Nairobi

Fourth Cluster Consultation on HIV/AIDS and Education

21 to 23 June 2005
Mombasa, Kenya

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Introduction

1. The fourth in a series of UNESCO-Nairobi Cluster Consultations on HIV/AIDS and education took place from 21 to 23 June 2005 in Mombasa, Kenya. [The Agenda of the consultation appears in Annex 1.] The consultation brought together senior education officials from Education and Teacher Service Commissions, Ministries of Education along with education and health stakeholders including representatives from teachers' unions and professional associations.[1] Also participating were members of the Kenya Association of Positive Teachers (KENEPOTE), a network of HIV-positive teachers.[2] [The list of participants appears in Annex 2.]

2. The purpose of the consultation was to take stock of progress made toward meeting the recommendations of the second cluster consultation that took place in Kampala, Uganda, in June 2003.[3] The Kampala consultation brought together for the first time education/teacher service commissions, teachers' unions and other stakeholders with the aim to increase awareness on the challenges imposed by HIV/AIDS to the provision and quality of the teaching service and to enhance commitment to respond swiftly and effectively. That consultation identified as a priority for the cluster, the development of policy frameworks on HIV/AIDS for the education workplace. Such workplace policy frameworks would outline the position of the Ministry of Education in relation to increasing the understanding of HIV/AIDS in the workplace and creating an enabling and supportive environment for those who are infected and all those living with HIV/AIDS. The workplace policy would address how Ministries of Education provide care and support to teachers and education employees already infected with HIV and propose how to organize and fund measures such as teacher replacement schemes, sick leave benefits, home-based care and more.

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[1] Two of the UNESCO-Nairobi cluster countries, namely, Eritrea and Rwanda were unable to participate in the Mombasa consultation due to unexpected circumstances.

[2] KENEPOTE was formed in 2003 as a network to unite HIV-positive teachers in Kenya in their fight against HIV and AIDS. The organization promotes positive living with the virus to prolong life and ensure continued productivity.

[3] See report of the UNESCO Nairobi Cluster Consultation: HIV/AIDS and the Role of the Education Service Commissions, 16 to 18 June 2003, Kampala, Uganda (http://education.nairobi-unesco.org/).

Opening remarks

3. The Honourable Professor George Saitoti, Kenya Minister for Education, Science and Technology, opened the Mombasa consultation. In his remarks, Professor Saitoti challenged members of the consultation to look hard for sustainable and culturally appropriate ways of addressing HIV/AIDS in the education workplace. He lamented that sub-Saharan Africa has been the hardest hit with Eastern and Southern Africa suffering the most plagued by an ever-growing number of orphans and child-headed households, widespread stigma and discrimination, lack of access to the most basic services and violation of human rights of those infected and affected.

4. Minister Saitoti referred to global estimates that call for US$ 1 billion annually to cover additional costs due to HIV/AIDS including those related to teacher absenteeism, teacher deaths and incentives to keep orphans and other vulnerable children in school. According to projections, he added that Kenya, for example, would lose 1.8% of its teachers annually during the present decade unless deliberate interventions are put in place. Moreover, the cost of providing care and social services to orphans and vulnerable children would require substantial financial resources.

5. The Honourable Minister was encouraged by progress being made in the UNESCO-Nairobi cluster countries to mitigate the spread and threat of HIV/AIDS particularly as it relates to the teaching force. He highlighted the development of relevant policies incorporating HIV/AIDS into establishing staffing norms and in the revision of teaching and learning materials. Specifically, he referred to the Kenya Education Sector Policy on HIV/AIDS which stipulates that all employees in the education sector should enjoy equal rights in terms of employment, promotion and in-service training and professional development. He indicated that the Education Sector Policy on HIV/AIDS focuses on prevention of new infections, care and support for the infected and affected and the management of the response. The sector policy stipulates zero-tolerance of sexual harassment, abuse, exploitation at the education workplace.

6. The Kenya Minister expressed hope that the partnership forged since the inception of the UNESCO-Nairobi cluster approach will continue to flourish. He thanked UNESCO-Nairobi for bringing together the cluster once again and pushing a common agenda of action in the fight against HIV/AIDS in the region.

7. As host of the cluster consultation, Mr. Ibrahim Hussein, Chairman, Kenya Teachers Service Commission (TSC), warmly welcomed participants to Mombasa. The TSC Chairman cautioned against complacency indicating that the little economic gains made over the years were being reversed by the HIV/AIDS epidemic with devastating and far-reaching effects on the education sector. For example, the estimated HIV prevalence rate in Kenya is 7% with about 2.9 million people affected. It is estimated that some 16,450 teachers are infected by the virus.

8. According to the TSC Chairman, the provision of quality education is being affected by HIV/AIDS particularly through increased rates of teacher absenteeism and

loss of learning time. Replacing chronically-sick teachers with relief/substitute teachers is problematic given the freeze on the national teacher wage bill.

9. Dr Susan Nkinyangi, Senior Education Adviser, UNESCO Nairobi Office, welcomed participants on behalf of UNESCO. She said that the UNESCO-Nairobi consultation process on HIV/AIDS started in 2003 and has shown the value of countries coming together to learn from each other and build on the solidarity of each. Working as a cluster is a key dimension of regional integration efforts in development, she said.

10. Through the UNESCO consultations on HIV/AIDS and education and other meetings within cluster countries, strong partnerships have developed. The cluster countries have made tremendous progress in developing and refining their response to HIV/AIDS in and through the education system. Over the past two years, cluster countries have spent time, effort and resources on policy development for HIV/AIDS and education. Given that teachers are central to the functioning and efficiency of education systems, the role of education/teacher service commissions along with that of the teachers' unions has been strategic in this policy formulation.

11. The UNESCO-Nairobi consultation process started in Kigali, Rwanda, in March 2003. In Kigali, the cluster countries agreed on priority areas for action. A second consultation was convened in Kampala, Uganda, in June 2003, specifically for the education/teacher service commissions and the teachers' unions. The Kampala consultation identified four areas to which education/teacher service commissions should give special attention: i) employment policy and regulations; ii) staff protection and prevention programmes; iii) sick leave and absenteeism management; and iv) employee assistance programmes. The third consultation took place in Kigali in May 2005 and served to develop projects for teacher capacity-building in each of the five cluster countries. [UNESCO-Nairobi is funding these capacity-building projects through the respective National Commissions for UNESCO.]

12. In a little more than two years, the cluster countries have succeeded in drafting **education sector policies on HIV/AIDS.** Eritrea, Kenya, Rwanda and Uganda have education polices on HIV/AIDS in place while Burundi is in the final stages of policy formulation. The cluster countries have also embarked on the next important step in preparing education workplace guidelines on HIV/AIDS. These would outline the position of the Ministry of Education as regard to ensuring an equitable approach to the prevention of HIV/AIDS amongst education employees and the management of the consequences of HIV/AIDS including care and support. They would cover education at all levels in formal and non-formal educational settings.

13. The keynote address was to be delivered by Professor Michael Kelly, a well-respected crusader in the fight against HIV/AIDS in the education sector in the region. At the last moment, Professor Kelly was unable to attend the consultation due to

unavoidable circumstances.[4] Dr. Nkinyangi delivered the keynote address on behalf of Professor Kelly.

