

# **THE IMPACT OF HIV AND AIDS ON TEACHERS IN KENYA: A PILOT STUDY IN NAIROBI, MACHAKOS AND SIAYA DISTRICTS**

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## **Abbreviations and Acronyms**

AEO	Assistant Education Officer
AIDS	Acquired Immune Deficiency Syndrome
AIW	Aids in the Work place
ARV	Anti-retroviral
CBE	Curriculum Based Establishment
CBO	Community Based Organization
DHRO	District Human Resource Officer
DSOs	District Staffing Officers
EFA	Education for All
EMIS	Education Management Information System
FBO	Faith Based Organization
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HBC	Home-based care
HBO	Home-based Organization
HBP	High Blood Pressure
HIV	Human Immunodeficiency Virus
KENEPOTE	Kenya Network of Positive Teachers
KESSP	Kenya Education Sector Support Programme
KNUT	Kenya National Union of Teachers
KUPPET	Kenya Union of Post Primary Education Teachers
MDG	Millennium Development Goal
MoE	Ministry of Education
MoH	Ministry of Health
NACC	National Aids Control Council, Kenya
NASCOP	National AIDS/STD Control Programme
NGO	Non-Governmental Organization
PLWA	People Living with HIV and AIDS
SPSS	Statistical Package for the Social Sciences
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TAA	Teachers Against AIDS
TB	Tuberculosis
TTC	Teacher Training College
UNAIDS IATT	UNAIDS Inter-Agency Task Force on Education
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

## **Executive Summary**

In Kenya, as in many other countries in sub-Saharan Africa (SSA), Acquired Immune Deficiency Syndrome (AIDS) threatens personal and national well being by negatively affecting health, life-span, and productive capacity of the individual hence severely constraining the accumulation of human capital and its transfer between generations. Data from recent research across many severely affected low-income countries clearly demonstrates that HIV and AIDS is the most serious impediment to economic growth and development and there is no reason to expect Kenya to be an exception. HIV and AIDS affects the Teachers' Service Commission's (TSC) ability to meet its mandate by its impact on teachers and ancillary staff. HIV and AIDS is known to affect the most productive members of the society in the 15-49 age bracket. Teachers' performance is, therefore, affected by loss of skills and experience through deaths, increased absenteeism as a result of repeated bouts of sickness, overworked teachers, in some cases increased reliance on less qualified teachers to relieve the ailing ones, stigma and discrimination and low morale among both infected and affected teachers.

## **Objectives of the Study**

The main aim of this pilot study was to: (i) Assess the impact of HIV and AIDS among teachers in three sampled districts in Kenya; and (ii) Identify existing interventions to address identified HIV and AIDS challenges as well as potential mitigations to enhance teacher effectiveness in Kenya. Further, the study was to document the findings and make recommendations on proposed strategies that would help the TSC mitigate the impact of the epidemic and finally to form a baseline for future monitoring of HIV and AIDS programmes in the education sector in Kenya.

## **Study Methods**

In order to mitigate the impact of HIV and AIDS on the teaching force, reliable and up-to-date data was collected through a survey in three sampled districts selected on the basis of their HIV and AIDS levels of prevalence, namely, Nairobi, Siaya and Machakos. Additional data was also obtained through a review of existing documents and literature on HIV and AIDS in schools. Questionnaires were administered, interviews conducted

and focus group discussions (FGDs) moderated among teachers and a few pupils in the randomly selected schools and other education institutions. All respondents were randomly sampled to ensure appropriate representation of all schools in the survey. Key informants were also interviewed. These included TSC staff, non-governmental organization (NGOs), Ministry of Education (MoE), and Ministry of Health (MoH) officials. A total of 2,427 randomly selected teachers (940 males and 1,427 females), from primary and secondary schools as well as technical institutions and special schools participated in the study. Qualitative data was analysed using the Statistical Package for the Social Sciences (SPSS) computer programme while qualitative data was thematically analysed based on the study objectives, which formed part of this report.

### **Key Findings**

The results of this study indicate that HIV and AIDS is a major threat to human capital development both on the part of the teachers and the learners in the sampled schools. While the actual magnitude of HIV prevalence was not easy to establish due to lack of surveillance testing, there were anecdotal evidences and some records from TSC departments such as the District Human Resource Officers (DHROs) suggesting that HIV and AIDS was a major cause of teacher ineffectiveness as a result of morbidity and mortality. Statistically, teachers are most affected because of deaths reportedly associated HIV and AIDS-related illnesses. This has led to irreplaceable human capital and reduced effectiveness of the affected teachers. .

### **The Impact of HIV and AIDS**

It was evident from the findings of this study that lack of accurate information was largely responsible for the social stigma attached to HIV and AIDS in the sampled districts. The study found that there were no mechanisms of tracking the challenges posed by HIV and AIDS in schools. However, investigations on perceptions, coupled with quantitative data generated valuable information. Teacher illnesses and deaths result in increased workloads for other members of staff. In addition the affected teachers end up utilizing scarce resources to support the sick and the bereaved in the school community. Additionally, illnesses and deaths affect academic programmes in the sampled schools.



HIV and AIDS also leads to tension, discrimination and stigma, and fear and suspicion among staff members and learners.

### **Institutional Response to HIV and AIDS Challenges**

The major challenges of HIV and AIDS in schools and other learning institutions evident in this study were absenteeism, attrition and mortality, transmission of HIV, stigma and discrimination, and HIV and AIDS related illnesses. Some schools have put in place mitigation strategies to manage the challenges. The study identified guidance and counselling as a common strategy that is being used in most schools to manage HIV and AIDS challenges. However, respondents went further to suggest some of the potential strategies that could be employed in schools to improve the situation.

### **Mitigation Strategies**

The study found that there were some interventions in place to address HIV and AIDS including national policy initiatives, establishment of TSC's Aids Control Unit (ACU), and support groups. However, because some of these initiatives are not effective, respondents recommended a number of potential strategies. These include demystifying HIV and AIDS; financially supporting teachers living with HIV; improving teachers' terms of service; enhancing guidance and counselling in schools; deployment of HIV and AIDS specialists in education institutions; and strengthening TSC's ACU through enhanced funding among other strategies.

### **Conclusion**

As a result of a reduction in teacher effectiveness, increasing AIDS orphans and teacher attrition rates, the study concludes that HIV and AIDS has a more serious impact on the country's education sector than has been previously realized as it affects education quality. However, it is possible that with the introduction of appropriate strategies such as instituting effective systems of collecting relevant data from schools, decentralizing TSC's ACU, greater involvement of teachers and deployment of HIV and AIDS specialists in schools, and demystifying HIV and AIDS so as to reduce stigma, the quality of education will be improved. It is important to point out that careful implementation of

clear policies and sustained commitment from the management of TSC and MoE at all levels are key to the management of HIV and AIDS in the education sector in the country.

### **Policy and Programmatic Recommendations**

Based on the findings, a number of specific recommendations were proposed. They include:

- The MoE should strengthen the education management information systems (EMIS) in order to implement an effective system of collecting accurate data on HIV prevalence, morbidity and mortality rates on a continuous basis.
- The TSC's ACU should be empowered through increased budgetary allocations its activities decentralized to lower levels and engagement of additional professionally qualified staff. Some of them should be teachers who are living with HIV.
- To overcome stigma, all stakeholders should demystify HIV and AIDS by urging churches not to insist on HIV status certificate before marriage and encouraging prominent personalities to openly declare their HIV status.
- School-level HIV and AIDS specialists should be hired and deployed to be in charge of response, framework, dissemination of current and new information, and curriculum.
- The TSC should improve on the existing guidance and counselling programmes by incorporating professional counselors to facilitate their effectiveness in schools. This would affirm the employer's involvement and interest in HIV and AIDS programmes.
- To respond to persistent financial crises that reduce the effectiveness of teachers who are HIV positive, relevant stakeholders such as the TSC and trade unions should improve the teachers' terms of service.
- Efforts should be made to ensure that the rights and other benefits of teachers living with HIV are carefully developed and clearly defined to them. This would be a critical step in an effort to address challenges of HIV and AIDS especially stigma.

- To ensure that it is well understood, the HIV and AIDS policy should be widely disseminated and simplified to make it user-friendly to all teachers.
- To reduce the apparent information gaps on HIV and AIDS, all stakeholders including teachers' unions, and education, and health groups should adopt a proactive and systematic approach and forge stronger linkages and alliances to sensitize teachers on policy issues and new information.
- To ensure that teachers affected by HIV and AIDS are adequately catered for in the workplace, relevant stakeholders should give all education institutions necessary technical and financial support to enable them develop and implement effective appropriate workplace HIV and AIDS policies.
- To enhance their ability to attract funding for capacity building and other operations in the districts and schools, the TSC and other stakeholders should support and strengthen socio-psycho groups, particularly KENEPOTE by developing functional collaborative links with them as well as helping them to establish clear administrative structures.
- So as to enhance education quality, the TSC and respective school committees should employ reserve/volunteer/assistant teachers in schools to ease the excess teaching workload when teachers living with HIV are unable to perform their duties effectively.
- In addition to ensuring that all stakeholders, including teachers and their unions are involved in the design and roll-out of any teacher training programmes adequate arrangements should be made to empower all teachers to teach about HIV and AIDS in schools.

## **1.0 INTRODUCTION**

Since it was first discovered over two decades ago, AIDS has become a major threat to socio-economic development in the world especially in economically poor countries. To address the AIDS epidemic, there have been promising global development efforts over the years, including increased access to treatment and prevention programmes. However, despite these efforts, the number of people living with HIV continues to grow, as does that of deaths due to AIDS. According to the UNAIDS' *2006 AIDS Epidemic Update*, a total of 39.5 million people were living with HIV in 2006 (of which less than 10% knew their status) – 2.6 million more than in 2004, a figure that includes an estimated 4.3 million adults and children who were newly infected with HIV in 2006 (of which less than 10% knew their status) - which is about 400,000 more than in 2004 (UNAIDS/WHO, 2005). In Eastern Europe, there was an increase of 70% in the number of newly infected adults between 2004 and 2006 (160,000 and 270,000 respectively). In Asia, national HIV infection levels are highest in South-East Asia, where combinations of unprotected paid sex and that of between men, along with unsafe injecting of drug use, are the largest risk factors for HIV infection. Whereas in South and South-East Asia the number of HIV infections rose by 15% in 2004-2006, in the Middle East and North Africa it grew by 12% compared with Latin America, the Caribbean and North America where new infections in 2006 remained roughly the same.

It is well known that HIV and AIDS pandemic has devastated sub-Saharan Africa. Despite carrying only 10% of the world's population, nearly two thirds (63%) of the world's HIV-positive population lives in sub-Saharan Africa, where 2.1 million AIDS deaths represent 72% of global AIDS deaths. About 32% of people with HIV globally live in Southern Africa, a region most affected and which is considered the epicentre of the global HIV epidemic. While there is recent evidence of a diminishing epidemic in some countries, most country trends appear to be stable partly because the number of people newly infected with HIV roughly equals the number of those dying of AIDS. Apart from Zimbabwe, which is the only country where national adult HIV prevalence has declined, it continues to grow in Mozambique, South Africa and Swaziland (UNAIDS and WHO, 2006 and NAPA, 2006).

Although the general trends of stabilizing or declining HIV prevalence appear to be continuing in East Africa, signs of injecting drug use, which has spread rapidly in the region (McCurdy et al., 2005) hint at the possible erosion of the gains Uganda made against AIDS in the 1990s. An estimated 1.4 million adults and children were living with HIV in the United Republic of Tanzania at the end of 2005, making it one of the most-affected countries in the world. However, HIV infection has decreased from 8.1% to 6.5% nationally between 1995 and 2004 (Somi et al., 2006), and from 14% to 11% among pregnant women in Dar es Salaam between 1995 and 2003 (Urassa et al., 2006).

Since the first case was diagnosed in 1984, HIV and AIDS spread rapidly in Kenya during the 1990's, reaching an estimated national prevalence rate of 15% (NASCO, 2001). However, there was decisive national response to the AIDS spread in the country. Kenya's Ministry of Health instituted an AIDS Control Committee in 1987, and developed the country's five-year strategic plans for AIDS control, the first one covering the period 1987 to 1991 and the second one for the period 1992 to 1996. The *Sessional Paper No. 4 of 1997 on AIDS in Kenya* (Republic of Kenya, 1997) marked an important change on the political front and outlined a new institutional framework. Increased public political commitment was apparent in 1999 when the former President Daniel arap Moi declared AIDS a "national disaster". Consequently, the National AIDS Control Council (NACC) was established in 1999 to spearhead the national response and to serve as the government's coordinating body. President Kibaki declared "Total war on AIDS" when he took office in December 2002. This was followed by a positive global response, which saw a remarkable increase in the number of actors and resources in the fight against HIV and AIDS.

