rarely harms a fly. A man who at 80 plus still goes about his life cores with dignity.

ABSTRACT

Acquired Immunodeficiency Syndrome (AIDS) remains a major health challenge world over. In this research, I tried to uncover its effects on performance in schools. It was found that its damage requires special efforts to address. "Ihira" was an illness that closely resembled AIDS. Its cause was "immoral conduct". The cure for "ihira" was a concoction of herbs called "amanyasi". Could the cure for AIDS lie in "Amanyasi?"

In chapter one I deal with the rationale, statement of the problem, objectives, scope of the study and significance. "In research on drug producing plants, a multi disciplinary approach which uses the various branches of bio-chemical and physical sciences is vital (Kenya Medical Research Institute, KEMRI-1995)

In chapter two, Review of the Related Literature is solely taken from a 2004 WHO report on the status of AIDS. The report highlights the re-emergence of diseases like tuberculosis and importance of ARVs.

Chapter three is on Research Methodology. Here research design, population sample, research instruments, validity and reliability are covered.

Chapter four is on results and data analysis.

Finally, chapter five covers summary, conclusion and recommendations.

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CHAPTER ONE

1.0 RATIONALE/BACKGROUND OF THE STUDY

Acquired Immunodeficiency Syndrome (AIDS) first surfaced in Kenya in 1984. It was first diagnosed by Prof. Arthur Obel. Twenty three years along the line no concrete cure has so far been found, world over. The result; a more uncertain and traumatized humanity.

The trouble is every body is expecting a drug to be discovered. But by who? Isn't it true that Africans, using their own indigenous knowledge had solutions to a wide variety of health problems? Has anybody ever taken the trouble to research among African communities if a problem similar to AIDS ever occurred?

This study is based on my own believe that the solution to AIDS lies in the African indigenous knowledge and that AIDS either directly or indirectly affects learning at all levels.

“In research on drug producing plants, a multidisciplinary approach, which uses the various branches of biochemical and physical sciences is vital” (KEMRI – 1993).

This theory is relevant to the study in that;

- The educator must know the problems of his learners.
- Health of the learners affects efficiency of learning.
- Education should offer social and health solutions.

1.1 Statement of the Problem

In my long experience as a teacher, I have come face to face with AIDS. I have witnessed parents, students and my colleagues who are teachers dying. I have seen no cure coming up. Orphaned children miss out on schooling. That is what has prompted me to make my modest contribution in the field.

1.2 Objectives

The objectives of this study were;

- i. To assess the impact of AIDS in learning institutions by looking at parameters like absenteeism due to sickness, rate of students, parents and teachers deaths due to AIDS related complications.
- ii. To find out if the local communities have or are trying to come up with a remedy to the problem.

1.3 Scope of the Study

This study is to find out how HIV/AIDS has affected the Education of children in Busia District of Kenya.

The study covers pupils , students and teachers

The study is to find the efforts the local communities are making to contain the problem.

1.4 Significance of the Study

The study will be valuable in the following areas:

- To find out how HIV/AIDS has affected learning in Busia District of Kenya.
- To find out if any herbal remedy could be in stock for further analysis with the aim of getting a drug for HIV/AIDS.

CHAPTER TWO

REVIEW OF THE RELATED LITERATURE

2.0 Introduction

This chapter deals with information from medical experts as expressed during the WHO annual conference (2004) in Geneva.

2.1 The views

Acquired Immune Deficiency Syndrome or Acquired Immunodeficiency Syndrome (AIDS) is a set of symptoms and infections resulting from the damage to the human immune system caused by the human immunodeficiency virus (HIV). This condition progressively reduces the effectiveness of the immune system and leaves individuals susceptible to opportunistic infections and tumours. HIV is transmitted through direct contact of a mucous membrane or the blood stream with a bodily fluid containing HIV, such as blood, semen, vaginal fluid, pre-seminal fluid, and breast milk. This transmission can involve anal, vaginal or oral sex, blood transfusion, contaminated hypodermic needles, exchange between mother and baby during pregnancy, childbirth, or breast feeding, or other exposure to one of the above bodily fluids. (World Health Organisation, WHO (2004).