Keynote address

14. Some twenty-four years ago, the Centers for Disease Control (CDC) in Atlanta, Georgia, USA, published a report about a new disease that was affecting homosexual men. This publication heralded the beginning of the Acquired Immune Deficiency Syndrome - AIDS - era. Since 1981, the medical profession has been confronting this new disease that has grown to nightmarish proportions, with almost every passing year seeing a revision upwards of dire estimates and predictions. The challenge today, according to Professor Kelly, is to put a halt to the obscene growth of this disease, to say to it in forceful action-backed terms: "Thus far and no further."

15. Sadly, global efforts are not succeeding as the epidemic seems to have the upper hand. It is rampaging through new populations and fears are growing that the availability of anti-retroviral (ARV) drugs which block the reproduction of the virus within the body may bred complacency. As global prevalence levels continue to rise, behaviour change programmes have not brought much success. At a special United Nations Ministerial Meeting in New York in early June 2005, the United Nations (UN) Secretary General, Mr Kofi Annan, openly acknowledged that "the world is losing the AIDS fight. HIV and AIDS are expanding at an accelerating rate in every continent. Treatment and prevention efforts are nowhere near enough."

16. At the same UN session, Dr. Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), said that without an exceptional response from the world's leaders and people, the AIDS epidemic would defeat us. He stated that closing the gap between need and action will require urgent and dedicated action along four lines: i) giving AIDS the same level of attention and concern as global security; ii) ensuring universal access to both HIV prevention and treatment; iii) making funds work for people on the ground, especially women; and iv) planning for the long term.

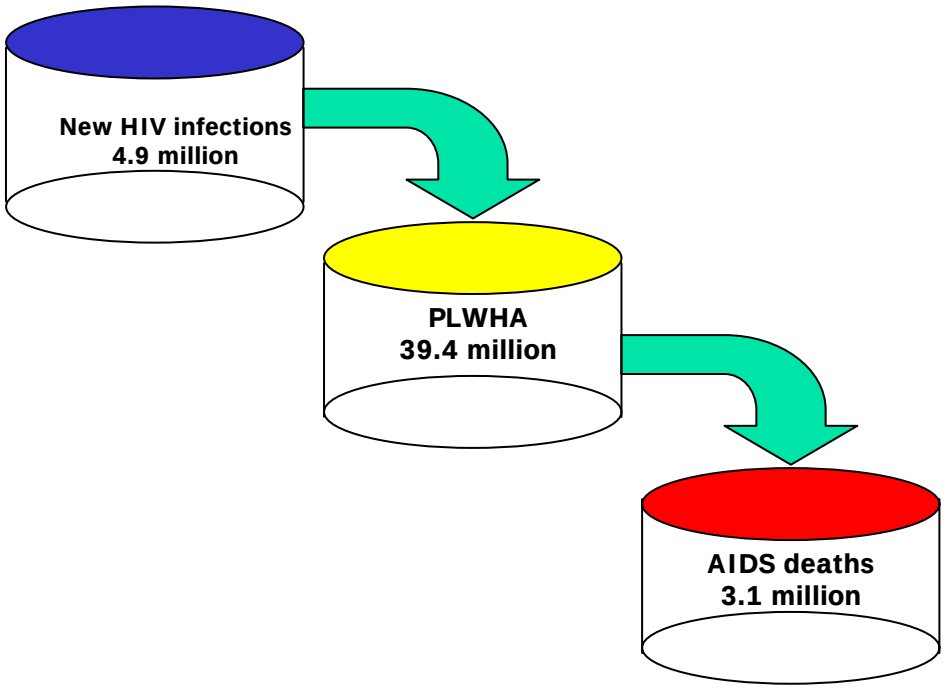
17. By the end of 2004, an estimated 60 million people had become infected with HIV, of whom about 20 million had died. During 2004, an estimated 4.9 million persons became newly-infected, that is, an average of about 13,500 new cases every day or more than nine people every minute. Worldwide, the incidence (the number of new infections in a year) has increased each year since the epidemic began. This is due to the spread of the disease to new populations and its continued proliferation in areas where it is already well-established. Although many deaths have been prevented by the availability of ARV treatment, this has not reached the majority of those in need. Hence, the number of AIDS deaths continues to grow, with an estimated 3.1 million occurring in 2004 alone. About ten times more people died because of AIDS in 2004 than lost their lives in the South-

[4] Professor Barnabas Otaala from the University of Namibia, another leading HIV/AIDS expert in the region, was also expected to facilitate the consultation. Similarly, circumstances prevented his participation.

East Asia tsunami of December 2004. Since there are more new infections than AIDS deaths, the global pool of infected persons grew in 2004 to 39.4 million.

18. Documentation on the impact of HIV and AIDS has expanded. Because of denial and secrecy so frequently associated with the epidemic, it is not always clear whether the impact is due to the disease or to other factors such as poverty, management weaknesses among others. Professor Kelly suggests that HIV/AIDS affects the education sector in ways similar to how it affects the human body. That is to say, it *highlights existing* problem areas (such as areas of weak capacity in the body's immune system/the education system). It *explodes* the *scale* and/or *complexity* of *existing* problems (such as those related to opportunistic infections that attack the body/teacher absenteeism that deteriorates the quality of education provision) and it *creates new* problems (such as stress and depression/psychological difficulties for teachers or learners).

Global HIV Dynamics, 2004



19. Education sector policies and practices can relate to HIV and AIDS in one of three ways: i) they can be favourable to HIV transmission without the relevant authority quite realising this; ii) they can inhibit HIV and AIDS; or iii) they can be irrelevant to HIV and AIDS. In a world with HIV and AIDS, any policy or practice that increases an individual's risk of becoming infected with the virus is questionable. Furthermore, anything that increases the possibility that an infected individual will remain silent and

not seek assistance, is also questionable. It is necessary for Ministries of Education to reflect on two hard questions:

i) Are any aspects of our policies or practices favourable to the transmission of HIV and therefore require examination and possible change with a view to reducing risk?

ii) Do any aspects of our policies or practices aggravate an infected individual's HIV and AIDS status, and if so, what should we do to remedy this situation?

20. Aspects that might be favourable to HIV transmission could include: any practice that places individuals in a position where casual sex is more likely and normal safeguards have not been provided. Such would be the case with teacher postings that entail the separation of spouses for protracted periods of time; salary payment procedures that require teachers to travel away from home for a period of time to collect their salaries; teaching practice arrangements that do not address the need for suitable accommodation; workshop and training activities that provide allowances in comfortable venues, that may lead to risky behaviour on the part of participants. Other common practices and arrangements that may favour the spread of HIV are boarding accommodations at schools, teacher colleges and tertiary institutions and 'token' preventive education. An institution that fails to provide adequately for good quality preventive education can be said to be acting favourably to HIV transmission — as is said so frequently in other circumstances, 'silence means consent'.

21. There are those aspects of a policy or practice that might aggravate an infected individual's HIV and AIDS status and these could include: the way policies have been portrayed making an individual suspicious of them, perceiving them as unfriendly, threatening, or discriminating. An education/teacher service commission needs to be aware that there can be quite a difference between its policies as they are formulated and the way users perceive them. Sensitivity to this possibility is especially crucial in areas dealing with HIV and AIDS to ensure that those affected interpret things in the way they were meant. A sick leave policy, terminal benefits, and equal opportunity policies (for promotion or further training) are areas that are readily subject to misinterpretation and require sound public relations efforts to ensure that they are not perceived as discriminatory or punitive.