As a result of the efforts made to combat the epidemic, sentinel surveillance data at the end of 2004 showed a decline in adult prevalence to 6.1 percent (NACC, 2005), which was a significant success for a sub-Saharan African country in the last two decades (UNAIDS/WHO, 2005). In 2007, NACC reported that HIV and AIDS prevalence rate in Kenya had dropped to 5.1% compared with 5.9% in 2006. NACC says that the HIV

prevalence rate in urban areas was 9.6% while in rural areas it stood at 4.6 % in 2006. By 2006, statistics show that the prevalence rate among the youth aged 15 to 24 years was high among girls at 4.5%, while it stood at 0.8% among boys.

Evidence suggests that this tremendous turnaround is reportedly a combination of factors including higher death rates, lower incidence, and behaviour change. Though behaviour change is only one factor, which may affect a prevalence decline, in the case of Kenya, evidence suggests that significant numbers of Kenyans have adopted safer sex behaviours in recent years, including increased condom use, delay in first sexual experience and reduction in partners (UNAIDS/WHO,2005). Although these statistics indicate an encouraging trend, Kenya still faces quite a number of challenges associated with HIV and AIDS. In 2007, it is estimated that 1.27 million Kenyans are infected with HIV, half of whom are women. In addition, there is an increase in the number of children being born infected with HIV.

Having recognized human capital as an important factor that brings about socio-economic development, governments all over the world have been making efforts to provide formal education to their citizens. A number of approaches have been adopted especially by less developed countries to increase school enrollments, including abolishing school fees, automatic grade promotion and the creation of community schools. Consequently, vast numbers of children and youth in several African countries have gained access to education. Unfortunately, the shortage and unequal distribution of essential inputs has meant that the quality of expanded schooling has suffered in some parts of the world, including many African countries (Allemano, 2003).

A UNESCO model identifies dimensions of quality and their relationships, which include learner characteristics, the educational context, teaching and learning, outcomes and learning inputs such as material resources (textbooks, learning materials, classrooms, libraries, school facilities) and human resources (managers, supervisors, inspectors and,

most importantly, teachers)<sup>1</sup>. Considering that it is what happens in the classroom level that determines whether learning takes place or not, the role of teachers has been underscored. The indicators most widely used to measure some of the learning inputs are pupil/teacher ratios, teacher salaries, public current expenditure per pupil and proportion of gross domestic product (GDP) spent on education.

Education systems of many developing countries are registering unfavorable quality indicators. HIV and AIDS is significantly affecting the supply of, demand for, and quality of education. Countries that are heavily affected by HIV and AIDS are experiencing severe losses in their teaching forces due to teacher illnesses or death, to care for family, or through transfers to other government or private sector institutions to replace personnel lost to AIDS (UNAIDS IATT, 2002). HIV and AIDS is threatening to reduce the effectiveness and efficiency of educational systems in high prevalence countries in sub-Saharan Africa where the attrition rates due to deaths, illness, financial constraints, demand for home care of the sick and other family and social circumstances are affecting education quality.

The disease has deprived countries of their scarcest human capital (World Bank, 2007). Zambia, for example, loses half as many teachers annually as it trains (Grassly et al., 2003). Despite reducing enrollment rates in some countries, on average, there are reported high pupil/teacher ratios in the affected schools. It is regrettable that just keeping children in classrooms without paying attention to the quality of instruction and learning outcomes will result in many children mastering only a small part of the knowledge, attitudes and skills they need to acquire for either further education or eventual integration into productive life (World Bank, 2003). Because the lives of millions of learners and teachers have been permanently changed by HIV and AIDS, in ways that constrain their ability to go to school, to stay in school and to learn or to teach (Ainsworth and Fimer, 2002; Bennel, et al., 2002; Case, et al., 2003; Boler, 2004) finding ways to meet these needs, to keep children in school and teachers teaching, is a pressing issue for the education community. There are three compelling reasons why there is need for

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<sup>1</sup> For a full discussion on education quality, see UNESCO (2004) and Allemano (2003), among other sources.

action to minimize the effects of HIV and AIDS. First, without a medical vaccine, education is considered a critical and most powerful “social vaccine” against HIV infection. Second, without a systematic strategy for mitigating its impact, AIDS will undermine the provision of education, thereby denying children access to the quality learning they need to stay safe from HIV, and slowing or even reversing progress towards universal education. Third, the children who most need the protection and skills afforded by education will not be able to attend school unless their special needs are met (Boler and Jellema, 2005).

The TSC is mandated, through an Act of Parliament, to establish and maintain a professional teaching service for Kenya’s primary and secondary schools in addition to specified educational training institutions. A recent review of research and policy issues in Kenya has shown that, first, HIV and AIDS affects education by lowering school enrolment as AIDS orphans increase and as more children get infected with AIDS. Second, it affects education supply through loss of teaching staff and increasing teacher absenteeism (Nyaga et al., 2004). The HIV and AIDS pandemic affects the TSC’s mandate through its impact on teachers and ancillary staff. HIV and AIDS is known to affect the most productive members of the society in the age bracket 15-49 years where majority of teachers fall. Educational services are suffering, as teachers are lost to AIDS. Teachers’ performance is, therefore, affected through loss of skills and experience through deaths, increased absenteeism through repeated bouts of teacher sickness, increased reliance on less qualified teachers to relieve sick ones and low morale of affected and infected teachers. Recent data, which is summarized in Table 1 and Figure 1, reflect the trend on teacher attrition in Kenya.

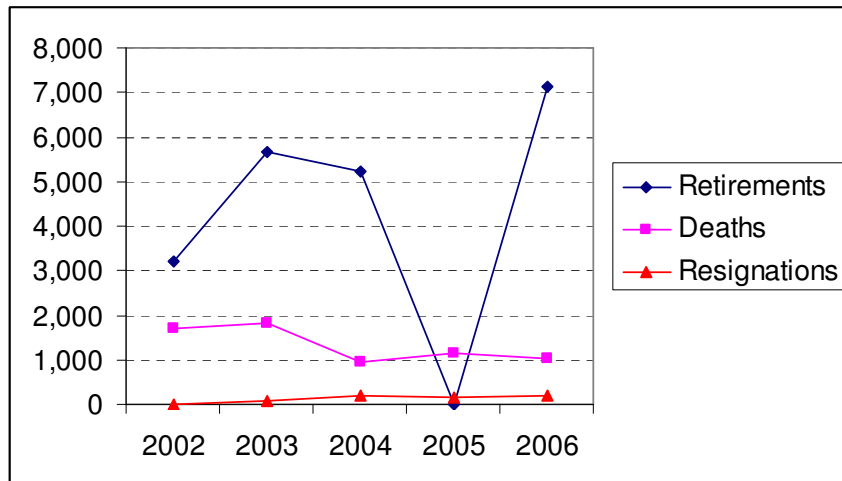


**Table 1: Teacher Attrition Rates in Kenya**

Form of attrition	2002	2003	2004	2005	2006	Total
Retirements	3,212	5,657	5,240	74,01	7,137	28,647
Deaths	1,715	1,834	951	1,145	1,030	6,675
Resignations	0	93	199	164	208	664

Source: TSC records, 2007.

**Figure 1: Teacher Attrition Trends in Kenya (number)**



Source: TSC records, 2007.

As Table 1 and Figure 1 indicate, the teaching force in Kenya is affected by attrition mostly in form of retirement and deaths, which has led to a great loss of skills and experience. Because it has not been possible to precisely determine the extent to which HIV and AIDS contributes to each form of attrition, its impact on the country's teaching force has remained a matter of speculation. Previous studies have used secondary data to suggest ways of responding to the impact of HIV and AIDS on Kenya's primary school (Njeru and Kioko, 2004), and suggest funding mechanisms of fighting against HIV and AIDS (Kioko and Njeru, 2004). In addition to these studies, Mutiso (2006) conducted a survey to establish the knowledge of HIV/AIDS and practice of health seeking behaviours among members of the Kenya National Union of Teachers (KNUT) in Kenya.

The TSC lacks formal data collection mechanisms on the impact of HIV to the teachers. It is feared that the reducing number of teachers has continued to undermine the country's

achievements in literacy by affecting the performance of the remaining teachers. Teacher attrition and absenteeism caused by HIV and AIDS leads to a decrease in the number of experienced and qualified teachers, principals, administrators, in teacher-pupil ratios and increased demand for health provision and funeral support. Demands placed on the education sector to train, replace, and care for HIV and AIDS-affected teachers draws funds from other areas (e.g., funds for equipment, materials, in-service training), and, together with increased absenteeism and attrition, will have negative consequences on education quality across the whole sector.

Not taking appropriate measures will lead to learners in Kenya's public schools and training institutions being poorly educated, thus undermining the country's efforts to achieve international goals especially Education for All (EFA) and the Millennium Development Goals (MDGs). Considering that both the Vision and Mission of the TSC continue to be negatively affected by HIV and AIDS, the Commission undertook this pilot study to find out the impact of HIV and AIDS on the teaching force in three sampled districts of Nairobi, Machakos and Siaya.

The specific objectives of the study were:

- i. To understand the extent of the impact of HIV and AIDS on the teaching force (supply, demand, quality and delivery of education);
- ii. To understand the impact of the current interventions on HIV and AIDS on the teaching force;
- iii. To form a baseline for future monitoring of HIV and AIDS programmes in the teaching force (data capture and management system); and
- iv. To propose appropriate HIV and AIDS intervention programmes for the teaching force.

## **2.0 METHODOLOGY**

This section of the report presents details of the study design, the target population, the sampling procedure, the sample size and the categories of respondents. It further describes the different types of research instruments used, their validity and reliability the data collection procedures, and data analysis. It also contains the schedules for actual fieldwork.

### **2.1 Study Design**

This survey engaged a multi-purpose design whose main thrust was a combination of an evaluative comparative approach, using cross-sectional data at different levels of observation to generate data that was both qualitative and quantitative in nature. Using both quantitative and qualitative approaches, several techniques were utilized to gather the required information from primary and secondary sources. Specifically, interviews and semi-structured focus group discussions, and all school and institutional literature review were also undertaken. One of the main benefits of this approach is that it facilitates triangulation, which was critical because of the nature of the study. A mixed design seeks elaboration, enhancement, illustration, and clarification of the results from one method with the results from another in order to increase the interpretability, meaningfulness and validity of constructs and inquiry results. Again, interview and focus group data complemented statistical data on morbidity and mortality trends and other impact indicators.

### **2.2 The Study Location**

The sampling strategy was a three-stage process. The first stage involved selection of the three districts of the study. Nyanza and Eastern Provinces were selected to represent high and medium prevalence regions, while Nairobi was included to represent urban areas. The three districts of Siaya, Machakos and Nairobi were therefore purposively sampled based on their levels of prevalence and to ensure urban and rural representation as well as for logistical reasons. Table 2 shows the study locations:

**Table 2: Level of HIV and AIDS Prevalence in Selected Study Locations**

Province	District	Level of prevalence
Nairobi	Nairobi	Medium HIV prevalence rate of (5.1%)
Eastern	Machakos	Lowest HIV prevalence rate in the country of (3.4%)
Nyanza	Siaya	Highest HIV prevalence rate of (10.8%),

Source: National AIDS Control Council, (2006).

The second stage involved selection of primary, secondary and special schools and technical institutions/colleges<sup>2</sup>, while the third stage involved selection of respondents from the sampled education institutions who were mainly teachers, learners and heads of institutions. Additionally, a sub-set of the sample in the third stage also included key informants as members of HIV and AIDS teacher support groups, NGOs and employees of relevant government ministries and departments.

### 2.3 Study Sample

A sample of primary, secondary, special schools and technical schools/colleges in the three sampled districts was selected from the sampling frame provided by the TSC. The schools in the three sample districts were selected from both the urban and rural set-ups. While it was not possible to visit all the public institutions under the auspices of the TSC, the survey was representative of each of the three sampled districts. The sampling procedure was random but proportionately distributed among the districts based on the total population of primary, secondary, special and technical institutions. Table 3 contains the number of sampled institutions in the study:

**Table 3: Distribution of Sampled TSC Institutions**

District	Primary	Secondary	Technical schools	Special schools	Total no. of institutions
Nairobi	49	13	2	6	70
Machakos	203	38	1	6	248
Siaya	93	21	1	5	120
<b>Total</b>	<b>345</b>	<b>72</b>	<b>4</b>	<b>17</b>	<b>438</b>

<sup>2</sup> These also include special schools.

## 2.4 Selection of Respondents

There were three main categories of respondents for the study. These included TSC employed teachers in all sampled institutions and members of staff based at the TSC headquarters as well as in the field. A representative sample of the three categories of TSC staff was selected from each district for interviewing. This particular group provided very rich and detailed information on the major impact of HIV and AIDS on the teaching staff in the three districts. Other respondents were key informants from HIV and AIDS teachers' support groups, NGOs and government institutions/departments. A total of 2,427 teachers were involved in the study. The breakdown is indicated in Table 4.