Most researchers believe that HIV originated in Sub-Saharan Africa during the twentieth century. The disease was first identified by the United States Centre for disease control and prevention in 1981 and its cause identified by American and French scientists in the late 1980s. AIDS is now a pandemic. In 2007, an estimated 33.2 million people lived with the disease worldwide, and it killed an estimated 2.1 million people, including 330,000 children. Over three-quarters of these deaths occurred in Sub-Saharan Africa, retarding economic growth, academic advancement and destroying human capital. In Kenya, about 2.8 million people are affected WHO (2004).

Although treatments for AIDS and HIV can slow the course of the disease, there is currently no vaccine or cure. Antiretroviral treatment reduces both the mortality and the morbidity of HIV infection, but these drugs are expensive and routine access to antiretroviral medication is not available in all countries

WHO – (2004). Due to the difficulty in treating HIV infection, preventing infection is a key aim in controlling the AIDS epidemic, with health organizations promoting safe sex and needle-exchange programmes in attempts to slow the spread of the virus.

AIDS affects education at a number of levels:

When parents die, school going orphans lack the parental care. School fees and other needs are not met. Children themselves may be infected and opportunistic infections keep them out of the school regularly. Apart from the social disorientation, there is also the neuro-degeneration in HIV infections. These, plus other factors compound matters for the child in class. KEMRI (2000).

By the end of 2003, an estimated 40 million people were living with HIV; 95% of them in low and middle-income countries. More people were infected in 2003 than in any previous year, and the epidemic is expanding most rapidly in the population centres of Asia and Eastern Europe. Gendel I (2000).

As the epidemic advances, its impact is becoming increasingly severe. More people died of HIV-related causes in 2003 than in any other year, 3 million in all, and the pace of AIDS deaths is accelerating quickly.

HIV/AIDS is contributing to a global resurgence of tuberculosis, and there is evidence that the epidemic may also be increasing vulnerability to malaria, the single greatest infectious killer of children in Africa and the third most important cause of death worldwide among communicable diseases. In southern Africa, which has been hit hardest by HIV/AIDS, the epidemic is contributing to chronic and intractable food shortages, and the loss of essential personnel in public sectors, education systems, and fragile healthcare institutions.

Even before the recent increase in the pace of AIDS deaths, HIV/AIDS had slashed more than two decades from the average life expectancy in several African countries, creating perverse national population structures composed of large numbers of the young and old but of alarmingly few working-age adults WHO. Although Africa has been most affected by the epidemic, several countries in other regions have confronted generalized epidemics, and the virus is rapidly spreading in China, India and Indonesia, three of the world's four most populous countries. Most disturbing is the fact that we are probably witnessing only the proverbial tip of the iceberg; as HIV progressively attacks the immune systems of tens of millions of people in developing countries who lack the most basic health services, today's catastrophe may pale next to what we are likely to see in the very near future.

Addressing this crisis will require an urgent strengthening and expansion of established HIV prevention strategies. Prevention alone, however, will not avert the looming humanitarian disaster. Only by significantly lowering HIV-related morbidity and mortality will it be possible to reduce the epidemic's short and long-term impact. WHO (2004)

Rapid expansion of access to antiretroviral therapy (ARV) is the best available means to minimize the epidemic's damage to global health. Between 1995 and 2001, AIDS deaths in the United States declined by 83% as a result of universal access to ARV.

As Teizeira describes in this issue, nationwide access to combination ARV in Brazil has, since 1996, enabled the country by 2002 to avert more than 60,000 new AIDS cases and 90,000 HIV-related deaths. To extend these extraordinary health benefits to other parts of the world, the World Health Organization WHO and UNAIDS are spearheading a global strategy to ensure the delivery of ARV to 3 million people by 2005.

Major donors, including the US government, the World Bank, leading foundations, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, are devoting unprecedented sums to treatment expansion. National governments in affected countries are also taking the initiative to bring ARV to those who need such therapies. Thailand has embarked on a major new effort to expand access to ARV. The governments of Botswana, Uganda, and other HIV-affected countries are also moving to provide ARV to individuals with HIV infection who are medically eligible for treatment. WHO (1996).

Notwithstanding this striking global momentum, there have been occasional voices of dissent. These primarily focus on the possibility that the too rapid introduction of ARV in resource-limited settings might cause the swift development of drug resistance, which, it is argued, would complicate and potentially negate long-term efforts to control the epidemic. It has been argued that patients in developing countries will be unable to adhere to ARV, that clinicians lack the means to monitor adherence, and that uninterrupted drug supply of suitable quality cannot be assured. GAO F. (1999).