22. Education policies or practices can inhibit the HIV and AIDS situation and it is altogether desirable that they do so. It is critically important for an institution to recognise where it is indeed taking action against the epidemic so that it reinforces them. Under such favourable circumstances, the questions become:

i. What aspects of an education policy or practice inhibit the transmission of HIV and therefore should be strengthened and encouraged?

ii. Do any aspects of education policies or practices support the improved health of an infected person, with a slowing down of progression from HIV to AIDS, and if so, what should be done to enhance this situation?

23. An education sector/teacher service commission that has taken its HIV and AIDS role seriously should be able to adduce many possibilities, such as:

- The promotion of an institutional culture that encourages the development of life-affirming attitudes and values, enshrines gender equity in principle and practice, proscribes substance abuse (drunkenness, drug taking), stresses the importance of a healthy life-style (positive living, good nutrition), and shows zero-tolerance for violence, stigma and discrimination.

- Improved education on prevention and life-skills in the workplace and for learners in educational institutions.

- Enhanced teacher ability to act as agents of social change in the areas of HIV/AIDS, sexuality and life-skills. While increased knowledge does not imply that desirable behaviour change will automatically follow, enhanced teacher understanding and skills will be supportive of desirable and safe practices.

- Greater accessibility of protection measures, such as voluntary counselling and testing, user-friendly facilities for the diagnosis and treatment of sexually transmitted infections (STIs), and ARV drugs. Provision of these is not the responsibility of the TSC itself, but policies should promote access to them, and practice should work with partners to ensure that they are more readily available and easily accessible.

- Improved teacher conditions: these not only help to improve the classroom motivation of teachers but also provide further motivation to keep HIV-free. Improved conditions also help teachers adopt an improved life-style, specifically in the area of nutrition, something that can offer some protection against initial HIV infection and prolong the period of progression to AIDS, should infection have occurred.

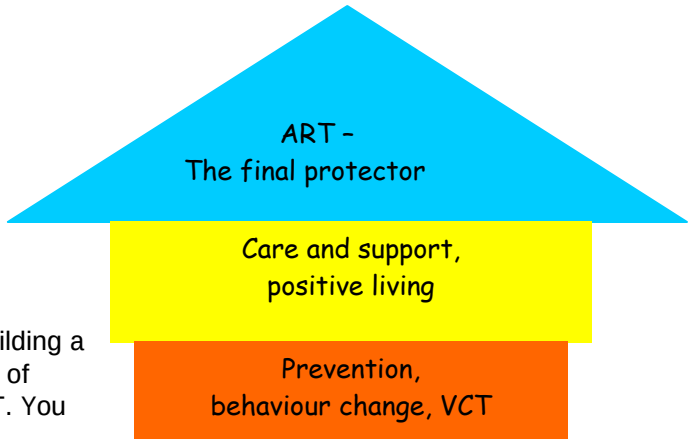
- Explicit, well-disseminated and implemented code of conduct: codes of conduct that have been reviewed to take into account the challenges of HIV and AIDS clarify the boundaries of acceptable behaviour and thereby promote behaviour that falls within approved limits. The preferred approach to such codes is to see them as formative and not simply negatively prescriptive.

24. To date, the greatest global breakthrough in responding to AIDS has been the development of ARV drugs. The dramatic transformation flowing from ARV treatment is aptly referred to as ‘the Lazarus effect’ because it signals an almost miraculous improvement in health and well-being. Nevertheless, ARV treatment is not a silver bullet for solving the HIV/AIDS problem. Adherence to an ARV regime will prevent HIV from developing into AIDS, but will not cure the infection. ARV adherence is the difference

between life and death. It must last through life and may have troublesome and sometimes serious side effects. [5]

25. ARV treatment should come towards the end of a comprehensive range of interventions. These extend from voluntary counselling and testing (VCT), through the treatment of opportunistic infections, to a number of social support activities (such as the development of social safety nets and the clarification of legal issues for ownership and inheritance purposes), and finally to ART itself. Attention is required throughout to improve nutrition and reduce stigma and discrimination. The complete process is like building a house. One starts with the foundation of prevention, behavioural change programmes and VCT. On this foundation one builds the walls of positive living, which include good nutrition and prompt treatment of common and opportunistic illnesses. Finally, one ends with the roof of ART. No builder would ever try to put the roof on a house until the foundation and walls were soundly in place. Likewise, apart from emergency cases where an individual may be at a very advanced stage of AIDS, much should be in place in advance of the provision of ART.

How prevention, care and support, and treatment relate to one another



Responding to HIV and AIDS is like building a house. You start with the **foundation** of prevention, behaviour change and VCT. You build the **walls** of positive living.
You end up with the **roof** of ART.

Source: Alex Coutinho, Director of TASO, Uganda

26. The education/teacher service commission does not have the role of providing health care. It can, however, facilitate a teacher's access to such care, including ART. How this can happen depends on arrangements in each country. In adopting its own stance, an education/teacher service commission might well look at the costs (other than

[5] General side effects may include: reactions in vital organs like the liver, kidney, pancreas, blood cells. Patients may experience skin rashes, nausea and vomiting, numbness of extremities and unequal fat distribution.

the cost of the ARV drugs) that an ART regimen might imply. Such costs would be those for VCT, medical visits, laboratory analyses, transport costs arising from regular visits to a clinic etc.[6]

27. ART also poses a challenge for an education/teacher service commission in the way it may put an additional constraint on the posting of teachers. Is it always possible to post an infected teacher within easy reach of ART services? If obliged to do so, the education/teacher service commission may encounter two problems: i) understaffed schools in areas where ART is not readily accessible; and ii) over-staffed schools in the proximity of clinics offering ART services. An education/teacher service commission must also consider the way ART raises certain practical teacher and school issues. At the teacher level there is the question whether a teacher's time spent on routine ART clinic visits is regarded as unavoidable absenteeism that does not carry any sanction or loss of benefit. While there could be a clear policy that this is so, there could be subtle forms of discrimination in the field if school heads or teachers manifest resentment at the repeated absence of a colleague.[7]

28. At the school level, one must ask what happens to the classes of a teacher who spends time on clinic visits and, even more, what happens if there are several teachers in a school who must make such visits. Because such visits occur on a fairly regular basis, they can be planned for. Hence, it might be necessary for an education/teacher service commission to write into its regulations the expectation that teachers who know that they will miss classes because of clinic visits should plan for such an eventuality and assign work to be done in their absence.

29. Finally, maintaining the number of teachers required by a school system has always been a problem for the education/teacher service commission. The AIDS epidemic aggravates this problem. First, it leads to an increase in teacher mortality. The extent of this increase depends greatly on the HIV prevalence levels in a country, the extent to which teachers are infected, and the extent to which they have recourse to ART. In many situations information on these factors is lacking. Hence, the following questions:

- Is there good data on AIDS-related teacher mortality?
- Are teacher numbers adequate to meet Education For All (EFA) and Millennium Development Goals (MDG)?
- Have International Monetary Fund (IMF) and other conditionalities resulted in a freeze on the employment/remuneration of teachers?

[6] In Zambia, for example the Ministry of Education has agreed that it will bear the basic costs of registration and clinical visits for every HIV-positive teacher who must go on to ART, though this benefit extends only to registered teachers and not to their spouses or members of their families.