**Table 4: Teachers Sample Breakdown by Gender**

	<b>Frequency</b>	<b>Percent</b>
Male	940	38.7
Female	1427	58.8
No response	60	2.5
<b>Total</b>	<b>2,427</b>	<b>100.0</b>

As shown in Table 4, close to 60% of the teachers who were involved in the study were female. Field observations also confirm that there were more female than male teachers in both primary and secondary schools and this resulted in the higher representation of the female teachers in this survey.

## 2.5 The Research Instruments Administered

In order to accord all key stakeholders an opportunity to make their contributions, six different instruments were administered to five groups of respondents who included heads of institutions and teachers of the sampled schools and institutions. Questionnaires and guides for focus group discussions and personal interviews were used. All respondents were resourceful because they possessed key information that was considered valuable for the study particularly in terms of managing the challenges of HIV and AIDS in learning institutions in the three sampled districts. Details of the research instruments used in the study were as follows:

### **2.5.1 A Semi-structured Questionnaire for Headteachers**

This instrument was used to generate data on identified study themes, mainly on current HIV and AIDS challenges, existing and proposed strategies to manage them based on stigma and discrimination, teachers living with HIV and AIDS and those affected.

### **2.5.2 Institutional Quantitative Data Instrument**

This questionnaire was designed to collect information for the previous one year on teacher numbers, enrolment, school performance, common illnesses, teacher absenteeism by gender and HIV and AIDS related deaths.

### **2.5.3 Focus Group Discussion Guide**

Focus group discussions were used to collect detailed information to enrich the quantitative data. During initial consultative discussions held with the officers of the ACU at the TSC Headquarters, there was need to conduct FGDs with randomly selected learners in the sampled educational institutions in order to corroborate data generated from other respondents from the same institutions. The FGDs consisted of a minimum of six and a maximum of 15 members. Teachers and learners' FGDs were moderated separately using loosely structured guidelines/statements. During the FGDs, both teachers and learners were able to strongly bring out more details on HIV and AIDS to supplement data collected through questionnaires. Key points from focus group discussions for teachers and learners were coded, collated and thematically analyzed by members of the research team.

### **2.5.4 Anonymous Teacher Questionnaire**

The study employed this instrument to collect information from teachers on their qualifications and work experience. The instrument also contained a set of items soliciting teachers' views on the impact of HIV and AIDS in their schools.

### **2.5.5 Interview Guide**

This research tool was designed to collect information from key informants on impact and management of HIV and AIDS challenges in learning institutions in the selected three districts. Ten semi-structured face-to-face interviews were conducted during the month of April 2007 with groups of individuals including TSC and MoE senior officers and relevant professionals in personnel departments at the headquarters (with exception

of non-formal education), and senior managers of NGOs that were partnering with schools in the management of HIV and AIDS challenges. Table 5 provides a breakdown of the questionnaires administered in the sampled learning institutions in the three districts by type of respondents.

**Table 5: Sample by District, Questionnaire Type and Response Rate**

District	Primary schools	Secondary Schools	Technical schools	Special schools	Total no. of schools	Total no. of questionnaires administered	Response rate ( %)
Nairobi	49	13	2	6	70	840	707: 84%
Machakos	203	38	1	6	248	2976	1182: 40%
Siaya	93	21	1	5	120	1440	1070: 74%
<b>Total</b>	<b>345</b>	<b>72</b>	<b>4</b>	<b>17</b>	438	<b>5256</b>	

## 2.6 Piloting

Prior to data collection, a pilot study was carried out in Nairobi in order to enhance content validity of the research tools. Nairobi was purposively selected for piloting because of its medium HIV and AIDS prevalence as well as its convenient transport and communication networks that allowed the research team adequate time for validating the instruments. So as to avoid biases due to any preconceived opinions, all respondents involved in the pilot study were excluded from the actual study. A total of 34 (18 schools/institutions) participated in the pre-test. The instruments were then analyzed to determine their reliability and validity for actual fieldwork after which they were subsequently modified. The actual survey was conducted between 16<sup>th</sup> May and 8<sup>th</sup> June, 2007.

## 2.7 Data Collection Procedures

Primary and secondary data was collected from a representative sample of all respondents and from other documented literature sources.

### 2.7.1 Primary Data Collection

The collection of primary data was done in stages. The first stage involved the recruitment of research assistants followed by a three-day training and briefing session so as to ensure a thorough understanding of the study purpose, design and data collection techniques. The piloting of the research tools helped the research assistants familiarize themselves with them for quality control purposes. The key researchers who were coordinating the study then proceeded to the districts where, with the help of the relevant

TSC field officers, educational institutions were sampled before actual data collection began. Schools were sampled from both urban and rural locations, but clusters of primary and secondary schools were reasonably representative of the overall population of education institutions and they provided very rich and detailed information on all the key aspects of impact of the HIV and AIDS on the teaching force. After sampling, to ensure appropriate representations of education institutions in the sampled districts, the date of the survey was communicated to schools through Assistant Education Officers (AEOs).

On scheduled times, a team of at least two research assistants accompanied by either an AEO or an appointed guide went to each sampled school to conduct the survey. Except in some schools in Nairobi where there was lack of cooperation from some headteachers, data collection went on smoothly.

### **2.7.2 Secondary Data Collection**

All relevant educational, financial, health and demographic data from secondary sources was collected from the Ministry of Education's Planning Unit and the TSC. Published data was obtained from government documents such as the *Economic Surveys and Statistical Abstracts*, in addition to recent reports of relevant institutions such as the NACC. These data was synthesized and forms part of the background to this study. Relevant literature was obtained from United Nations institutions such as United Nations Programme on HIV/AIDS (UNAIDS), United Nations Education and Cultural Organization (UNESCO), United Nations Development Programme (UNDP) and United Nations Children Fund (UNICEF); and NGOs such as World Vision and ActionAid .

### **2.8 Data Analysis**

Data analysis for this study was done both quantitatively and qualitatively. The process of data preparation and analysis was done through validation, editing and coding processes. In the coding process, uniform categories of responses were identified and classified into code numbers already assigned to the questionnaires. Questionnaires were then reviewed and specific responses fed into appropriate categories in the computer worksheet where data was analyzed using the Statistical Package for Social Sciences (SPSS) and Microsoft Excel programmes.



Qualitative data was categorized and analyzed according to themes based on the study objectives. The findings of this study, which are based on both qualitative and quantitative data, are presented in the next sections of this report.

### 3.0 MAIN RESEARCH FINDINGS

Consistent with the study objectives, the main research findings are described in the specific sub-sections, namely: why teachers move out of their work stations; prevalence of common illnesses among teachers; mortality incidences among teachers; and the impact of HIV and AIDS on teachers.

#### 3.1 Why Teachers Move from their Workstations

Teachers were reportedly transferring from one school or education institution to another. It is possible that such moves disrupt the normal running of the affected educational institutions. The study sought to know reasons why teachers left their workstations. Headteachers were, therefore, asked to indicate why teachers had left their school/institution in the past one year (between May/June 2006 to the same period in 2007). Although not in all cases, some of the teacher transfers were reportedly as a result of HIV related-illnesses. The reasons are summarized in Table 6.

**Table 6: Teachers' Reasons for Leaving Workstations (%)**

Reason for leaving	District			School type		All n=292
	Nairobi n=61	Machakos N=121	Siaya n=141	Prim/ special n=240	Sec n=52	
Schools with teachers who left institution in the past one year	84.7	74.2	85.0	81.3	76.9	80.5
Schools with teachers who left due to transfer or promotion	66.1	65.8	69.0	67.5	65.4	67.1
Schools with teachers who left due to normal retirement	35.6	16.7	11.5	20.8	7.7	18.5
Schools with teachers who left for further training/studies	20.3	4.2	13.3	8.3	23.1	11.0
Schools with teachers who left due to death	16.9	2.5	10.6	9.2	5.8	8.6

As shown in Table 6, on average, about 80% of all schools in the three districts reported that teachers left for various reasons, with Siaya district having the largest proportion, followed by Nairobi and then Machakos. A larger proportion of primary schools (81.3%) witnessed a departure of teachers than secondary schools (76.9%). Teachers in all sampled districts reportedly left their workstations mainly due to transfers or promotions

in Nairobi, Machakos and Siaya (66.1%, 65.8% and 69% respectively) compared to normal retirement (35.6%, 16.7% and 11.5%), deaths (16.9%, 2.5% and 10.6%) or to go for further studies (20.3%, 4.2% and 13.3%). Whereas Nairobi had the highest proportions of schools where teachers left due to death, normal retirement and going for further studies, Siaya district reported the highest proportion of schools with teachers moving on transfers or promotion.

Despite the fact that teachers living with HIV would be expected to request for transfers on medical grounds, none of the teachers reported that their colleagues had left their workstations due to HIV and AIDS related illnesses. Equally, considering that school records did not show reasons for teacher transfers, it was difficult to ascertain whether they were due to HIV and AIDS related or other forms of illnesses. However, from the discussions with education officers and TSC field staff it emerged that some of the teachers sought transfers on medical grounds so as to have easy access to health facilities. An in-depth discussion with members of Kenya Network of Positive Teachers (KENEPOTE) in Nairobi revealed that HIV positive teachers were unwilling to disclose their status because of stigma. Therefore, it is possible that some of the teachers seeking transfers on medical grounds were probably HIV positive.

### **3.1 Prevalence of Common Illnesses among Teachers**

As a proxy to HIV prevalence, teachers and headteachers were also asked to indicate the common illnesses among the teaching staff in their schools by using a four level rating scale [1. Low prevalence 2. Moderate prevalence 3 High prevalence 4. Very high prevalence]. The results were disaggregated according to gender and presented in Table 7.

**Table 7: Level of Prevalence of Illnesses among Male Teaching Staff (%)**

<b>High or very high prevalence illnesses</b>	<b>Nairobi</b>	<b>Machakos</b>	<b>Siaya</b>	<b>All</b>
Malaria	12.2	14.7	35.3	22.3
TB	5.0	5.0	6.8	5.7
Cholera	3.3	0.7	5.5	3.2
Pneumonia	4.0	6.6	6.7	6.1
Meningitis	2.1	1.2	2.2	1.8
Typhoid	11.4	19.4	18.5	17.5
Cancer	2.0	0.5	2.4	1.6
Diabetes	4.8	8.4	4.4	6.2
HBP	9.6	9.8	6.6	8.6

From Table 7, it is evident that overall, the common illnesses among male teachers in the three districts were malaria (22.3%), followed by typhoid (17.5%), high blood pressure (8.6%), pneumonia (6.1%) and TB (5.7%). Other kinds of illnesses were also mentioned but were rated very low. The study findings show that malaria and typhoid pose a threat to male teachers and is likely to affect teaching and learning in schools in Siaya, Machakos and Nairobi. The survey found a similar trend in terms of common illnesses but with a higher rating compared with their female counterparts as reflected in Table 8.

**Table 8: Level of Prevalence of Illnesses among Female Teaching Staff (%)**

<b>High or very high prevalence illnesses</b>	<b>Nairobi</b>	<b>Machakos</b>	<b>Siaya</b>	<b>All</b>
Malaria	13.3	19.7	41.5	26.8
TB	6.6	4.4	7.2	6.0
Cholera	4.7	1.2	5.9	3.8
Pneumonia	5.7	9.2	6.6	7.5
Meningitis	3.8	2.0	2.0	2.4
Typhoid	12.8	20.8	20.4	19.1
Cancer	2.0	2.6	3.2	2.7
Diabetes	4.3	8.0	4.1	5.7
High blood pressure	12.0	12.6	10.0	11.6

From Table 8, it can be seen that whereas malaria is most prevalent among female teachers in Siaya (41.5%) and Nairobi (13.3%), the most prevalent illness in Machakos is typhoid (20.8%). Other common illnesses in Nairobi include typhoid (12.8%), high blood pressure (12%), TB (6.6%) and pneumonia (5.7%). Common illnesses among female teachers in Machakos are malaria (20.8%), high blood pressure (12.6%), pneumonia (9.2%) and diabetes (8%). Apart from malaria, a major threat to female teachers in Siaya

included typhoid (20.4%), high blood pressure (10%), TB (7.2%) and pneumonia (6.6%). From the prevalence levels, it would appear that whereas malaria poses a greater threat among female teachers than their male counterparts in Nairobi and Siaya, TB and typhoid affects more male teachers than their female colleagues in the same districts.