Nemes. and Soares (2004), demonstrates that years of ARV access have not generated problematical levels of resistance in Brazil, which, although a middle-income country, nevertheless has substantially fewer resources than the US, Canada and countries in western Europe.

In much poorer Haiti, as Koenig explain, a community- based programme of AIDS care has achieved high rates of adherence and viral suppression among 86% of the patient population. Similarly, Coetzee (2002), analysed data from 24 months' experience in the provision of ARV to patients in Khayelitsha community in South Africa, finding high levels of viral suppression and a low probability of viral rebound.

As ARV is further expanded in developing countries, established strategies are needed to promote treatment adherence. As Kuritzkes explains, (2004) therapeutic regimens now available for highly active antiretroviral therapy are not only much simpler but are much more likely than regimens used earlier in the era of highly active antiretroviral therapy to promote sustainable viral suppression.

WHO has issued clear guidelines to countries on the selection of optimally simple, highly potent front-line therapies. Lazzari (2003), describe how WHO and partners have embarked on the development of a global HIV drug resistance surveillance programme, to enable health policy-makers to identify patterns of drug resistance, and to respond in an appropriate and timely manner. In both Haiti and South Africa, pilot ARV projects have incorporated thoughtful strategies to promote patient adherence, with apparent success.

As Moatti (2004). argue, concern about ARV drug resistance in developing countries, although reasonable on the face of it, represents yet another variant of the double standard between north and south that has long governed the delivery of health services.

Lange (2004) noted that high rates of ARV resistance in the USA and Europe, much higher than those reported in developing countries, have hardly prompted health authorities in high-income countries to restrict access to ARV. In reality, as Kuritzkes notes, clinical and immunological benefits often persist long after ARV resistance has developed.

Experience with tuberculosis, malaria and other diseases underscore the fact that drug resistance is not a matter to be taken lightly. As Amorosso (1999) caution, therapeutic approaches thus far have not always prevented the emergence of drug resistance among indigent patients in high-income countries.

Fortunately, established strategies exist to minimize the emergence of ARV drug resistance, and these approaches are being prioritized as access to ARV is expanded in developing countries. As Wainberg (2004) notes, HIV resistance is unlikely to develop into a serious global problem. Given the immensity of the global health crisis posed by HIV/AIDS, the theoretical future risks associated with drug resistance cannot justify withholding life-preserving treatments to individuals, families, communities and countries that are now struggling under the epidemic's ever-increasing burden.

(UNAIDS GENEVA (Switzerland) (2003). AIDS epidemic update; 2003, Elzinga G, Raviglione MC, Mather D. Scale up: meeting targets in global tuberculosis control. Lancet (2004, 363:814-819).

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

The chapter deals with research design, population sample, validity and reliability of research instruments, data collection procedure and time schedule.

3.1 Research Design

Busia district is sub-divided into three divisions, Butula, Nambale and Matayos. I sampled ten schools per division using random method. Two questionnaires were designed. One for the head teacher and the second for the pupil/students. Head teachers were interviewed. The study involved both qualitative and quantitative surveys.

Duration was between May to Mid-July / 2008.

3.2 Population and Sample

In the ten schools sampled per division, the head teacher and class eight pupils (40) acted as samples. In Secondary section, the principals and form for four students (40) acted as samples. There are about 164 schools in Busia District.

3.3 Research Instruments

Questionnaires and interviews were used.

3.4 Validity and Reliability of Research Instruments.

The accuracy of the answers given depends on the level of education of the respondent.

3.5 Data Collection Procedure

I moved around schools giving questionnaires and interviews to teachers.

3.6 Data Analysis

The results from the questionnaire, interviews and schedules will be analyzed separately.

Each will be analyzed by making tally marks and drawing of frequency polygon, from which the conclusions will be drawn.

Quantitative data generated will be computed into frequency courts and percentages using the formula below.

$$\text{Percentage} = \frac{F}{T} \times 100$$

Where F = Number of respondents (sample)

T = Total number of students and teachers in Busia District, Kenya.

Qualitative analysis: Data from questionnaires will be presented and discussed in a descriptive form.

3.7 Time Schedule

The research took two and a half months. This time included;

Logistical work,

Printing of questionnaires,

Practical research,

Data analysis and writing a report.



CHAPTER FOUR
PRESENTATION, DATA ANALYSIS AND INTERPRETATION.

4.0 Introduction

The chapter deals with results and data analysis from students and teachers.