[7] Some education ministries (and other public service areas) have the practice of allowing female employees one free day every month in response to the needs of their monthly cycle. One might ask whether a TSC might be well-advised to build something similar into its practices in response to the ART needs of many of its employees.

- What can the TSC do to provide replacements for chronically-ill or dead teachers?
- Are conditions good enough to attract promising candidates into teaching?
- Are there other mechanisms for teacher recruitment that could be employed, say the use of relief/substitute teachers?
- Is there provision for relief/substitute teachers? If so, does this extend across the country?

Updates from the Education/Teacher Service Commissions

30. The Secretary/Chief Executive of the Kenya TSC, Mr. Gabriel K. Lengoiboni, provided an overview of the HIV/AIDS pandemic in his country. He indicated that the Kenya government established the National AIDS and STDs (Sexually Transmitted Diseases) Control Programme (NASCOP). This programme was set up to create public awareness, to strengthen laboratory services for HIV testing, to collect data and information, and to train health workers on the management of HIV/AIDS and STIs. Mr. Lengoiboni referred to the major accomplishments to date as: 95% awareness of the disease among the general population; 99% blood safety guaranteed; reduction of STIs prevalence from 9% to 1%; and the establishment of a comprehensive national surveillance system. In 1999, the government created the National AIDS Control Council (NACC) to mobilize and coordinate resources and activities to fight HIV/AIDS. AIDS Control Units (ACUs) have been established in line ministries and key institutions such as the TSC.

31. While updating the consultation on activities and programmes in Kenya, the TSC Secretary said that sensitization workshops for employees had been conducted on HIV and AIDS and these have covered key areas including: facts about HIV/AIDS, modes of transmission, signs and symptoms of the disease, coping mechanisms including nutrition among others. A series of capacity-building workshops have also been conducted on the management of HIV and AIDS at the workplace. A guidance and counseling programme is in place at the TSC Headquarters in Nairobi and a training workshop for trainer of trainers has been conduced on the management of HIV/AIDS.

32. Speaking more on gains since the Kampala consultation in June 2003, Lengoiboni said that 95% of the TSC Headquarters employees have been sensitized on HIV/AIDS. TSC Commissioners, senior management, provincial directors of education and district education officers have similarly participated in capacity-building workshops on the management of HIV/AIDS at the workplace. TSC District Staffing Officers (DSOs) have been trained on the management of HIV/AIDS at the workplace and each of the districts in the country now has a sub-ACU that is managed by the DSO and the District Human Resource Officer (DHRO) both of whom are in daily contact with headteachers and classroom teachers in their districts. The TSC has engaged two professional counselors within its ACU and has also trained ‘peer leaders’ at the TSC Headquarters to provide guidance to their colleagues on HIV/AIDS issues. Information, education and communication materials (IEC) have been disseminated to most of the TSC District Units across the country. An innovative way of HIV/AIDS sensitization has been the posting of

messages and key information on the monthly pay slips of all teachers and other TSC employees. TSC is also in the process if producing a bi-annual magazine on HIV/AIDS for distribution to all schools. Lastly, the TSC actively participated in the development of the Kenya Public Sector Policy on HIV/AIDS at the Workplace and the National HIV and AIDS Strategic Plan for 2005-2010.

33. Among the challenges facing the TSC in Kenya are slow changes in behaviour and attitudes despite sensitization workshops compounded by strong cultural and individual beliefs. As result, stigma and discrimination are still prevalent at the workplace. Further, there is the lack of up-to-date information on the impact of HIV and AIDS at the workplace and this makes it difficult to plan for specific interventions that may be required. There are financial constraints that have made it difficult to run programmes that can reach all the 240,000 teachers employed by the TSC countrywide. A major problem of the TSC is teacher absenteeism associated with chronic opportunistic infections. Since many teachers still fear to disclose their HIV-status, the TSC may be forced to interdict and apply disciplinary measures when a teacher absconds from duty without appropriate justification.

34. The Deputy Chairperson of the Uganda Education Service Commission (ESC), Mr. Matthew Okot-Garimoi, provided an update on activities of the ESC[8] in pursuance of the recommendations of the Kampala consultation. First, he informed participants that the Government of Uganda has a National Strategic Framework for HIV/AIDS that serves as a guiding document to all stakeholders in the fight against HIV/AIDS.[9] Second, Mr. Okot-Garimoi indicated that HIV/AIDS ranks fourth among the leading causes of mortality and morbidity with the adult prevalence rate estimated at 5% (as compared to 18% in 1990). Over 120,000 new AIDS cased are reported annually. An estimated 800,000 people are living with HIV in Uganda today.

35. The ESC participated in the preparation of the Uganda Education Sector Policy on HIV/AIDS and the development of public service guidelines for public officers on accessing HIV/AIDS care, treatment and support. The public service guidelines are now in force and have called for the appointment within the ESC of an HIV/AIDS Focal Officer. Further, the ESC has participated in the review of the (draft) HIV/AIDS Policy for the Public Service which is now operational across the public service.

36. The ESC has embarked on the process of development of the Education Service HIV/AIDS workplace policy guidelines. This covers the prevention of the spread of HIV/AIDS in the education service, promotion of care and support for affected learners and teachers; and sustaining the quality of education provision in the country. The guidelines are contributing to the on-going review of the Government of Uganda's

[8] The ESC is responsible for 65% of the teaching workforce including primary, secondary and tertiary level teachers and those responsible for departmental training.
[9] The Uganda National Strategic Framework for HIV/AIDS has these objectives: to reduce the HIV/AIDS prevalence by 25%; to mitigate the effect of HIV/AIDS; and to strengthen national capacity to respond to the epidemic.

Standing Orders with reference to education sector personnel and HIV/AIDS intervention measures.

37. The ESC has developed and forwarded to the Uganda AIDS Commission a project for the sensitization of ESC Commission members, staff and members of teachers' associations. This was favorably received and start-up funding was provided to the ESC. These funds have been used to sensitize all ESC Commission members and staff.

38. Among the challenges faced are the problems associated with identifying education personnel infected and affected with HIV/AIDS and, as in Kenya, this complicates the planning of appropriate intervention measures. In large part, this is attributed to the stigma associated with HIV/AIDS. Finally, financial resource limitations are curtailing the ESC's efforts to implement its HIV/AIDS programmes and activities.

39. As for the way forward, the ESC plans to sensitize all executives of the teachers' associations, teachers' unions and district service commissions. The ESC intends to review the teachers' professional code of conduct with a view to incorporating concerns arising from HIV/AIDS. It plans to carry out a study on the possible strategies to address teacher absenteeism and effectiveness. It will complete the workplace policy guidelines on HIV/AIDS and mainstream HIV/AIDS issues in ESC policies, regulations and programmes.

40. Mr. Aloys Ndemeye, Secretary-General of the Burundi National Commission for UNESCO, briefed members of the consultation on the situation in his country. Although epidemiological studies specific to the education sector are lacking, socio-behavioral studies indicate that risk factors are prevalent among learners and educators. A study (conducted in 2000) showed a debut of sexual relations among youth occurring well before the 15th birthday. HIV/AIDS has become the principle cause of death in the country among youth and adults with an estimated prevalence rate of 8.3% among the adult population. Moreover, the number of teacher deaths and the increasing number of orphans attest to the impact of HIV/AIDS on the education sector. The position now is that the entire teaching force must be mobilized to change risky behaviors and to take safe preventive measures.