All the sampled teachers were further asked to indicate the level of prevalence of common illnesses among teachers in specific age groups (20-30 years, 31-45 years, 46 years and above) using a similar four-scale rating. Their responses are shown in Table 9:

**Table 9: Prevalence of Illnesses among Teachers Aged 20-30 Years (%)**

Illnesses	Prevalence level		
	None/Low	Moderate	High/Very high
Typhoid	50.5	27.6	21.8
Pneumonia	69.9	18.7	11.4
Malaria	73.8	16.4	9.8
TB	73.8	16.4	9.8
Cholera	82.2	10.3	7.5
Meningitis	88.1	7.6	4.3
HBP	83.1	13.0	4.0
Diabetes	85.7	11.3	3.0
Cancer	90.1	7.6	2.3

Table 9 indicates that the illnesses with the highest prevalence among all teachers aged 20-30 years are typhoid (21.8%), pneumonia (11.4%), malaria (9.8%) and TB (9.8%). The same illnesses were reported with a moderate prevalence but in higher proportions (27.6%, 18.7%, 16.4% and 16.4% respectively). It is important to point out that the largest proportions of respondents reported a low prevalence of other diseases among teachers such as cancer (90.1%), diabetes (85.7%), meningitis (88.1%) and cholera (82.2%). This means that despite the varying levels of prevalence, it would appear that teachers in the sampled districts were susceptible to nearly all these illnesses, most of which are closely associated with HIV and AIDS. Table 10 outlines the prevalence of illnesses among teachers in the 31-45 age bracket.

**Table 10: Prevalence of Illnesses among Teachers Aged 31-45 Years (%)**

<b>Illnesses</b>	<b>None/Low prevalence</b>	<b>Moderate prevalence</b>	<b>High/Very high prevalence</b>
Malaria	33.8	37.9	28.3
Typhoid	45.4	30.4	24.1
HBP	63.0	21.6	15.3
TB	68.5	17.1	14.4
Pneumonia	64.9	23.0	12.0
Diabetes	72.5	18.0	9.5
Cancer	82.5	9.3	8.2
Cholera	81.9	10.4	7.7
Meningitis	85.1	8.6	6.4

As shown in Table 10, the illnesses that were most prevalent among teachers in the 31-45 age bracket were malaria (28%), typhoid (24.1%), high blood pressure (15.3%), TB (14.4%) and pneumonia (12%), while the same illnesses were reported to have a moderate prevalence in the same order of proportions as for teachers in the 20-30 age bracket.

Except for slight variations, almost a similar pattern of prevalence of illnesses among teachers aged 46 years and above is shown in Table 11.

**Table 11: Level of Prevalence of Illnesses among Teachers Aged 46 Years and Above**

<b>Illnesses</b>	<b>None/Low prevalence</b>	<b>Moderate Prevalence</b>	<b>High/Very high prevalence</b>
HBP	55.0	19.7	25.3
Malaria	45.5	29.7	24.8
Typhoid	51.4	27.2	21.4
Diabetes	62.3	17.2	20.5
TB	71.0	16.6	12.3
Pneumonia	71.1	17.9	11.0
Cancer	80.8	9.5	9.7
Cholera	85.2	8.3	6.5
Meningitis	88.6	7.7	3.7

Among teachers who were aged 46 years and above, illnesses with the highest prevalence were high blood pressure (25.3%), malaria (24.8%), typhoid (21.4%), diabetes (20.5%) and TB (12.3%). Illnesses with low prevalence but which strongly featured among teachers in this age group included meningitis (88.6%), cholera (85.2%), cancer (80.8%) and pneumonia (71.1%).

Comparing the results of this study and other similar studies in Kenya and elsewhere in Africa, there was some evidence of consistency in terms of levels of prevalence of common illnesses. For instance, a survey conducted by the NACC in 2005 reported that the HIV prevalence in women in the 15-49 age bracket was 8.7%, while for men of similar age group it was 4.6% and that female to male ratio of 1.9 to 1 was higher than that which was found in other population based studies in Africa. The same study further revealed that the prevalence of HIV among women aged between 20 and 24 years was over four times that of men in the same age group (NACC, 2005). It is important to point out that although there were no clinical tests conducted among teachers in this study, the results closely tally with the NACC findings. In this study, the prevalence of common illnesses is higher in the 20-30 age groups compared with the older age groups. It was evident, therefore, that the prevalence of common illnesses among female teachers was higher than that of male teachers. As already reported, the prevalence of the common illnesses that are often associated with HIV and AIDS in this study are malaria (22.3% for male teachers and 26.3% female teachers), typhoid (17.5% male, 19.1% female teachers), and TB (5.7% male, 6.0% female teachers).

From the respondents' ratings in all the sampled districts, malaria, typhoid and TB were the most prevalent illnesses among males and females. Without taking HIV tests, it was not possible to determine the prevalence of HIV and AIDS among any group of people, including teachers. It was for this reason that members of the Nairobi branch of KENEPOTE reported that it was not possible to estimate the prevalence of HIV teachers in Nairobi. They revealed that owing to stigma, teachers living with HIV were discouraged from disclosing their status to their heads; instead they gave other excuses to seek permission to be away from school only for them to visit private hospitals for treatment. They feared that there were more infected teachers than any official records might show. Having been established that clinical treatment for malaria was three times more likely in adults with HIV, these findings have implications on the prevalence of HIV and AIDS in the study districts. Moreover, there is a growing body of evidence from many parts of sub-Saharan Africa showing that malaria tends to occur with increased frequency and severity in HIV-infected adults (UNAIDS, 2006).

Based on data on the prevalence of common illnesses, HIV prevalence among teachers in Kenya could be much higher than ever thought. It was reported that many teachers had not come out to declare their status because of a number of reasons. First, in the past, teachers suspected to be HIV positive were victimised either by the school administration or the TSC, leading to punitive transfers, interdictions or dismissals. Second, teachers were afraid of the stigma associated with the HIV, which led to discrimination from fellow teachers, pupils as well as parents. Third, there was reported lack of capacity building in the schools in terms of guidance and counselling to strengthen positive teachers to declare their status to enable them get support from the TSC, colleagues, learners, parents and community. Fourth, many teachers, including some headteachers, did not know of the existence of the ACU at the TSC where they could seek assistance on HIV and AIDS-related issues.

### **3.2 Mortality Incidences among Teachers**

A first evident impact of the epidemic is through mortality due to AIDS related illnesses. Given the overall size and key role of teachers, it is surprising that no detailed HIV risk assessment of the teaching profession, which is the conventional basis of estimating mortality rates has been undertaken in Kenya to establish the exact profile of HIV infection among teachers,. In the absence of this information, the only way to assess the impact of the epidemic is to use data on **absolute mortality** – i.e. the number of teachers who have died of AIDS-related illnesses. But even such data was difficult to obtain from schools where causes of death among teachers were neither openly discussed nor clearly known. Hence, it was not possible to obtain systematic data to be able to estimate AIDS-related mortality rates among teachers in the sampled districts. Similarly, it was further revealed that district hospitals do not classify deaths by occupation, thus making access to such information even more difficult.

In this study, data collected from the TSC district and divisional headquarters was used to report the teachers' mortality incidences in the three sampled districts. District Human Resource Officers (DHROs) in the three districts of study were asked to report the impact



of HIV and AIDS on the teaching force. These officers provided data on HIV and AIDS-related deaths, which are summarized in Table 12.

**Table 12: HIV and AIDS Mortality Incidences among Teachers**

Impact of HIV & AIDS	Nairobi		Machakos				Siaya			
	Both primary & secondary schools		Primary		Secondary		Primary		Secondary	
	M	F	M	F	M	F	M	F	M	F
HIV & AIDS-related deaths	2	3	36	20	9	5	56	11	4	0

From the survey data shown in Table 12, in absolute terms, primary schools in the sampled districts were more affected by HIV and AIDS-related deaths than secondary schools. More male teachers were reportedly dying from HIV and AIDS-related illnesses than their female counterparts in the sampled districts. As a result of deaths, teacher shortages were reported in schools.

To obtain further information from the schools, teachers were asked to indicate whether any of their colleagues had died in the past one year and the causes. About 87% of teachers indicated that there had been no deaths, while only 13% said that there were some deaths in their schools during that period. Hence very few of the sampled teachers reported having lost a colleague through death in the past one year in the three districts of study. Based on teacher opinions, the total number of reported teacher deaths by district is reflected in Figure 2.

**Figure 2: Teacher Deaths by District in the Past One Year**

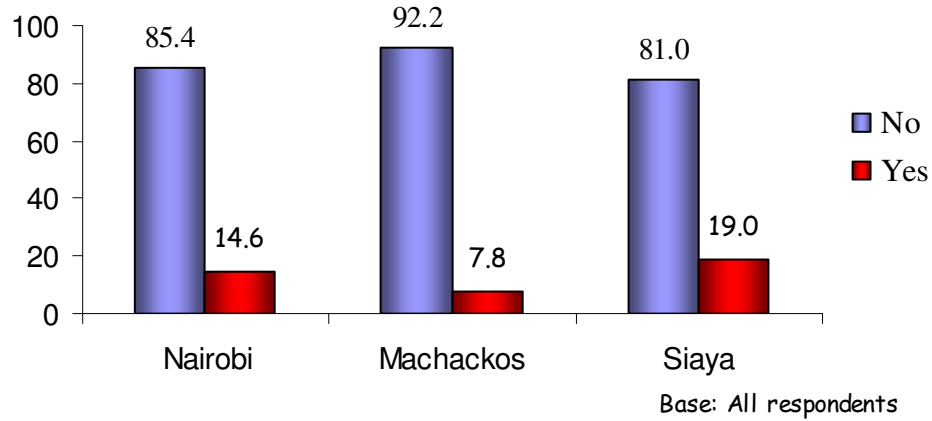
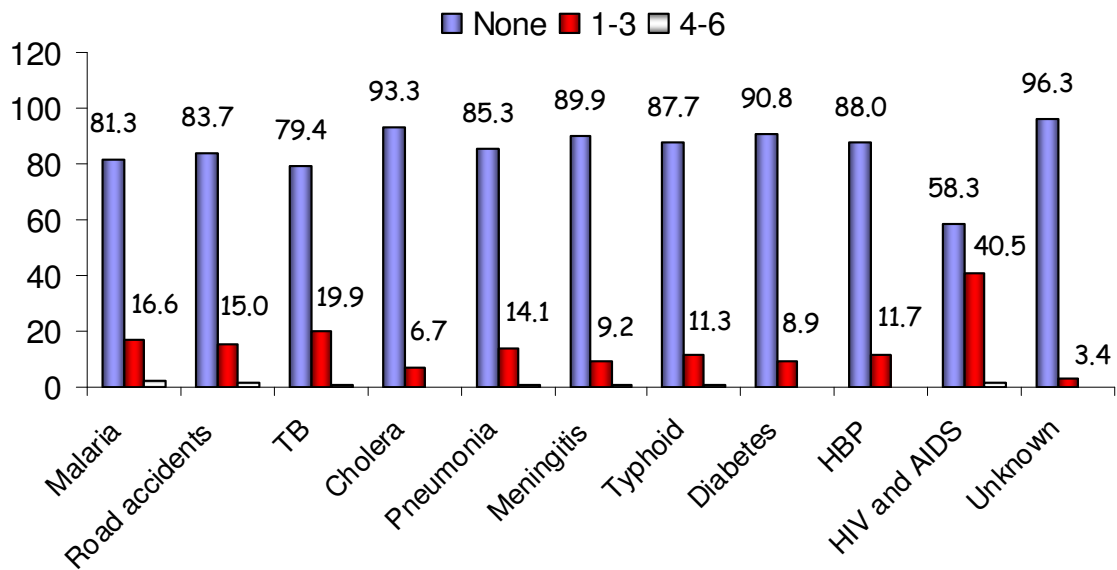


Figure 2 indicates that Siaya had the highest number of teachers who reported deaths in their schools (19%) followed by Nairobi (14.6%) and Machakos (7.8%). The Nairobi branch of the Kenya National Union of Teachers (KNUT) reported that four female members died in the month of May 2007 alone. Although the causes of reported deaths were not identified by most of the respondents across the districts, a fairly high score of 40.5%, HIV and AIDS-related deaths override others as indicated in Figure 3.

**Figure 3: Causes of Death among Teachers**



Base: All that reported a death

During FGDs, it was pointed out that it was not possible to attribute the death of teachers or learners to HIV and AIDS since none of the sampled teachers openly declared their status. Teachers were not ready to freely speak about their HIV positive colleagues in case one of them was participating in the FGDs. Learners would speak freely of many orphans in their respective schools but were not aware of the causes of their parents death. The same applied to teachers who could not disclose the exact cause of their colleague’s death. However, field observations revealed incidences where HIV positive teachers quietly approached the researchers for support on their status while others also sought more information about the HIV virus. During the entire study, it was only at Ukwala Boy’s Primary School where both the teachers and the headteacher openly revealed that two teachers had died from HIV and AIDS-related illnesses. In general, responses given in questionnaires were not necessarily attributed to HIV and AIDS but rather to other illnesses.

### 3.3 The Impact of HIV and AIDS on Teachers

The impact of HIV and AIDS on the teaching force can be demonstrated by examining a number of indicators such as levels of teacher absenteeism, teaching workloads, reduced effectiveness of teachers and learning in schools.