4.1 Results and Data Analysis

The questions posed to the teachers and students about AIDS awareness can be categorized into the following five levels:-

1. AWARENESS about the existence of AIDS
2. AWARENESS that AIDS kills
3. AWARENESS about the negative effects of AIDS on education.
4. AWARENESS that similar diseases to AIDS existed in the past.
5. AWARENESS about possible AIDS herbal cure.

4.2 Results from Head Teachers

1. A total of 30 head – teachers, ten (10) from each division, were sampled. They were from the ten schools sampled.
2. The questions posed to them can be categorized into four levels of AIDS awareness as shown in the table below:

Table 1/i:- Awareness that AIDS exist

LEVEL OF AWARENESS	AGREE		DISAGREE		UNDECIDED	
	NO	%	NO	%	NO	%
Awareness that AIDS exists	30	100	0	0	0	0

A hundred percent of the teachers are aware of AIDS existence.

Table 1/ii Awareness about the effects of AIDS and lack of parental care on discipline and performance.

LEVEL OF AWARENESS	AGREE		DISGREE		UNDECIDED	
	NO	%	NO	%	NO	%
Awareness about the effects of AIDS and lack of parental care, on discipline and performance in school	28	93	2	6.6	0	0

Ninety three percent of the teachers are aware that AIDS affects standards of education.

Six point six disagree and none is undecided.

This shows that the effects of AIDS are widespread.

Table 1/iii: Awareness about a disease similar to AIDS in the past

LEVEL OF AWARENESS	AGREE		DISGREE		UNDECIDED	
	NO	%	NO	%	NO	%
Awareness about a disease similar to AIDS	24	79.2	5	16.6	1	4.2

A total of twenty four (79.2%) out of 30 teachers said they knew of a disease similar to AIDS in the past.

Five disagreed while only one was undecided.

Table 1/iv :- Awareness about AIDS curative herb.

LEVEL OF AWARENESS	AGREE		DISAGREE		UNDECIDED	
	NO	%	NO	%	NO	%
Awareness about AIDS curative herb	20	66.6	2	6.6	8	26.4

- On AIDS curative her, 66.6% (20) out of 30 teachers said they are aware of a herb that could cure a disease similar to AIDS.
- About 6.6% disagreed while 26.4% were undecided.

4.3 Results from Pupils / Students

1. A total of 1200 pupils and students from 30 schools (8 primary, 2 secondary per division were sampled).
2. Standard eight (40) and Form Four (40) were used.

TABLES SHOWING LEVELS OF AWARENESS AND RESPONSES AMONG PUPILS /STUDENTS.

A total of 1200 respondents were sampled.

Table 2/a — Awareness that AIDS exists

LEVEL OF AWARENESS	AGREE		DISAGREE		UNDECIDED	
	NO	%	NO	%	NO	%
Awareness that AIDS exist	1187	98.9	13	1.1	00	00

A big proportion (98.9%) of pupils and students believe AIDS exist.

Thirteen believe it is a myth.

None is undecided.

Table 2 /b: - Awareness that AIDS kills.

LEVEL OF AWARENESS	AGREE		DISAGREE		UNDECIDED	
	NO	%	NO	%	NO	%
Awareness that AIDS kills	907	75.7	133	10.64	160	12.8

A sizeable proportion of students (75.7%) are aware that AIDS kills. Only 12.8%

Were undecided while 133 students disagreed.

Table 2/c :- Awareness about the negative effects of AIDS on education.

LEVEL OF AWARENESS	AGREE		DISAGREE		UNDECIDED	
	NO	%	NO	%	NO	%
Awareness about the negative effects of AIDS on education	1188	99	03	0.24	09	0.96

- Most of the learners (99%) know that AIDS affects their education in one way or another.

- About 0.24% said they didn't see any effect, while 0.96% were undecided.

Table 2/d:- Awareness that similar diseases to AIDS existed in the past.

LEVEL OF AWARENESS	AGREE		DISAGREE		UNDECIDED	
	NO	%	NO	%	NO	%
Awareness that similar diseases to AIDS existed in the past	929	77.4	93	7.75	146	12.16

- Students were aware that illnesses similar to AIDS existed (77.4%).

- About 93 (7.75%) disagreed while 12.16% were undecided.

Table 2/e:- Awareness about possible AIDS herbal cure.