41. ACUs have been set up in each of the line ministries and at provincial level. These are involved in capacity-building, prevention, care and support involving people living with HIV/AIDS. Although condoms are not distributed in the schools, their use is discussed with teachers and parents and they are readily available in the community. VCT is free and adults with a high HIV viral load and low CD4 count are eligible for free ARV treatment, when appropriate.

42. In terms of the education sector policy on HIV/AIDS, work is being carried out on the draft which is expected to be finalized shortly with stakeholder groups. The importance of the Burundi education sector policy on HIV/AIDS is underscored by the proportion of the population that it covers. Of a total population of 6.8 million, the

education sector encompasses 1.5 million in its service and learning institutions. HIV/AIDS has been on the increase in both rural and urban areas. Teachers generally fall within the 15 to 44 year age group which also is the age group with the highest HIV sero-positive prevalence rates.

Perspectives from Teachers' Unions

43. Representatives of teachers' unions were given the opportunity to report on union activities further to the Kampala recommendations. Mr. Richard Etonu, Coordinator, Uganda National Teachers' Union, launched the discussion. He informed participants that his union has been closely involved in the consultations on the Education Sector Policy on HIV/AIDS and on the workplace guidelines on HIV/AIDS for the education sector personnel. One of the biggest hurdles yet to over come in Uganda, according to the union leader, is for teachers to accept disclosure of their HIV-status. Generally speaking, teachers are failing to be open fearing job insecurity. Many are afraid, avoid counseling, and hence, treatment, if necessary. There is need to build confidence and assure teachers that the Ministry will by all means possible ensure that no prejudice or discrimination occurs against an employee on account of HIV-status.

44. There is need for strengthening partnership especially with non-governmental organizations (NGO's) and other civil society groups. For example, World Vision has been active on workplace issues in Uganda. Teachers tend to go through the NGOs when they are entering into a desperate stage. Partnerships with these other groups will ease the work of the teachers' unions. Nonetheless, it is possible that teachers will disclose and come out voluntarily if they are assured of getting support without discrimination.

45. Uganda, like other countries in the region, is struggling to assure quality of education. Provision of universal primary education (UPE), teacher absenteeism and deaths are affecting quality of service. Shortly, headteachers will be subject to performance contracts. In light of this arrangement, many headteachers are getting threatened and some do not want to allow sick teachers in their schools because they fear that the chronically sick teacher will hamper learning and school performance. This example further underscores the need for workplace policy guidelines on HIV/AIDS that ensure compliance with fair labour practices.

46. Teachers also need support and guidance on how to deal with traumatized children. For example, a teacher had asked a boy a question relating to his parents. Both his parents were dead and the child stopped talking all together. The teachers' union must have the capacity to help teachers confront such issues affecting the well-being of their learners.

47. In his remarks, Mr. Francis M. Ng'ang'a, Secretary-General of the Kenya Union of Teachers (KNUT) deplored that the greatest number of those suffering form HIV-related sickness were in sub-Saharan Africa which is also plagued by other diseases and widespread poverty. Mr. Ng'ang'a said that we must prioritize our goals to counter the pandemic as it stands to destroy what has been achieved since independence. We must

not lose site of the key role that teachers play as they interact with children especially those under 15 years of age who are our 'window of hope'. Yet HIV/AIDS has increased the number of teacher deaths with no replacement in sight. There is increased teacher absenteeism and teachers' workload has also increased. Absent teachers raise the teacher/pupil ratio as fellow teachers step in for absent colleagues.

48. The KNUT has realized that the only way to fight HIV/AIDS is through close collaboration with the education sector, other government ministries and NGOs. KNUT has taken the following steps:

i.) Involvement of the TSC and the Ministry of Education, Science and Technology in the KNUT's HIV/AIDS programme.

ii.) Active participation in the development of the Education Sector Policy on HIV/AIDS and an active role in its dissemination.

iii.) Through a consultative forum, the KNUT has developed draft policy guidelines on HIV/AIDS and these will be used to ensure that HIV/AIDS measures are developed and put into place for the benefit of teachers affected and those living with HIV/AIDS.

iv.) The KNUT has established an ACU at its Head Office and plans are underway to establish sub-ACUs at the branch level once the KNUT's workplace policy guidelines are finalized. [This should ensure that every branch is actively involved in the campaign.]

49. The main role of the KNUT-ACU is to coordinate activities which include: management of HIV/AIDS education programmes, development and dissemination of education, information and communication (IEC) materials, creation of partnerships and an HIV/AIDS network. The ACU has put into place prevention, treatment and access programmes with the support of the American Federation of Teachers (AFT) and USAID-Kenya. These target prevention of the spread of HIV infection amongst teachers through a peer-based education programme known as 'study circle' which advocates for the use of condoms. [Condoms are distributed during training and at KNUT branch meetings.].

50. In close collaboration with UNESCO, KNUT has been distributing the Education Sector Policy on HIV/AIDS to teachers during peer education and branch meetings. The Chairman stressed that the extensive communication structure of the KNUT is an important avenue to reach and sensitize as many teachers as possible on the Education Sector Policy on HIV/AIDS.

51. The KNUT is also working on care and support through its networking and linkages with NGOs involved in various aspects of HIV/AIDS including quick referral of

members to VCT services. Finally, through the help of Education International (EI)[10], KNUT has been working to mainstream HIV/AIDS in school activities through the use of the World Health Organization (WHO) exercise book for 'study circle' members and classroom use.

52. Mr. Ng'ang'a referred to salient achievements of KNUT since the Kampala cluster consultation. These include: i) the development of a comprehensive teacher training kit with a manual for teachers and the WHO HIV/AIDS exercise book for learners; ii) HIV/AIDS training in seven pilot districts -- Kisumu, Nakuru, Mombasa, Meru, Nairobi, Kakamega, Busia; iii) training of more than 270 school heads and principals and 28 district 'Master Trainers'; iv) participation of some 600 teachers in 15 'study circle' sessions; and v) sensitization of some 1,000 teacher trainees in the teacher training colleges. Since January 2005, KNUT has been encouraging a 30 to 40-minute HIV/AIDS sensitization session during all its regular branch meetings. Through these sessions on HIV/AIDS, some 25,000 teachers have been reached.

53. On the way forward, the KNUT intends to continue its dissemination of the Education Sector Policy on HIV/AIDS to ensure that all teachers and school heads are informed on the scope of its application, rights and responsibilities and so on. The KNUT will also complete its draft policy guidelines on HIV/AIDS at the workplace. It will enhance and expand its Parent Teacher Association (PTA) programme in the seven pilot districts in addition to some other districts -- Malindi, Machakos, Kericho, Uasi Gishu, Kirinyaga and slum schools in Nairobi) during the next twelve months. It will further develop proposals and linkages with the government and other partners to raise more funds to be able to reach its other 64 branches. The KNUT will also work to develop its own capacity to handle the demand imposed by the pandemic.

54. The challenges are many, according to the KNUT Chairman. First, there is the coordination of HIV/AIDS-related programmes with stakeholders in the Ministry of Education, TSC and the Ministry of Health. Admittedly, the dissemination and implementation of the Education Sector Policy on HIV/AIDS has been slow. There is need to revise the Code of Regulation for teachers in line with emerging issues including teacher posting, redeployment with balancing, pension and medical schemes. There is also a shortage of Ministry of Health staff in hospitals to deal with HIV/AIDS related illnesses and a lack of staff available for HIV/AIDS sensitization and prevention education.