#### 3.3.1 Teacher Morbidity and Absenteeism

Although data based research cannot clearly ascribe it to HIV and AIDS, absenteeism has become an increasingly significant problem in several service sectors including education. AIDS-related morbidity is expected to have the most serious impact on schools and the entire education system. Sickness lowers teaching quality and results in high rates of teacher absenteeism, with long-term persistent absenteeism becoming disruptive to learning in schools. Table 13 shows data from the DHROs in the sampled districts on HIV and AIDS-related absenteeism, transfers and desertions in the respective schools.

**Table 13: HIV/AIDS-related Absenteeism in Sampled Districts**

Impact of HIV & AIDS	Nairobi		Machakos				Siaya			
	Both primary & secondary schools		Primary		Secondary		Primary		Secondary	
	M	F	M	F	M	F	M	F	M	F
HIV & AIDS-related absenteeism	1	5	37	11	4	2	24	4	5	0
HIV & AIDS-related transfers	0	0	394	211	0	0	12	13	1	1
HIV & AIDS-related desertions	3	1	0	0	0	0	16	4	5	0

From Table 13, HIV and AIDS-related teacher absenteeism affects schools in each of the sampled districts. Machakos district had the largest number of recorded cases, followed by Siaya and Nairobi. In Machakos and Siaya districts, there were more cases of HIV and AIDS absenteeisms in primary schools than secondary schools, and in both districts, more male teachers were absent than females. It was reported that there were some cases where teachers were transferred without immediate replacement, leaving some classes without teachers in the affected schools. In both Siaya and Nairobi, teacher absenteeism in schools was exacerbated by desertions as a result of HIV and AIDS. Whatever the

cause, teacher absenteeism is undesirable in schools because it affects learning and it has been associated with dropout of pupils who feel demoralized because they are not learning.

To find out the extent of absenteeism problem in their respective schools, sampled teachers were asked to indicate reasons for their absence and the number of times it had happened during first term of 2007. The results are summarized in Table 14 and Figure 4.

**Table 14: Teachers Absent for at Least Five Times in the Last One Year**

Reason for absence	District			School type		All n=237
	Nairobi n=51	Machakos n=85	Siaya n=101	Pri/spec ial n=190	Sec n=47	
Absent at least 5 times due to further training	9.8	10.6	15.8	12.6	12.8	12.7
Absent at least 5 times due to attending official function	15.7	11.8	31.7	18.9	29.8	21.1
Absent at least 5 times due to attending funeral	9.8	4.7	9.9	7.4	10.6	8.0
Absent at least 5 times due to sick leave	21.6	14.1	8.9	13.2	14.9	13.5

**Figure 3: Teacher Absenteeism and Reasons for Absence (%)**

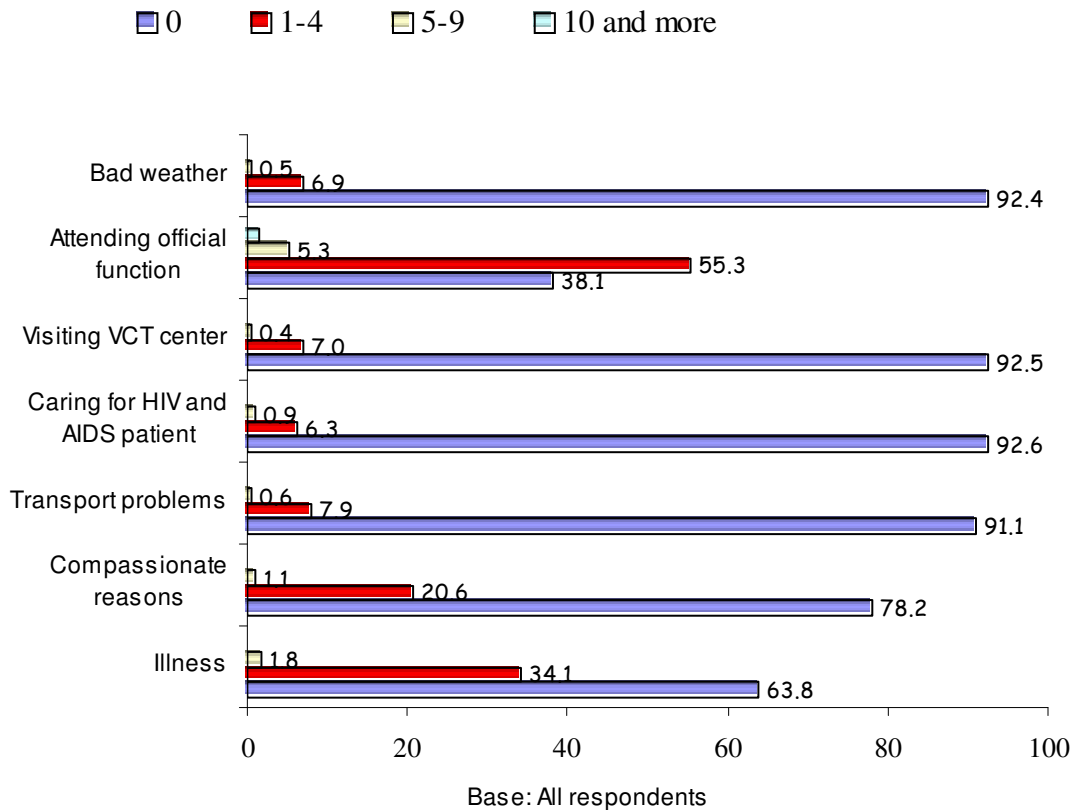


Table 14 and Figure 4 show that whereas about 55% of the teachers reported that they had been absent between 1-4 times to attend official functions, 34% were absent for a similar duration of time as a result of illness. These two reasons featured most prominently among other reasons that were given for being absent from school. Among the teachers who were absent 1-4 times, there were those who took compassionate leave (21%). This kind of leave is usually granted to members of staff to make arrangements for funerals of close relatives or to nurse sick family members. However, most of the teachers reported that they had not been absent from school. This was a response mainly attributed to fear that if the teachers said the truth about why they were absent, then TSC would effect a salary deduction, sack or demote them among other disciplinary actions. The survey shows that Siaya had the highest number of teachers who were absent at least once (91%), followed by Nairobi (74%) and Machakos (69%). All the three districts recorded an average of 78% in teacher absenteeism, which was quite high.

Selected reasons were cross-tabulated by district and by type of school to find out if there was any significant difference among the three districts for the teachers who were absent from school at least five times. Table 15 shows the results.

**Table 15: Teacher Absenteeism by Category of School and Gender (%)**

Reason	District			School		Sex		All
	Nairobi	Machakos	Siaya	Pri/special	Sec/tech	Male	Female	
Absence due to illness	32.2	27.6	48.5	36.6	34.6	37.0	35.7	36.2
Absence due to compassionate reasons	24.9	14.8	27.7	21.0	25.3	22.7	21.2	21.8
Absence due to transport problems	7.9	4.9	13.9	7.5	15.0	12.3	6.7	8.9
Absence due to caring for HIV& AIDS patient	5.3	4.4	12.2	7.6	6.6	8.7	6.7	7.4
Absence due to visiting VCT centre	3.9	4.1*	13.8	8.2	4.6	8.8	6.7	7.5
Absence due to attending official function	54.7	55.7	73.7	60.8	68.7	68.3	58.0	61.9
Absence due to bad weather	5.7	4.0	12.9	6.5	12.1	10.6	5.3	7.6

There was no significant difference in teacher absenteeism due to illness between primary and secondary schools and also across gender. However, attending official function was the main reason why teachers were absent from school with an average of 62% in the three study districts followed by illness. It was difficult to establish whether the funerals that teachers attended were due to HIV-related deaths or not. However, records at the DHRO's office in Siaya indicated that most of the funerals attended by teachers were as a result of AIDS-related deaths. Overall, a larger proportion of male teachers were reportedly absent from schools compared with their female colleagues.

Absenteeism, which was a major concern reported by the teaching staff in the selected schools greatly affected learning. During focus group discussions with teachers, it was

reported that whenever those living with HIV were sick, their colleagues in the school took up their lessons.

### 3.3.2 Heavy Teaching Workloads

In an effort to understand its impact in schools, teachers were asked to give their opinion on how HIV and AIDS challenges affected their schools/institutions using a five-point rating scale. The results in the Tables 16 and 17 were generated and disaggregated in terms of HIV and AIDS challenges affecting teaching and learning respectively.

**Table 16: How HIV and AIDS Affects Teaching (Mean Rankings)**

<b>Rated as seriously/very seriously</b>		
<b>Challenges affecting teaching</b>	<b>Mean</b>	<b>Std. Deviation</b>
Heavy workload	3.28	1.36
Lack of personnel	2.68	1.33
Inadequate learning facilities	2.54	1.25
Illness	2.28	1.00
Lack of clean drinking water	2.2	1.33
Hunger/poverty	2.15	1.26
Absenteeism	2.11	1.07
Indiscipline	2.01	1.16
Attending to HIV and AIDS patients	2.01	1.16
Attending funerals and cultural ceremonies	1.98	0.95
HIV and AIDS illnesses	1.91	1.13
Visits to hospitals and home	1.89	0.86
Deaths	1.88	1.11

Scale: 1- Not at all 2- To some extent 3 – Moderately 4- Seriously 5- Very seriously

A heavy workload tops the list of HIV and AIDS challenges that were seriously affecting teaching as it had a mean ranking of 3.28, while as a challenge that affected learning it had a mean ranking of 3.14 as shown in Tables 16 and 17. Teachers were reported to be enduring heavy workloads while taking up their sick colleagues lessons when they were unable to fully take up their teaching duties. Teachers living with HIV were reportedly absent from school to seek treatment or attend to sick family members or orphans. Ultimately, the affected teachers were burdened, thus reducing their effectiveness in their official work.



**Table 17: HIV And AIDS Challenges that Affect Learning (Mean Rankings)**

Rated as seriously/very seriously		
Challenges affecting learning	Mean	Std. Deviation
Heavy workload	3.14	1.36
Hunger/poverty	3.03	1.36
Absenteeism	2.75	1.13
Lack of personnel	2.64	1.30
Inadequate learning facilities	2.62	1.26
Illness	2.55	1.02
Indiscipline	2.51	1.16
HIV and AIDS illnesses	2.28	1.26
Lack of clean drinking water	2.27	1.35
Deaths	2.18	1.22
Attending funerals and cultural ceremonies	2.12	1.04
Visits to hospitals and homes	1.96	0.92
Attending to HIV and AIDS patients	1.92	1.01

Scale: 1- Not at all 2- To some extent 3 – Moderately 4- Seriously 5- Very seriously

As Table 17 indicates, teachers reported hunger and poverty (3.03) and absenteeism (2.75) as common concerns brought about by HIV and AIDS-related challenges that affected learning in schools. Being a socio-economic problem, HIV and AIDS affects schools in other ways such as indiscipline (2.51), which are difficult to handle.

On being asked the number of lessons they were teaching per week, teachers provided data as summarized in Table 18.

**Table 18: Number of Lessons Per Week (% of cases)**

Workload	Primary			Secondary		
	Nairobi	Machakos	Siaya	Nairobi	Machakos	Siaya
0-10	0.8	1.6	2.7	4.9	3.0	2.5
11-20	3.1	2.0	5.1	18.3	23.1	26.6
21-30	11.1	14.5	30.0	73.2	63.3	57.6
31-40	78.1	69.4	54.7	1.2	8.9	8.9
Above 40	2.9	10.3	5.7	0.0	0.6	1.3

The Curriculum Based Establishment (CBE) for regular teachers is 27 lessons per teacher each week in an ordinary secondary school and 35 for primary schools. As shown in Table 18, more than half of all teachers in primary schools in the sampled districts have between 31 and 40 lessons per week with 2.9%, 10.3% and 5.7% of the teachers handling

more than 40 lessons per week in Nairobi, Machakos and Siaya respectively. The situation is not different in secondary schools where more than half of the teachers are assigned between 21 and 30 lessons per week, with 0.6% and 2.1% of teachers in Machakos and Siaya respectively handling over 40 lessons per week. These data confirms that some teachers were overloaded in the sampled districts.

### 3.3.3 Reduction in Overall Teacher Effectiveness

The survey found that as a result of the consequences of HIV and AIDS, the effectiveness of teachers in the schools gets increasingly reduced. This was confirmed during focus group discussions, where members of KENEPOTE expressed the fear that HIV and AIDS was a real threat to human capital formation among teachers and learners than any person would think. Using a set of attributes, teachers were asked to state the extent to which HIV and AIDS challenges affected their institutions on a five-scale rating. Their ratings on each attribute are indicated in Table 19.