LEVEL OF AWARENESS	AGREE		DISAGREE		UNDECIDED	
	NO	%	NO	%	NO	%
Awareness about possible AIDS herbal cure	280	23.3	613	51	307	25.5

- According to the table above, 280 (23.3%) agreed that there is a possible herbal cure.
- 613 (51.0%) disagreed and 307 were undecided.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS.

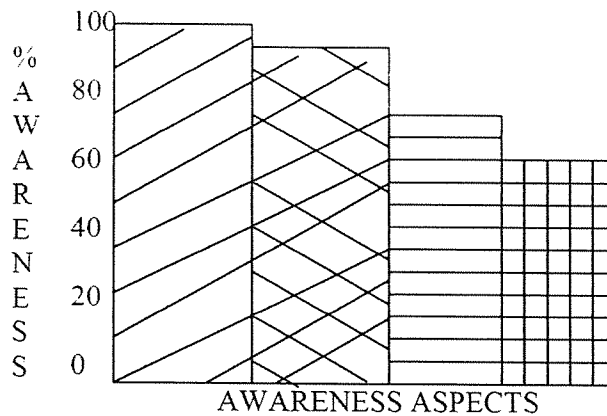
5.0 Introduction

Chapter five covers summary, conclusion and recommendations.

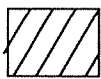
5.1 Summary

i). Teachers

- a) About 93% of all the head-teachers agreed that AIDS affects the standards of education at different levels.
- b) The bar chart below shows the percentage AIDS awareness levels on different aspects.



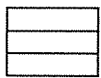
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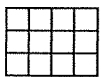
AWARENESS about existence of AIDS



AWARENESS about the negative effects of AIDS and lack of parental care
On discipline and performance.



AWARENESS about a disease similar to AIDS in the past



AWARENESS about an AIDS curative herb.

ii). Students / Pupils

- a) About 99% of pupils / students are aware that AIDS affects education in different ways.
- b) About 93% of the pupils / students are aware that diseases with similar symptoms to AIDS existed in the past.
- c) Only 23% of the students are aware of any herbal remedy to AIDS as opposed to 66% of their teachers.
- d) The two groups agreed that AIDS causes loss of parental care, affects the students themselves and causes poor performance in schools.
- e) Both groups agreed that diseases similar to AIDS existed in the past but differed on the existence of a cure while 66% of the teachers thought there was a remedy for AIDS like diseases (Ihira), only 23% of the students thought so.

5.2 Conclusion

The first objective was to assess the impact of AIDS in learning institutions by looking at parameters like absenteeism, students and teachers deaths and class performance of affected students. The study revealed that AIDS affects education in terms of discipline due to lack of parental guidance and provision of basic personal and school facilities.

The second objective was to find out if the local communities have or are trying to come up with a remedy to AIDS.

Most teachers (66.6%) agreed that similar diseases to AIDS in the past had a cure.

They recommended research from African communities herbal medicines. Students disagreed, probably due to influence of Western culture and lack of exposure.

5.3 Recommendations

1. AIDS is likely to be with us for many years to come. I therefore recommend the following long and short term solutions:-
2. Efforts should be made to discover a drug among the African indigenous communities.
3. Education Ministry should consider putting up or supporting orphanage homes.
4. Home - based orphanage support schemes should be part of welfare government schemes.

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APPENDICES

APPENDIX A: CURRICULUM VITAE

PERSONAL INFORMATION

NAME : ASIBA OUMA LINUS.
AGE : 45 YEARS.
SEX : MALE.
MARITAL STATUS : MARRIED.
CIVIL STATUS : TEACHER, UNIONIST.

EDUCATIONAL BACKGROUND

PRIMARY SCHOOL : LUNGA.
SECONDARY SCHOOL: BUJUMBA.
HIGH SCHOOL : SIGALAME.

PROFESSIONAL BACKGROUND

DIPLOMA IN SCIENCE EDUCATION (KENYA SCIENCE TEACHERS COLLEGE).

NATIONAL TRUSTEE, KENYA UNION OF POST PRIMARY TEACHERS (KUPPET).

APPENDIX B: TRANSMITTAL LETTER FOR THE HEAD TEACHER

KAMPALA INTERNATIONAL UNIVERSITY (IODL)

P.O. BOX 20000

KAMPALA

30TH APRIL 2008

THE HEAD – TEACHER

.....
.....

Dear Sir / Madam,

REF: PERMISSION TO DO RESEARCH

I am a graduating student of Kampala International University from the Institute of Distance and Open Learning (IODL), Faculty of Education.