55. The KNUT has over 200,000 members in its seventy branches and so far only 1,000 of them have been reached with intensive HIV prevention programmes. Yet rolling out prevention education to all members is still beyond reach. KNUT has been unable to assure ready access to services for care, support and treatment of its members. Partnerships must be expanded especially to those offering treatment suitable to teachers' situations while maintaining confidentiality and dignity. The greatest challenge, however,

[10] Education International (EI) represents more than 29 million teachers and education workers. It has 348 member organizations that operate in 166 countries, from pre-school to university. It is the world's largest Global Union Federation, and the only one representing education workers in every corner of the globe.

is the sustainability of HIV/AIDS programmes in a way that quality services are offered by different bodies especially in the area of ARV treatment.

56. Ms. Laurence Jisho, Union Leader from Burundi, indicated that education sector personnel in her country are grouped into five unions.[11] Each of these unions has prioritized HIV/AIDS. Among the accomplishments are: i) a plan of action including capacity-building for trainers in pedagogy and counseling; ii) organization of information sessions for union members where specialists are invited to speak on topics and carry out workshops for teachers; iii) production of educational radio programmes to disseminate HIV/AIDS information and prevention education;[12] iv) organization of activities to motivate teachers to contribute to the teachers' solidarity fund that covers treatment and other costs incurred by infected teachers (this is also being used to encourage teachers to be open and disclose their HIV-status); v) training for 'master teachers' in primary and secondary schools and STOP-SIDA clubs in schools; vi) validation of a code of ethics as regard HIV/AIDS that has recently been developed; and vii) negotiation of fair labour practices in collaboration with the Ministry of Education.

57. The Burundi teachers' unions face a number of challenges. One is the integration of HIV prevention into competency-based life skills education in schools and into pre and in-service training programmes. Generally, teachers have been neglected as targets of HIV-prevention education, care and support. Many are infected and affected and more support is desperately needed. The teachers' solidarity fund is one measure that has been taken to address this. There is still the fear that teachers on prolonged sick leave will be terminated from service. Although HIV/AIDS is part of the overall public service policy, Burundi union leaders are reticent and are appealing for a sectoral policy to protect teachers and education employees living with HIV and AIDS. Lastly, there are many social, cultural and religious beliefs that need to be addressed to fight the pandemic.

58. The three main lines of action for the unions in Burundi are: prevention, care for the infected and affected, and building the capacity of educational institutions. In the area of prevention, there are both short and long term needs. In the short term, it is necessary to: i) produce teaching-learning materials for use by the five unions; ii) assess the impact of HIV/AIDS on the education sector; iii) train some 4,000 primary and secondary school teachers; iv) sensitize university students and personnel for behaviour change; and v) facilitate access to condoms for educational personnel. Prevention in the longer-term would cover: i) integration of life skills into the initial training of all teachers; and ii) establishing counseling services in schools to encourage VCT. Under care and support, short term actions include: i) sensitizing teachers to create a fund for ARV treatment; and ii) good management of sick leave and reduction in the workload of infected teachers. Longer term actions cover: i) creation of a budget line to support HIV infected teachers

[11] The five unions in the education sector of Burundi are: STUB (*Syndicat des Travailleurs de l'Université du Burundi*), CONAPES (*Conseil National du Personnel de l'Enseignement Secondaire*), STEB (*Syndicat des Travailleurs de l'Enseignement du Burundi*), SLEB (*Syndicat Libre des Enseignants du Burundi*), and SYNAPEP (*Syndicat National du Personnel de l'Enseignement Primaire*).

[12] Further to these educational radio broadcasts, teachers have created an association of teachers like the *'Association Educateur Enseignant – STOP-SIDA'* which is registered and functioning.

and those living with AIDS; and ii) mobilization of partners to support infected and affected teachers.

59. Finally, actions to build capacity in the short term would: i) establish school committees to fight HIV/AIDS; ii) reinforce teacher union structures relating to HIV/AIDS; iii) finalize the education sector policy on HIV/AIDS and disseminate it to all teachers and employees in the sector. Looking further ahead, it will be necessary to find mechanisms for the replacement of sick teachers.

Views from an association of HIV-positive teachers

60. Ms. Margaret Wambete, Chairperson, Kenya Association of Positive Teachers (KENEPOTE)[13], gave an uplifting and heart-warming presentation. It is stigma and discrimination, said Ms Wambete, "from all quarters – the students, the parents, the church and colleagues alike – that kill teachers faster than HIV and AIDS. If we do not kill denial, self-stigma, stigma and discrimination even ART will be null and void." Ms. Wambete spoke vividly of students who refuse to take instruction from an HIV-positive teacher. Some (students) do not want to hand their books to the teacher for fear of contamination. Some say, "Good morning, teacher virus." Some parents withdraw their children from classes and recommend that the HIV-positive teacher to be transferred to another school far away. The headteacher also reject you, said Ms Wambete. He/she says, "look at yourself, you look like a scare crow." The HIV-positive teacher is also stripped of her/his position in the church. People start 'over-loving' you for what you own. They say that they will take care of your children.

61. Ms Elsa Ouko, Executive Director, KENEPOTE, reported that her association aims to: i) intensify its lobbying for the protection of the rights of teachers living with HIV/AIDS through support groups across the country; ii) reduce stigma and discrimination within the education system and elsewhere; and iii) inspire HIV and AIDS positive teachers to know their status and be aware that they have a network to support them. KENEPOTE collaborates with all concerned stakeholders including the Ministry of Education, TSC, KNUT, Kenya Union of Post-Primary Education Teachers (KUPPET), Members of Parliament and development partners such as USAID through its POLICY project and the AFT. Ms. Ouko emphasized working with HIV positive teachers as a way of stemming the spread of AIDS. She also remarked that the AIDS Coordinating Unit at the Kenya TSC has been particularly helpful when working with HIV positive teachers

62. Ms. Ouko appealed to the TSC and other partners to offer a more conducive workplace for HIV-positive teachers and consider key concerns such as teacher transfers to convenient locations, reducing teacher workload in cases of chronic illness, providing rules to protect teachers, and observing rights. The participation of members of KENEPOTE in the Mombasa consultation was an inspiration and a sign of hope for a more tolerant and caring education workplace.

[13] KENPOTE has grown in membership to 1,500 HIV-positive teachers from nursery to university. Its members come from across the country and are living positively with HIV/AIDS.

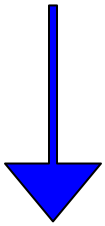
Workplace policies on HIV/AIDS

63. A key recommendation of the Kampala consultation was the need to formulate workplace policy guidelines on HIV/AIDS for the education sector. It is well-accepted that HIV/AIDS is a workplace issue. Conditions at the workplace must be healthy and minimize the risk of HIV transmission by taking the necessary infection control measures. Further, the workplace must assure safety with zero-tolerance for sexual harassment, abuse and exploitation. There should be no discrimination against employees on the basis of real or perceived HIV status. Those living with HIV/AIDS and those perceived to be HIV positive should be protected from discrimination and stigmatization at the workplace.