**Table 19: Other Effects of HIV and AIDS Challenges on Teachers (%)**

High/very high	District			School		All
	Nairobi	Machakos	Siaya	Pri/ special	Sec/ tech	
Institutional administration	4.0	3.9	10.6	6.8	4.4	6.3
Teachers effectiveness	7.7	6.8	14.3	10.9	4.8	9.7
Teachers attitude towards work	9.3	8.7	15.5	12.8	4.9	11.3
Teachers class attendance	9.7	8.6	14.9	12.3	6.3	11.1
Teachers professional growth	10.6	9.0	15.2	12.4	8.4	11.7
Teachers participation in community affairs	10.0	9.2	15.6	13.0	6.1	11.7
Teachers conduct	12.7	10.6	15.8	14.0	8.9	13.0
Learners concentration on studies	12.9	10.9	24.0	16.6	13.6	16.2
Learners overall academic performance	14.2	9.7	26.5	17.5	13.8	16.8
Stigma and discrimination	10.6	8.8	19.5	14.0	9.6	13.1
Teachers attitude towards their HIV and AIDS positive colleagues	6.9	9.4	15.1	12.1	5.7	10.9

Scale: 1- Very Low 2- Low 3 – Moderate 4- High 5- Very High

Table 19 indicates how HIV and AIDS challenges such as teacher absenteeism, heavy teaching workloads, HIV and AIDS illnesses and deaths, attending funerals, visits to hospitals and attending to HIV and AIDS patients affected education institutions. All these had a significant effect on teachers in a number of ways. Siaya district scored

highly on each of the mentioned attribute compared to Nairobi and Machakos suggesting that the challenges associated with HIV and AIDS had a serious impact in the sampled schools. Teachers reported that the challenges of HIV and AIDS greatly affected learners' overall academic performance in Siaya, Nairobi and Machakos (26.5%, 14.2% and 9.7%).

### **3.3.4 Stigma and Discrimination**

From this study, stigma and discrimination was reported as a major challenge to schools (24%), particularly among the teachers living with HIV. In an in-depth interview, officials of KENEPOTE revealed that owing to stigma, HIV and AIDS was still a big challenge in many schools. It was noted that stigma was higher in primary compared with secondary schools because of reportedly higher levels of ignorance about HIV and AIDS in the former. Given the level of stigma that was attached to HIV and AIDS, teachers were not ready to reveal their HIV status for fear of negative reactions from colleagues and the entire community where they live. Weighed by the severity of stigma and discrimination, some of the affected teachers were forced to stay away from school, thus increasing incidences of absenteeism. Since the focus of this study was HIV and AIDS, members of the research team were informed that some teachers were not free to give their opinions on the subject. Some respondents confided that a number of teachers were a little uneasy while filling in the questionnaires due to stigma and discrimination. It was also reported that, headteachers requested for transfers of teachers whom they suspected of being HIV positive in an effort to minimize absenteeism in their schools. It was also revealed that some teachers were reportedly giving fake reasons to skip school so as to seek treatment. Because of this, it is possible that incidences of absence from school on medical grounds as per school records could have been grossly understated.

These findings are consistent with a survey on HIV and AIDS in Kenya, which pointed out that stigmatisation of people living with the disease leads to their discrimination and rejection at home, at work and in public places. The same study reported that stigmatisation, which takes the form of social ostracism and exclusion from usual family or community networks, discourages individuals from going public about their status or in accepting their condition once diagnosed to be HIV positive (Nyaga et al., 2004).

### **3.3.5 Low Productivity**

On average, 9.7% of the sampled teachers reported that challenges associated with HIV and AIDS contributed to reduced teacher ineffectiveness. From interviews and discussions during the survey, it was reported that teachers living with HIV become weak and often unable to concentrate on their work. Considering the little effort and time they exert in lesson preparation, if such teachers do not receive adequate support, they become less productive.

### **3.3.6 Low Morale**

HIV and AIDS-related challenges were reported by 11.3% of the sampled teachers to be affecting their attitude towards work. Increasing levels of staff morbidity, the overall incidences of AIDS-related deaths were adversely affecting a number of teachers thus reducing their morale to work. This was partly caused by the increasing workloads and the bereavement teachers suffered by losing their colleagues. Irrespective of their HIV status, teachers revealed in discussion groups that low morale reduced their effectiveness.

### **3.3.7 Permanent Financial Crises**

Teachers who were interviewed pointed out that HIV and AIDS had left households in permanent financial crises, occasioned by increasing medical expenses on self or close family members in addition to supporting AIDS orphans. During a number of focus group discussions, some teachers confirmed that they supported AIDS orphans both financially and materially.

### **3.3.8 Limited Professional Growth**

Due to the challenges associated with HIV and AIDS, 11.7% of the teachers reported that their professional growth had been thwarted. This can be understood from socio-economic perspectives, because HIV affects individuals, households and schools. The affected teachers reported that the challenges they face cannot allow them to pursue activities that can enhance their professional growth such as further education and training. Coupled with other factors such as low morale, limited professional growth of the affected teachers is likely to ultimately affect their effectiveness.

Qualitative data from interviews and focus group discussions showed that HIV and AIDS affected teaching and learning in Siaya, Machakos and Nairobi in several ways.

Some of the personal comments made on the impact of the challenges of HIV and AIDS in schools include the following:

- “Due to HIV and AIDS-related illnesses among spouses and children, teachers are generally affected such that they are unable to concentrate on their schoolwork. In addition to looking after sick family members, affected teachers are expected to raise funds for their treatment. Some of them are supporting AIDS orphans in their classrooms and schools, leading to severe financial constraints”.
- “There is need for psychosocial support groups to deal with stress in schools. Stress of loosing a parent or other family members reduces the ability of a teacher or a learner to cope with work. Teachers and learners living in families affected by HIV and AIDS worry about the future and this causes behavior problems such as absenteeism. Stigma and discrimination further lead to stress among teachers dealing with HIV and AIDS”.
- “At times, as a result of being on drugs, HIV positive teachers are not effective in their duties as they are unable to concentrate”.

*(Personal experiences respondents in focus group discussions and interviews during the survey, May-June 2007)*

### **3.3.9 Impact of HIV and AIDS on Learners**

Owing to the fact that it was not possible to establish whether their pupils’ parents had died of HIV and AIDS, data on orphans in schools was not systematically collected. However, the sheer presence of many orphans in some of the sampled schools signalled a serious challenge, which needs to be addressed. According to some school records, it was found that as many as 50% of all pupils in some primary schools were orphans. A few instances demonstrate the severity of the challenge of AIDS orphans.

In Siaya district, out of 400 pupils at Simenya Primary School, 150 were orphans, while at Simenya Secondary School, out of 300 students, 112 were orphans. Whereas 413 out of 600 pupils who were enrolled at Siranga Primary School were orphans, 143 of 392 pupils in Wang’Chieng Primary School were orphans. In Sylvester Anyiko Primary School, there were 105 orphans out of 670 pupils, while Kochieng Primary School had more than 100 orphans out of the less than 300 pupils enrolled in the school. It was

reported that these orphans were being taken care of by their uncles and grandmothers. The study also found that about 50% of student population in Boro Secondary School were orphans. As a result of lack of appropriate arrangements for providing basic needs to the orphans since the school had no feeding programme, it was reported that some orphans were dropping out of school to work in sand harvesting and quarry sites. Other than these activities, which enabled these pupils' households to generate some income, some of the pupils were reportedly involved in the rampant cases of casual sex activities, which was a threat to the human capital formation in the district.

During FGD in Machakos district, teachers reported that a large numbers of pupils had been orphaned by AIDS especially in primary schools. For instance, Kathithyamaa Primary School was reported to have many orphans being taken care of by their grandparents. Although it was difficult to tell if these were AIDS orphans or not, members of a teachers' FGD were of the opinion that these were indeed AIDS orphans.

Due to financial constraints, guardians, who included teachers, were not able to adequately meet the needs of the affected children. However, it was heartening to note that teachers were indeed playing a significant social role in assisting some AIDS orphans in their schools. Teachers revealed that orphaned school children in Siaya district were normally absent-minded in class and were therefore unable to concentrate on their studies. Additionally, teachers commonly observed that orphans often became withdrawn while in class and this interfered with their learning process. This was confirmed by one teacher at Ngiya Girls' Primary School, Siaya who said:

*“An orphan is absent-minded and cannot concentrate in class”.*

Teachers revealed that those learners who missed school to attend funerals often lagged behind in their studies and could hardly catch up with the rest. It was also noted that some orphans did not want to go home for holidays because they did not have anyone to adequately care for their physical and emotional needs. It is on the basis of such observations that 24% of teachers in Siaya, 10.9% in Machakos and 12.9% of those in

Nairobi felt that the challenges associated with HIV and AIDS affected learner's concentration (see Table 15). Similarly, while 16.2% of all the teachers in the sampled districts felt that the challenges associated with HIV and AIDS affected learner's concentration, 16.8% of them thought that their overall academic performance was affected. These findings indicate that the implementation of the Free Primary Education (FPE) in Kenya faces challenges that go beyond inadequate resources. The quality of learning in the country's schools is threatened.

It is regrettable that very few case studies have been conducted on the impact of HIV and AIDS in Kenyan schools to determine the extent to which learners are affected so as to take appropriate measures.

### **3.3.10 Impact of HIV and AIDS on Schools**

This study found that apart from the teaching force, HIV and AIDS also affects support staff. Teachers reported that non-teaching members of staff who were infected with HIV were not effective in their duties. This led to poor services in some critical areas such as catering, at times causing delays in students' meals. Teachers who were interviewed feared that delayed or missed lessons would lead to non-completion of the curriculum, which, among other factors will ultimately affect school academic performance.

From FGDs, this study found that there was an increasing number of orphans in Machakos district, which is one of the serious challenges of HIV and AIDS. Because of the rising levels of poverty, the extended family system here is not able to adequately cater for the needs of these children. Poverty has eroded the capacity of guardians to take up additional children and responsibilities. Therefore, respondents expressed concern that stakeholders in the education sector do not have adequate resources and structured strategies for fending for the needy orphaned learners.

## **4.0 MITIGATION STRATEGIES**

This section contains interventions that have been put in place by the Government of Kenya, education institutions and other stakeholders as well potential mitigations to enhance the fight against HIV and AIDS.

### **4.1 Existing Mitigation strategies**

During the survey, stakeholders confirmed that the following initiatives had been taken to combat HIV and AIDS in Kenya.

#### **4.1.1 Declaration of HIV and AIDS as a National Disaster**

The study confirmed that to a large extent, success in the fight against HIV and AIDS in the country is attributed to the fact that HIV and AIDS has been officially recognised as a major challenge towards the provision of education in Kenya; has been declared a national disaster and resources have been mobilised to combat it. Respondents affirmed the effectiveness of the national campaigns including a nationally televised advertisement with the words “Pamoja Tuangamize Ukimwi” (Together let’s eliminate AIDS) in which the head of state featured.

#### **4.1.2 Policy Response**

As an official response to HIV and AIDS, Kenya developed a policy, which has gone through a number of significant phases. A National AIDS Committee was created in 1985, followed by a National AIDS and Sexually Transmitted Diseases (STDs) Control Programme (NAS COP) established in 1987 under the MoH and the Sessional Paper No. 4 of 1997 titled “*HIV and AIDS in Kenya*” (Republic of Kenya, 1997). The policy saw the creation of NACC to spearhead a multi-sectoral and participatory approach to checking the spread of HIV infections in the country. In addition to these milestones, having realized the adverse consequences of AIDS on the education sector, the Government of Kenya, with assistance from UNESCO, launched the *Education Sector Policy on HIV and AIDS*, which focuses on measures of preventing HIV infection, care and support for all affected, workplace issues and management of response and advocacy activities. The study found that due to the evolving policy response, a multi-sectoral approach had been adopted, making it possible for a number of government ministries, departments and agencies to share responsibilities that were once shouldered by the MoH



alone. The MoE has put in place a curriculum to address the challenges of HIV and AIDS in the country's education institutions. However, it was found that whereas the HIV and AIDS policy document had been disseminated to a significant number of education institutions, it was neither well understood by teachers nor translated well for easy operationalization.

#### **4.1.3 Training Teachers on HIV and AIDS**

The Government realized that the majority of teachers in the service had completed their training in teacher training colleges (TTCs) without adequate knowledge of HIV and AIDS. The survey found that a number of stakeholders were involved in HIV and AIDS training programmes where some of the sampled teachers had been involved. Interviews held at a TTC that was included in the survey as well as discussions with officials of the ACU at the MoE headquarters confirmed that principals and deputies of all private and public TTCs in Kenya had received training on HIV and AIDS. In order to enhance these mitigation efforts, HIV and AIDS was included as one of the 23 national investment programmes under the Kenya Education Sector Support Programme (KESSP) 2005-2010 (Republic of Kenya, 2005), which was being implemented during the survey. However, apart from lacking in clarity of strategies and priorities, it was reported that lack of resources was hindering the implementation of the programme resulting in a number of teachers remaining untrained on HIV and AIDS.