I hereby request your permission to carry out research on: “EFFECTS OF AIDS ON STANDARDS OF EDUCATION AND A POSSIBLE SOLUTION, IN BUSIA DISTRICT”, in your school.

Thanks in advance for your co-operation.

Yours faithfully,

.....
LINUS OUMA ASIBA

Noted by

.....
SUPERVISOR.

APPENDIX C: QUESTIONNAIRE FOR THE HEAD TEACHER

Thro:
THE D.E.O.
BUSIA DISTRICT

TOPIC: ACQUIRED IMMUNODEFICIENCY SYNDROME
(AIDS)AND PERFORMANCE OF PUPILS/STUDENTS IN BUSIA
DISTRICT, KENYA.

This questionnaire is seeking information about the effects of AIDS on education standards in Busia District. It also seeks to know how our people are managing AIDS at their own level and if their indigenous knowledge can be panel beaten into a solution.

The information you will give will be treated with utmost confidentiality.

INSTRUCTIONS: Fill in the spaces provided or tick the appropriate response only.

Tick the one most applicable to you.

KEY:

Strongly Agree SA Agree A Undecided UN Disagree D

Strongly Disagree SD

1. You have been in this school for 1-5 years.

SA A UN D SD

2. You have lost many teachers, parents and students due to suspected AIDS complications in the last 5 years in your school.

SA A UN D SD

APPENDIX D: QUESTIONNAIRE FOR THE STUDENTS

TOPIC: ACQUIRED IMMUNODEFICIENCY SYNDROME

**(AIDS)AND PERFORMANCE OF PUPILS/STUDENTS IN
BUSIA DISTRICT, KENYA.**

This questionnaire is seeking information about the effects of AIDS on education standards in Busia District. It also seeks to know how our people are managing AIDS at their own level and if their indigenous knowledge can be panel beaten into a solution.

The information you will give will be treated with utmost confidentiality.

INSTRUCTIONS: Fill in the spaces provided or tick the appropriate response only.

Tick the one most applicable to you.

KEY:

STRONGLY AGREE

AGREE

UNDECIDED

SA

A

UN

DISAGREE

STRONGLY DISAGREE

D

SD

Example

AIDS is caused by a virus:

SA A UN D SD

1. You have heard of AIDS.

SA A UN D SD

2. All your friends/ school mates know of AIDS.

SA A UN D SD

3. You know of your village mates and friends whose parents have all died.

SA A UN D SD

4. They miss to come to school because they are either sick, lack school uniform or school levies.

SA A UN D SD

5. From this area or your home, you have heard of stories of diseases that had symptoms close to those of AIDS.

SA A UN D SD

6. They had a herb for the treatment of the diseases.

SA A UN D SD

7. Those herbs have been forgotten.

SA A UN D SD

THANK YOU

APPENDIX E: LIST OF SCHOOLS IN BUSIA DISTRICT

There are three divisions in Busia District:

1. LIST OF SCHOOLS IN BUTULA DIVISION

PRIMARY SCHOOLS

- | | |
|------------------|-------------------|
| 1. Bujumba | 26.Igula |
| 2. Bukhalalire | 27.Khunyangu |
| 3. Bukhwaku | 28.Kingandole |
| 4. Bumala A.C. | 29.Madola |
| 5. Burinda | 30.Mung'ambwa |
| 6. Buriya | 31.Musoma |
| 7. Busibula | 32.Neela |
| 8. Busire | 33.Nyalweda |
| 9. Dadira | 34.Saka |
| 10.Ikonzo | 35.Sikoma |
| 11.Masebula | 36.Simuli |
| 12.Namwitsula | 37.St. Augustines |
| 13.Nango | 38.Buduma |
| 14.Nyamwala | 39.Buhuyi |
| 15.Bukhalire | 40.Bukati |
| 16.Bukhuma | 41.Bumala R.C. |
| 17.Bulwani | 42.Butula Boys |
| 18.Bumutiru A.C. | 43.Butula Girls |
| 19.Bumutiru R.C. | 44.Elukhari |
| 20.Busiada Mixed | 45.Esibina |
| 21.Butunyi Mixed | 46.Isongo |
| 22.Bwaliro | 47.Kalalani |
| 23.Elunyiko | 48.Kanjala |
| 24.Emagombe | 49.Lugulu A.C. |
| 25.Enakaywa | 50.Makwara |