64. The Chairman of the Kenya TSC briefed participants on the development of the Kenya Public Sector Workplace Policy on HIV/AIDS that was submitted to Cabinet and approved in April 2005. This overarching policy covers all employees of the public service including teachers. The two Kenya policy documents -- the Education Sector Policy on HIV/AIDS and the Public Sector Workplace Policy on HIV/AIDS – will now be used to develop workplace guidelines for the education sector. These guidelines would stipulate rights and responsibilities, affirmative action and non-discrimination and discipline procedures, etc.

Kenya Public Sector Workplace Policy on HIV/AIDS

Kenya Education Sector Policy on HIV/AIDS



Education sector workplace guidelines on HIV/AIDS

- ***Rights and responsibilities***
- ***Affirmative action***
- ***Discipline***

65. The Uganda Commissioner for Secondary Education and HIV/AIDS Education Sector Coordinator, Mr. Yusuf Nsubuga, presented the education sector draft workplace policy on HIV/AIDS that is being discussed with stakeholders. This will be submitted to the Public Service for integration into the Public Service Policy on HIV/AIDS at the Workplace. The draft covers general principles of non-discrimination observing that HIV infection and AIDS should be treated like any other serious illness that may affect employees, confidentiality, and the right to privacy. However, in line with the philosophy of openness, employees should be encouraged to be open about their HIV/AIDS status.

The draft policy covers the promotion of a non-discriminating workplace environment to ensure that no prejudice or discrimination take place against any employee on account of his/her HIV status. It rejects HIV testing as a prerequisite for recruitment, access to training or promotion. However, it does promote access to voluntary confidential testing and counseling for all employees. It stipulates conditions relating to the capacity to perform, reduced workload and alternative suitable employment, early termination of employment and retirement on medical grounds.

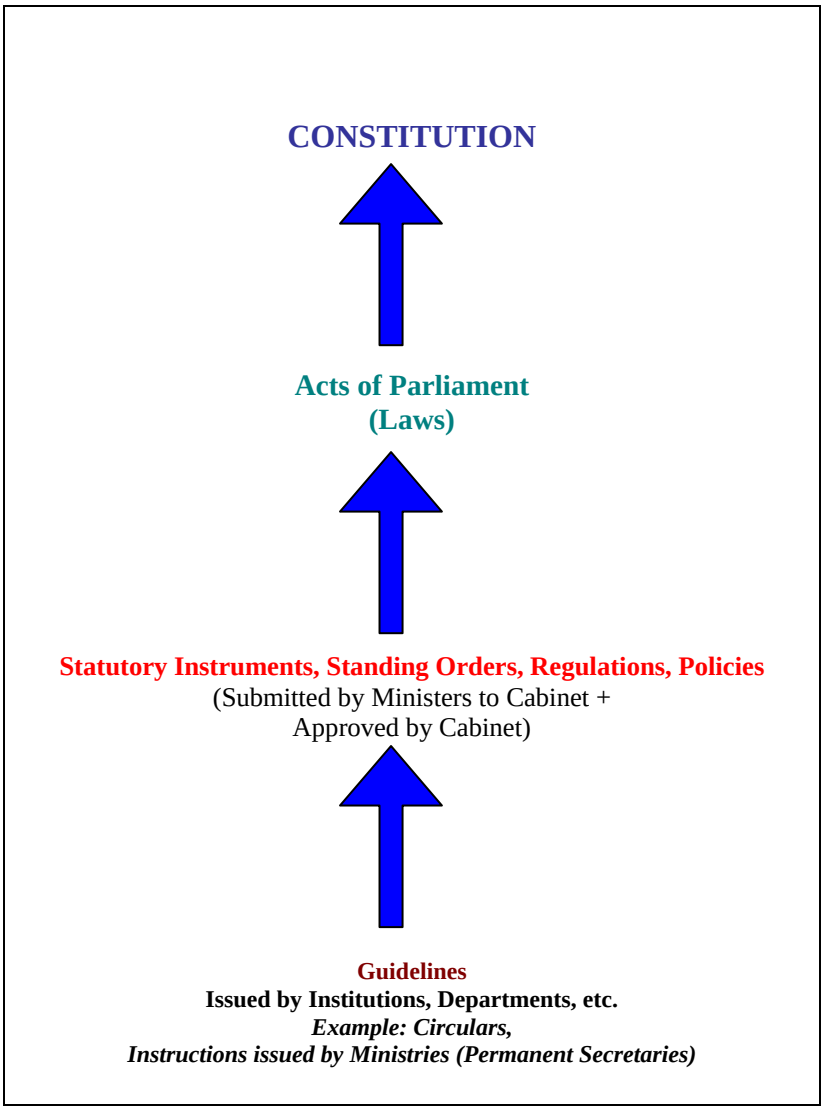
66. The draft workplace policy document also covers discipline and grievance procedures with these taking into account the confidential nature of the HIV-positive status of an aggrieved employee. The draft discusses health promotion covering topics of prevention awareness and education, support and care, ARV therapy[14], wellness programmes including positive lifestyles, nutritional programmes, regular medical check-ups, psychosocial support, home-based care, and legal advice for HIV/AIDS positive employees and eligibility.[15] The final section deals with the management of risk through creating a safe environment at the workplace, post-exposure prophylaxis, responsibilities of the employer and employees, organizational arrangements, implementation and monitoring.

67. The Uganda workplace document has been drafted using a highly consultative process. According to the Commissioner for Secondary Education, "we are building the boat as we sail."

68. The Mombasa consultation had a lively discussion on the difference between a workplace policy and workplace guidelines on HIV/AIDS. It was generally agreed that the term 'policy' has been over-used and generalized. There was a growing sense among concerned parties that too many policies on HIV/AIDS concerning the education sector will be counter-productive, perhaps confusing and possibly contradictory.

69. It was agreed at the Mombasa consultation that our objective should be to elaborate workplace guidelines for the education sector. These would be inspired by the prevailing public service/sector workplace policy on HIV/AIDS and 'customized' to the needs of teachers, education employees and the education sector. The following was used to illustrate the various stages in policy formulation, Acts of Parliament (Laws) and Constitutional review.

[14] There is an overall public service policy on anti-retroviral therapy concerning ARV treatment for public officers. The education sector is expected to adhere to the prevailing ARV policy for the public service.
[15] Eligibility for prescribed services, including ART for all HIV positive employees would include, if funds permit, members of the immediate family with children up to the age of 18 years.



Policy to practice

71. The Mombasa consultation considered the urgency of taking policy (even those in the protracted process of development) to practice. In this regard, UNESCO-Nairobi has funded the drafting of a generic training kit to support stakeholders and the education sector in the five cluster countries to bridge the HIV and AIDS policy-to-practice divide. The training kit is premised on the need to address the multiple challenges inherent in translating policy-to-practice. Given that most cluster countries have finalized their education sector policy on HIV/AIDS, the generic kit could be useful for the training of education sector trainers with view to enhancing the capacity of those responsible for implementing the country's sector policy on HIV/AIDS.

72. Ms. Rose Smart, a consultant with wide experience in policy and practice, has been working on the draft training kit. This was shared at the Mombasa consultation. Participants spent time in groups reviewing the various sections of the kit and critiquing them. Overall, participants concluded that it was a potentially worthwhile and valuable tool. Detailed comments and suggestions were made and these will be incorporated into the next draft of the training kit. It was agreed that after the suggestions of the Mombasa consultation have been incorporated, the draft training kit would be produced in English and French and sent to the Secretaries-General of the five UNESCO National Commissions in the cluster. UNESCO-Nairobi will draw up a small contract with each of the National Commissions to facilitate the organization of a two-day stakeholders' in-country review workshop. In this way, the five cluster countries can contribute to the final elaboration of the generic training kit.