Members of the research team visited the Kenya Institute of Education (KIE) and held discussions with the Institute's ACU officials who confirmed that there was a national AIDS education curriculum for colleges, primary schools and secondary schools. Aimed at enhancing appropriate behaviour and change to the youth at their developmental stage to help in HIV and AIDS prevention and control, the curriculum is being infused and integrated into the TTCs curriculum in subjects such as biology, social ethics, Christian religious education, home science and consequently taught in primary schools. Pre-service training was an ongoing programme, which was being implemented in colleges for teacher trainees.

The effectiveness of empowering teachers with knowledge on HIV and AIDS through an infused and integrated national curriculum was not clear, with some respondents suspecting that lack of adequate training could be compromising its proper implementation. Considering that infusion and integration of knowledge on HIV and AIDS was not well implemented, respondents in this survey strongly recommended that teachers should be adequately trained on effective implementation of the HIV and AIDS curriculum in schools. During the survey, it was found that KIE was in the process of developing a curriculum for a stand-alone subject on HIV and AIDS to be taught in all education institutions in the country<sup>3</sup>. However, during focus group discussions, teachers noted that instead of adding an extra subject to the school curriculum, the content of the existing subjects should be modified so as to include HIV and AIDS education. They also suggested that for teachers to be effective in implementing HIV and AIDS education in schools, they should be adequately trained.

#### **4.1.4 AIDS Control Units**

Another strategy that was being used by the MoE to address the challenges of HIV and AIDS was the creation of ACUs to provide support to government employees. The study established that ACUs had been established at the Kenya National Union of Teachers (KNUT), each national university and in all its semi-autonomous government agencies. Interviews with officials of the MoE headquarters revealed that ACUs were taking leadership in championing NACC policies so as to integrate AIDS prevention and control priorities into mainstream ministry functions. For instance, the ACU at the MoE was reportedly working alongside similar units in the country's higher education institutions including universities as well as the one at the TSC.

The study found that the ACU at the TSC was involved in a number of activities aimed at minimizing the impact of HIV and AIDS among teachers. Box 1 highlights its ongoing efforts.

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<sup>3</sup> It is significant that members of the Kenya Network of Positive Teachers (KENEPOTE) strongly supported the development of a stand-alone subject on HIV and AIDS to be taught in education institutions.

### **Box 1: Teachers Service Commission AIDS Control Unit**

The ACU of the TSC is working on a programme to strengthen management of HIV and AIDS in all public schools in Kenya. The highlights of their programme are:

- Engage all DSOs and District Human Resource Officers DHROs to organise capacity building workshops in their districts. ACU proposes that 70 teachers from each district be trained as Trainers of Trainers (ToTs).
- Work out/establish a coordination mechanism with the MoE, KNUT, KUPPET, Kenya Secondary School Heads Association and Kenya Primary School Heads Association on the training of the ToTs.
- Harmonise the training tools and programmes.
- Carry out a baseline survey on what has been done on the ground on the management of HIV/AIDS.
- Ensure that monitoring and evaluation is part of a continuous process of the ACU strategies.
- Build capacity of all teachers and ensure that every school in Kenya has a Guidance and Counselling teacher who is capacity-built on HIV and AIDS management.
- ToTs operationalise programmes to the district sub-ACUs.
- Roll out more Information, Education and Communication (IEC) materials to all schools regularly
- Disseminate policy documents to the grassroots (all schools).
- Strengthen the capacity of district branches of the KENEPOTE.

Like other ACUs within the MoE of Education, TSC's unit faces challenges including financial constraints, which affects the implementation of the proposed programmes. The study found that there was an urgent need for adequate and active involvement of all teachers in the activities and programmes aimed at controlling HIV and AIDS in the education sector. Members of KENEPOTE who were interviewed pointed out that centralizing the services offered by ACU makes it difficult for their members to receive quick assistance when in need. These teachers recommended a decentralization of the ACU's services so as to reduce the amount of time teachers spend traveling the TSC headquarters to seek assistance. They felt that the current centralized ACU was not effective.

#### **4.1.5 Teachers' HIV and AIDS Support Groups**

The study found that psychosocial groups had been established to support teachers who were living with HIV in some schools in the sampled districts. However, it was not possible to establish the existence of these groups in areas where respondents denied the presence of HIV positive teachers in their schools.

**Kenya Network of Positive Teachers (KENEPOTE):** A major effort that was reported to be fruitful in addressing challenges caused by HIV and AIDS among teachers in Kenya was KENEPOTE, which has enabled the TSC's ACU to meet some of its objectives. As a

result of stigma, respondents reported that HIV and AIDS was still a big challenge in schools. This had resulted in the organization's membership being limited to only 4,000 in all schools countrywide. It was revealed that stigma was higher in primary schools compared with secondary schools owing to higher levels of ignorance on HIV and AIDS in the former. Members of KENEPOTE who were interviewed said they regretted that because of stigma, there were many cases of transfers of teachers suspected of being HIV positive. This was because such teachers were reportedly prone to absenteeism. During interviews with teachers, it was revealed that because of stigmatisation, a number of teachers were unwilling to reveal their HIV status in addition to skipping school to seek treatment without divulging reasons for being absent.

It was noted that a number of KENEPOTE members acknowledged the pivotal role that the TSC was playing in supporting HIV positive teachers. This is demonstrated by the support it has been giving members by stressing that no teacher would be transferred, interdicted or retired due to his/her HIV status. Such teachers would be allowed to serve as TSC employees for as long as they were able to discharge their duties until they attained the retirement age. It was hoped that if more efforts were put in mobilizing more HIV positive teachers to join KENEPOTE, the Government would be able to assist them become more effective in their work. From focus group discussions held with members, it was noted that KENEPOTE has a unique role in addressing the HIV and AIDS challenges among teachers. The network, however, lacks comprehensive donor support to enhance its institutional strengthening, and strategic planning which would ensure its sustainability. Owing to internal disagreements among members, it was reported that a splinter group of KENEPOTE had emerged in Nairobi. This group was called Teachers Against AIDS (TAA).

**Teachers Service Commission Network for Positive Living (TESCONEP):** This is an organisation of the TSC headquarters' employees living with HIV. TESCONEP was established in 2005 and had a membership of 200 at the time of the study. Enjoying the support of the Commission's ACU, TESCONEP had been sensitising all officers at the

secretariat about stigma in the workplace. TSC employees interviewed said that the organisation was working well with the members.

#### 4.1.6 HIV and AIDS Mitigation Strategies Adopted in Schools

The study sought to establish the HIV and AIDS challenges facing schools in the three sampled districts. From a list of six common HIV and AIDS challenges, teachers were asked to indicate the ones faced by their schools/institutions. The results are indicated in Table 20.

**Table 20: Existence of HIV and AIDS Challenges in Schools (%)**

HIV and AIDS challenges in schools	District			School		All
	Nairobi	Machakos	Siaya	Prim/special	Sec/tech	
Teacher absenteeism	71.2	77.3	89.7	81.2	76.2	80.3
Teachers sickness	77.0	81.2	92.6	86.1	76.7	84.3
HIV and AIDS stigma & discrimination	78.2	81.6	89.8	85.3	77.1	83.7
Transmission of HIV	82.2	86.9	92.5	89.0	82.6	87.8
Death of teachers' spouse, child due to HIV& AIDS	70.2	72.1	84.0	77.6	68.5	75.9
Teacher shortage	74.1	81.2	91.8	83.9	80.6	83.3

From the data in Table 20, Siaya district had the highest proportion of schools facing each HIV and AIDS challenge, followed by Machakos and then Nairobi. The implication of this finding is that the two rural districts have more HIV and AIDS challenges to deal with than Nairobi. This suggests a higher impact of HIV and AIDS prevalence in Siaya and Machakos districts compared quite well to that of Nairobi. Each sampled district identified with all the six HIV and AIDS challenges provided and the results were above average. However, a few extreme scores were evident for some challenges in Siaya such as strategies to deal with teacher sickness (92.6%) and those for transmission of HIV and AIDS had a similar response (92.5%). Additionally, primary schools appear to have more HIV and AIDS challenges than secondary schools as shown in the Table 16.

Further, teachers were asked to indicate the strategies that were being used to manage the HIV and AIDS challenges provided in the questionnaire. Their responses are summarized in Table 21.

**Table 21: Strategies Employed by Schools/Institutions (%)**

Strategies for various challenges	District			School	
	Nairobi	Machakos	Siaya	Prim/ special	Sec/ tech
<b>Teacher absenteeism</b>					
Provide homework for learners	69.2	76.0	70.9	72.9	70.5
Transfer the teacher	1.9	3.3	5.1	4.0	2.6
No action is taken	5.1	3.3	4.5	3.8	5.8
Engage teacher substitutes/relief teachers	50.8	33.3	41.9	42.0	33.5
Reallocation of work	38.3	37.5	45.3	40.5	41.9
<b>Teacher sickness</b>					
Reduce workload	48.3	43.2	44.9	45.4	43.1
Engage teacher substitute/relief teachers	39.2	31.6	37.2	35.6	35.1
Solicit support for sick teachers	29.8	29.1	28.4	29.6	26.1
Recommend guidance and counselling	42.5	44.2	31.4	41.1	27.6
Encourage teacher to seek medical help	55.9	62.8	77.7	70.3	52.0
<b>Stigma and discrimination</b>					
Create HIV and AIDS awareness	77.0	69.4	71.1	72.7	67.4
Encourage guidance and counselling	74.1	78.1	70.6	75.7	67.7
Promote psychosocial support groups	36.8	31.8	36.5	36.0	28.6
<b>Transmission of HIV</b>					
Encourage guidance and counselling	69.3	78.1	68.6	73.4	68.5
Inviting relevant guest speakers	59.1	50.2	40.9	46.9	57.1
Organize HIV and AIDS open days	35.7	42.2	33.2	38.1	33.6
Promote use of condoms	13.2	13.8	18.5	15.7	14.1
Facilitate training on HIV & VCT	51.1	43.7	39.8	45.5	36.3
Encourage visits to VCT	35.7	37.6	49.8	43.9	32.0
<b>Death of teachers, spouse or child</b>					
Financial support to family	76.0	73.9	66.1	71.8	68.5
Temporary taking up of missed classes	50.1	45.9	66.8	56.4	48.9
Empathize with them	52.8	47.3	33.2	42.4	45.7
<b>Teacher shortage</b>					
Distributing workload appropriately	82.2	76.0	74.2	76.9	75.1
Use of substitute/relief teachers	35.0	38.9	56.2	45.0	44.5
Report matter to TSC for action	42.8	45.0	42.4	41.7	51.9
Use Multi-grade teaching	23.1	29.0	20.8	42.5	52.5
Use Multi-shift teaching	9.7	10.7	8.3	10.7	4.4

Table 21 shows that varied strategies were being used to manage HIV and AIDS in different schools and institutions most of which were common across the sampled districts. Providing homework for learners (averagely rated 72%), was used as a temporary remedy to manage teacher absenteeism while transfer of teachers was hardly used as a mitigation strategy. Sick teachers were encouraged to seek medical advice in all the schools/institutions. Reduced workload for the sick teachers was also another strategy for managing the challenge. Stigma and discrimination was being managed through

creation of HIV and AIDS awareness and encouraging teachers to seek guidance and counselling services. A similar strategy was used to manage challenges such as transmission of HIV. It was also found that inviting relevant guest speakers was a strategy that was adopted in most schools in the three study districts to manage stigma and discrimination. Financial support featured top as a strategy for managing the problem of loss of teachers and their spouses, children and other relatives as a result of HIV and AIDS illnesses. Respondents revealed that their schools distributed workload appropriately among the serving teachers at any given time when there was teacher shortage.

It was evident therefore that in all the districts, schools/institutions preferred employing guidance and counselling as a strategy to manage teacher sickness, stigma and discrimination and transmission of HIV. In addition to the mitigations reported in Table 20, teachers' focus group discussion mentioned some institutional measures to address HIV and AIDS-related challenges. These included creating HIV and AIDS awareness among teachers and students through clubs, providing emotional, social and financial support to the affected teachers, development of lesson make-up policy to manage absenteeism in schools, among others.

#### **4.1.7 HIV and AIDS Workplace Policy**

The study found that some national education institutions such as TTCs had developed HIV and AIDS workplace policies to mitigate the impact mainly by preventing new infections and to support staff directly affected. However, almost every teacher interviewed in this study lamented about the absence of well-conceived AIDS in the Workplace (AIW) programmes in their schools. Therefore, there is an urgent need to mainstream HIV and AIDS in Kenya's education institutions so as to effectively deal with its consequences, which are affecting the school operations.

#### **4.2 Proposed Mitigations**

It was necessary to also find out if there were any other mitigation strategies that could be adopted to manage the challenges associated with HIV and AIDS in the sampled districts. Respondents of this survey were therefore asked to state their opinions on what they

thought could be done differently so as to manage the challenges of HIV and AIDS. The proposed mitigations target teachers as well as specific categories of other key stakeholders.