51.Masendebale
52.Mauko D.E.B.
53.Mung'abo
54.Musibiriri

55.Sikarira
56.Siribo
57.Siunga
58.Tingolo
59.Masendebale

SECONDARY SCHOOLS

1. Butula Girls
2. Butula Boys
3. Kingandole
4. Bujumba
5. Lugulu A.C.
6. Bumala A.C.
7. Tingolo
8. Bwaliro
9. Ikonzo
- 10.Buhuyi
- 11.Sirihaya
- 12.Busiada
- 13.Bukhalalire
- 14.Bumala A.C.
- 15.ST. Monica Butunyi
- 16.Bumutiru
- 17.St. Josephs Royal Bumala
- 18.Buriya Girls

2. LIST OF SCHOOLS IN NAMBALE DIVISION

PRIMARY SCHOOLS

- | | |
|--------------------|------------------|
| 1. Buyofu | 21.St. James |
| 2. Dulionge | 22.Nambale Urban |
| 3. Ekisum | 23.Sidende |
| 4. Elwanikha | 24.Kisoko |
| 5. Igara | 25.Emuhuyu |
| 6. Kaludeka | 26.Kisoko Boys |
| 7. Kapina | |
| 8. Katira | 27.Mang'eni |
| 9. Khayo | 28.Emakina |
| 10.Lupida | 29.St. Marys' |
| 11.Madende | 30.Manyoke |
| 12.Madibo | 31.Lwanyange |
| 13.Mungatsi | 32.Nambale A.C. |
| 14.Musokoto B | 33.Segero |
| 15.Musokoto D.E.B. | 34.Malanga |
| 16.Mwenge | 35.Maolo |
| 17.Namahindi Otiri | 36.Mabunge R.C. |
| 18.Sianda | 37.Sibembe |
| 19.Siera | 38.Khwirale |
| 20.Sikinga | |

SECONDARY SCHOOLS

1. Nambale Boys
2. Kisoko Girls
3. Madende Mixed
4. Malanga
5. Igara
6. St. Apolonea
7. Nasira
8. Sunrise
9. Busidibu



3. LIST OF SCHOOLS IN MATAYOS DIVISION

PRIMARY SCHOOLS

- | | |
|------------------|--------------------------|
| 1. St. Eugene | 17. Murende |
| 2. Busibwabo | 18. Lung'a |
| 3. Busidibu | 19. Alungoli |
| 4. Busabakhwa | 20. Buyama |
| 5. Indoli | 21. Township Primary |
| 6. Nangoma | 22. St. Teresa |
| 7. Nasira A.C. | 23. Budokomi |
| 8. Lwanya | 24. Spring Board Academy |
| 9. Nasira R.C. | 25. Mabale |
| 10. Nambere | 26. Mundika Primary |
| 11. Muyafwa | 27. Munongo |
| 12. Busende | 28. Mundulusia |
| 13. Nasewa A.C. | 29. Burumba |
| 14. Mabunge A.C. | 30. Busia G.P. School |
| 15. Igero | 31. Buyende |
| 16. Luliba | 32. Nang'oma |

33.Mujuru

34.Mundika Boys

35.Bugengi

36.Air Strip

37.Mundika Girls

SECONDARY SCHOOLS

1. Murende

2. Lwanya

3. Busende

4. Mundika Boys

5. Budokomi

6. Nasewa

7. St. Mathias Busia

8. Our Lady of Mercy

9. Brother Nichols (Private)

LIST OF SCHOOLS SAMPLED

There are three divisions in Busia District. The schools sampled in each division are:-

1. BUTULA DIVISION

PRIMARY SCHOOLS

Butula Boys

Butula Girls

Namwitsula

Busiada Mixed

Igula

Siribo

Tingolo

Lugulu A.C.

SECONDARY SCHOOLS

1. Butula Boys

2. Bujumba

NAMBALE DIVISION

PRIMARY SCHOOLS

Ekisumu

Khayo

Musokoto D.E.B.

St. James

Kisoko

Manyole

Segero

Maolo

SECONDARY SCHOOLS

Madende

Busidibu

MATAYOS DIVISION

PRIMARY SCHOOLS

1. Busibwabo

2. Nangoma

3. Mabunge

4. Luliba

5. Murende

6. Lunga

7. Budokomi

8. Burumba



SECONDARY SCHOOLS

1. Mundika

2. Murende