73. The Permanent Secretary, Kenya Ministry of Education, Science and Technology, Professor Karega Mutahi, presided over the closure of the consultation. He called upon the Honourable Assistant Minister for Public Health, Dr. Mohamed Abdi Kuti, to deliver the closing statement. The Honorable Minister said that HIV/AIDS is more than a serious threat to social and economic development, it is a threat to our very existence. The education sector has not been spared with its high mortality rates among educators and the increasing number of orphans. In Kenya, the HIV/AIDS infection rate stands at around 2.9 million people with the age bracket between 15 to 49 years being the hardest hit. In this regard, the Government of Kenya has undertaken several measures to address the issue of HIV/AIDS. Prevention of new infections is a priority and the government has scaled-up its campaign for VCT as a key intervention in the infection prevention strategy.

74. Increasing availability and access to counseling and testing are central to combating the spread of HIV/AIDS and behaviour change. Individuals who test negative should be motivated to safely guard their zero-status while those who test positive can be advised on how to protect others from infection. Infected individuals can be put on ARV treatment, where and when appropriate, and live normal lives for years. The Honorable Minister was pleased to report that Kenya has developed a national ARV treatment programme which aims at professionally delivering effectively ARVs to 50% of those who need treatment by the end of 2005 and to 75% by 2010. The second control measure is the use of condoms for the prevention of HIV and other STDs. The Kenya government is also expanding prevention of mother to child transmission of HIV and this service is currently being provided in about 400 antenatal clinics across the country. There will also be continued focus on behaviour change communication and it is hoped that by promoting abstinence the number of young teens engaging in sexual practices will be reduced.

75. For those already infected and affected by HIV/AIDS, the Honourable Minister said that the government will improve the availability and access to treatment, care and support while scaling up home-based care services. The government is committed to fight stigma and discrimination through encouraging citizens to: i) establish their sero-status through voluntary testing and adopting self-disclosure when one tests positive; ii)

disseminate information on HIV/AIDS in strategic places; and iii) go public on the cause of death at burials.

76. The Honourable Minster thanked participants for their contribution and assured them of the full support of the Kenya government. He expressed appreciation to UNESCO-Nairobi for its continued support in the education sector and cluster countries.

Recommendations on the way forward

77. The following recommendations on the way forward were made at the Fourth UNESCO Nairobi Cluster Consultation convened in Mombasa, Kenya, from 21 to 23 June 2005:

1) Countries in the UNESCO-Nairobi cluster will undertake to develop operational guidelines for the education workplace on HIV/AIDS and these would be derived from the Public Sector/Service Workplace Policy on HIV/AIDS and the Education Sector Policy on HIV/AIDS. Preparation of the guidelines will be done in close collaboration with teachers' unions and other education stakeholders. The workplace guidelines would be disseminated through the existing structures within the education/teacher service commissions, ministries of education and teachers' unions and shared among the cluster countries.

2) The education/teacher service commissions will identify and forward to the relevant authorities in government specific provisions within the context of HIV/AIDS that require review and have financial implications (such as sick leave, relief teachers, early retirement on medical grounds, HIV-testing etc.) for incorporation within the existing legal framework of the country.

3) The education/teacher service commissions and teachers' unions and other education stakeholders will continue to develop and enhance programmes and activities for the implementation of the HIV/AIDS policies in the education sector.

4) Under the auspices of the UNESCO National Commissions in the five cluster countries (Burundi, Eritrea, Kenya, Rwanda, Uganda) and in collaboration with key stakeholders, in-country reviews of the generic training kit – "Policy to Practice" will be organized to further enrich the document and contribute to its finalization. [The generic training kit will be published and disseminated in both English and French.]

5) Through support from UNESCO's International Institute for Educational Planning (IIEP), research will be undertaken on the cost of teacher absenteeism and financing of relief/substitute teachers.

6) The teachers' unions are encouraged to develop operational guidelines on HIV/AIDS at the workplace for their members and employees and these should be shared with other teachers' unions and stakeholders in the cluster.

7) UNESCO-Nairobi should collect and share relevant HIV/AIDS and education policy documents, rules and regulations and guidelines for dissemination in the cluster.

Susan Nkinyangi
Nairobi, 26 June, 2005

ANNEX 1

Nairobi

Fourth Cluster Consultation

HIV/AIDS and the Role of Education Service Commissions

Travellers Beach Hotel
21 to 23 June 2005
Mombasa, Kenya

Agenda

Monday, 20 June 2005

Arrival of participants

Tuesday, 21 June 2005

8:45-9:00	Registration
Session 1	
9:00-11:00	Opening ceremony • Chairman, Teachers Service Commission, Kenya • UNESCO • Participant introductions Official opening by the Guest of Honour, *Hon. Professor George Saitoti, Minister for Education, Kenya*
11:00-11:30	Tea/coffee break
Session 2	
11:30-12:00	Keynote address: Education/Teacher Service Commissions and the challenges of HIV/AIDS, *Dr Susan Nkinyangi*
12:00-12:15	Background, objectives and expected outcomes of the consultation, *Dr Susan Nkinyangi, UNESCO Nairobi*
12:15-13:00	Updates from Education and Teacher Service Commissions • Kenya • Uganda
13:00-14:00	Lunch break

Session 3

14:00-16:00	Perspectives from Teacher Unions • Representatives of Teacher Unions
16:00-16:30	Tea break
16:30-17:00	Kenya Association of Positive Teachers
	Plenary discussion

Wednesday, 22 June 2005

Session 4

9:00-9:30	Update from Burundi
9:30-11:00	Education sector workplace policies/policy frameworks on HIV/AIDS • Burundi • Kenya • Uganda
11:00-11:30	Tea/coffee break
11:30-13:00	Continuation of education sector workplace policies/policy frameworks with plenary discussion on issues and concerns, strategies and implementation
13:00-14:00	Lunch break

Session 5

14:00-16:00	Presentation on cluster HIV/AIDS generic teacher package for capacity-building, *Ms Rose Smart*
16:00-16:30	Tea/coffee break
16:30-17:30	Group work on HIV/AIDS teacher package

Thursday, 23 June 2005

Session 6

9:00-10:30	Report back on the teacher educator package and recommendations
10:30-11:00	Tea/coffee break

Session 7

11:00-13:00	Discussion on workplace operational guidelines
13:00-14:00	Lunch break

Session 8

14:00-15:30	Plenary on priorities and actions – setting cluster priorities Recommendations on the way forward
15:30-16:00	Tea/coffee break

16:30-17:00	Official closing, *Dr. Honourable Mohamed Abdi Kuti, Assistant Minister for Health, Kenya*
20:00	Evening hosted by the Teacher Service Commission, Kenya

Friday, 24 June 2005

Morning visit organized by the Teachers Service Commission, Kenya

Departure of participants

ANNEX 2

Nairobi

Fourth Cluster Consultation

HIV/AIDS and the Role of Education Service Commissions

Travellers Beach Hotel
21 to 23 June 2005
Mombasa, Kenya

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