#### 4.2.1 Proposed Mitigations for HIV Positive Teachers

Members of KENEPOTE who participated in the FGDs identified stigma and denials as the major hindrances to the fight against HIV and AIDS in schools. According to them, stigma prevents teachers from knowing their HIV status, thus resulting in untimely deaths when they do not seek appropriate medical attention in time. With this in mind, teachers were asked to propose potential ways of managing stigma and discrimination. Based on the major challenges facing teachers who were living with HIV, they proposed several mitigations, which are summarized in Table 22.

**Table 22: Proposed Mitigation Strategies for HIV Positive Teachers**

<b>Strategies</b>	<b>N</b>	<b>%</b>
Encourage/train/counsel the teachers to live positively	1079	38.7
Encourage teachers to seek medical care (including ARVs)	454	16.3
Give teachers material/financial support	378	13.6
Be lenient on teachers in terms of workload	320	11.5
Colleagues should show compassion and provide moral assistance	189	6.8
Openly discuss HIV issues/ encourage them to join support groups	91	3.3
Train teachers on balanced diet	45	1.6
Give equal rights/treat everyone without discrimination	39	1.4
Take over teaching in their classes	20	0.7
Have favourable policy guidelines e.g. early retirement	20	0.7
Train teachers to become HIV and AIDS trainers or crusaders	15	0.5
Post teachers to schools of their choice/nearer home	11	0.4
Give talks on HIV in schools	4	0.1
School should not recruit infected teachers	2	0.1
Take no action	119	4.3
<b>Total</b>	<b>2786</b>	<b>100.0</b>

From Table 22, potential mitigations that were recommended by respondents include providing guidance and counselling in schools/institutions for both the infected and affected teachers, which featured most prominently (39%), followed by encouraging teachers living with HIV to seek medical attention (16.3%), giving teachers material/financial support (13.6%), reducing teaching workload (11.5%) and urging teachers to show compassion to their colleagues who are HIV positive. Members of KENEPOTE proposed that appropriate services should be extended to HIV positive teachers, including retired teachers and those who were serving in private schools. They



felt that this would enhance their effectiveness because all teachers were serving Kenyan children.

Teachers were also asked to suggest potential mitigations for teachers who were in one way or another affected by HIV and AIDS. Their responses are shown in Tables 23.

**Table 23: Proposed Mitigation Strategies for Affected Teachers**

<b>Strategies</b>	<b>N</b>	<b>%</b>
Do more guidance and counselling/post guidance and counselling teachers to schools	1,115	44.8
Provide material/financial and moral support	587	23.6
Show compassion	277	11.1
Allow time to attend to the infected/ reduce workload	180	7.2
Form support groups to share experiences among teachers	116	4.7
Organize HIV and AIDS open days/trainings/regular in-service for teachers	106	4.3
Involve the affected in normal duties/treat them normally	26	1.0
Allow them early retirement with full benefits	19	0.8
Post them nearer home	11	0.4
Take no action	54	2.2
<b>Total</b>	<b>2,491</b>	<b>100.0</b>

As shown in Table 23, respondents prescribed mitigations for the affected teachers that were almost similar to those for teachers who were living with HIV and had been stigmatized. For instance, most of the respondents (44.8%) recommended provision of guidance and counselling services in schools/institutions, followed by provision of material/financial and moral support (23.6%), showing compassion (11.1%), and reducing workload (7.2%). Use of friends to talk to those affected in the schools was also floated and strongly recommended by teachers who were living with HIV as an effective gesture of compassion. It is significant to note that, apart from the provision of financial or material support to the affected teachers, some of the potential mitigations recommended such as showing compassion and guidance and counselling can be implemented in schools at considerably minimal costs. However, it was noted that some teachers were not aware of available provisions by the TSC for managing some of the HIV and AIDS challenges that they were facing.

#### 4.2.2 Proposed Mitigations for Transmission of HIV

On being asked to indicate how HIV transmission can be minimized, teachers recommended a number of prevention measures that are shown in Table 24.

**Table 24: Proposed Mitigation Strategies for Transmission of HIV**

Measures/strategies	N	%
Emphasize HIV prevention/Encourage use of protection/safe sex	1,765	68.5
Encourage abstinence/discipline/self preservation/good morals	355	13.8
Sensitise the teachers on being faithful to one partner	205	8.0
Encourage disclosure of HIV status	111	4.3
Promote behaviour change	48	1.9
Prosecution of those who deliberately transmit the virus	20	0.8
Support by government/create support groups	16	0.6
Inclusion of HIV and AIDS issues in the syllabus	15	0.6
Take no action	39	1.5
<b>Total</b>	<b>2,574</b>	<b>100.0</b>

From Table 24, most of the teachers in the sampled schools felt that HIV infections among teachers could be prevented through the use of protection methods/engaging in safe sex (68.5%), encouraging abstinence/discipline/self preservation/good morals (13.8%) and sensitising teachers on being faithful to one partner (8.0%). Again, these are mitigations that can be implemented in schools. For instance, an empowered TSC's ACU (with the support from relevant stakeholders within its network) can assist teachers to minimize new HIV infections so as to ultimately reduce the impact of HIV and AIDS on the country's education sector.

Although few respondents (4.3%) recommended declaration of HIV status as a potential mitigation to minimize new infections, members of KENEPOTE indicated that it was critical for all teachers to know their status. To encourage them to do so, it was suggested that VCTs should be made user-friendlier by locating them within health facilities and manned by professionally qualified and experienced counsellors to cater for clients of all age groups. They pointed out that owing to stigma, teachers were unwilling to visit VCTs that were in distinct locations.

#### 4.2.3 Proposed Mitigations for Stigma and Discrimination

During the survey, teachers in the sampled districts were asked to prescribe specific strategies of managing stigma and discrimination, which was identified as a major

challenge in the fight against HIV and AIDS among teachers. Their proposals are presented in Table 25.

**Table 25: Proposed Mitigation Strategies for Stigma and Discrimination**

<b>Strategies</b>	<b>N</b>	<b>%</b>
Increase teachers' awareness on HIV transmission	606	28.2
Encourage visits to the infected to give support and compassion	501	23.4
Discourage discrimination and stigmatization in schools	488	22.8
Encourage positive living of those affected	488	22.8
Educate HIV positive teachers on their rights	9	0.4
Isolate the infected and affected	2	0.1
Take no action	50	2.3
<b>Total</b>	<b>2,144</b>	<b>100.0</b>

As can be seen in Table 25, potential HIV and AIDS mitigations that were recommended include increasing teachers' awareness on HIV transmission (28.2%), encouraging teachers to emotionally support their HIV positive colleagues (23.4%), minimizing stigma and discrimination in schools (22.8%), encouraging teachers living with HIV to adopt positive living (22.8%) and sensitize HIV positive teachers on their rights (0.4%). It was reported that among people without AIDS education, fear of being suspected to be HIV positive was a major deterrent to the management of HIV and AIDS in schools. Stigma was therefore the main reason why teachers were unwilling to know their HIV status. Members of KENEPOTE felt that HIV positive teachers could be assisted to adopt positive living as they undertook their duties. Given the TSC's ACU mandates, it is feasible that some of the potential strategies of managing stigma and discrimination can be implemented in schools. They strongly recommended also that stakeholders should urge churches not to insist on HIV status certificates before marriage and encourage prominent personalities, including members of the clergy and other leaders to openly declare their HIV status. It is hoped that this will encourage more teachers to declare theirs too.

#### **4.2.4 Proposed Mitigations for Absenteeism**

Although it is difficult to ascribe causes, teacher absenteeism was considered a major problem in schools. As reported in Table 11, between 8% and 21.1% of all the teachers in the three sampled districts reported that they had been absent from school at least five times during the first term of 2007 for reasons including sick leave, attending official

functions or funerals. Whatever the cause, teacher absenteeism affected learning and hence the quality of education in schools. A number of mitigation strategies of managing teacher absenteeism in schools/institutions were proposed during FGDs. These include the following:

**Hiring support or relief teachers on contract:** Respondents recommended that school management committees or boards of governors should hire teachers to relieve HIV positive teachers when they are unable to teach. It was reported that some schools in some parts of Kenya were hiring bright secondary school leavers to coach standard eight pupils for the Kenya Certificate of Primary Education (KCPE). Such persons may be used to assist teachers living with HIV in the classrooms when they are weak but can teach. This is a common practice in some parts of the world where such persons are referred to as “assistant teachers” or “classroom aides”. However, hiring such teachers will depend on the government making appropriate frameworks to ensure availability of resources in the affected schools if such a strategy was to become operational.

**Employing more trained teachers:** Teachers suggested that training more teachers and employing them could manage absenteeism in the affected schools. This proposal should be considered in the light of the ‘freeze’ by Kenya’s donors on hiring more civil servants including teachers as conditionality for further donor funding of the country’s development programmes. However, the merit of this proposal is that the implementation of the FPE programme led to an increase in enrolment in the country’s primary schools without a corresponding increase in the number of teachers. Consequently, it was reported that teaching was not effective in some of the sampled schools. This was partly because these schools were not receiving new teachers to replace those leaving due to natural attrition, dismissals, and retirement or joining other careers. From discussions with other education stakeholders, formally training more teachers to fill staff shortages and cover absenteeism shall not be a viable solution to the problem of teacher absenteeism. This is because despite a reported acute shortfall of teachers in schools, there was a stock of trained but unemployed teachers.

**Reducing workload:** Some respondents suggested that absenteeism should be managed by reducing the workload of the teachers who were living with HIV so that they can teach a manageable number of lessons. It was found that this was the practice in a number of schools visited, with the consequence that other teachers were handling huge workloads, which meant that teaching and learning was ineffective. Considering that teachers living with HIV were reportedly emotionally stressed for fear of losing their jobs thereby reducing their effectiveness, they suggested that their salaries should not be stopped but instead they could be allowed to retire on medical grounds and be paid their benefits.

**Educate the school management on how to cope with absenteeism:** Another proposal was empowering school committees to be able to manage teacher absenteeism. This was a plausible recommendation considering that school managers were expected to be in full control of situations in the schools especially to ensure that the curriculum was carefully implemented. This is consistent with devolution, which has been embraced in the management of education in many countries.

**Sensitising all teachers on HIV and AIDS policies and frameworks:** During focus group discussions with teachers, it was revealed that some teachers who were living with HIV in the sampled districts were either not aware of or did not understand the existing HIV and AIDS policies and frameworks. Respondents expressed a strong desire for information, training, prevention strategies, and curriculum support in the light of the challenges associated with HIV and AIDS. They should know the provisions available for HIV positive teachers, legal rights, and adequate medical protection. From this survey, it would appear that equipping all teachers, especially those living with HIV, with relevant details of the existing policy frameworks would enable them to cultivate a more positive attitude towards life. As mitigations are adopted to manage teacher absenteeism in schools, the study found a compelling need for pupils to have access to a good quality education even as teachers are wont to short- and long-term absenteeism and death. It was felt that proactive strategies and policy options should be designed and carefully implemented so as to address the reported teacher shortages and absenteeism at the school level.

### **4.3 Mitigations Proposed for Specific Stakeholders**

On being asked to identify strategies to be adopted by key stakeholders to enhance the management of HIV and AIDS challenges in schools, respondents suggested a number of potential strategies. It is hoped that a summary of these strategies will supplement other potential mitigations discussed elsewhere in this report.

#### **4.3.1 Ministries of Education and Health**

Respondents recommended that the use of artificial sex objects as a means of communicating HIV and AIDS messages should be discouraged in schools. Instead, teachers felt that stepping up HIV and AIDS awareness in schools through drama, open days and seminars would be more effective. They also recommended that the MoE should provide medical, financial and material assistance directly to the affected teachers and ensure that facilities and finances for HIV and AIDS reached schools in time. Such financial support could be in form of increased pay and allowances for HIV positive teachers who were faced with persistent financial crises due the high cost of treatment among other reasons.

During the study, it was recommended that the Government through the MoE should not only involve teachers and school management in HIV and AIDS activities in schools but also undertake continuous monitoring and evaluation of ongoing programmes to ensure their effectiveness. Most respondents in the survey urged all government departments and agencies to mobilize funds so as to conduct regular HIV and AIDS surveys in schools. Some teachers suggested that relevant government officers should make regular visits to schools to conduct impact assessments on HIV and AIDS. For convenience, a number of respondents expressed the desire for the provision and expansion of HIV and AIDS services such as VCTs within the vicinity of school communities<sup>4</sup>. This would ensure that HIV positive teachers and other members of the school community have access to Anti-retroviral drugs.

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<sup>4</sup> Members of KENEPOTE reported that their colleagues were discouraged from visiting VCTs located outside of hospitals and health centres for fear of being stigmatised.

#### **4.3.2 Teachers Service Commission**

Whereas most of the respondents acknowledged the Commission's concern about their welfare, they expected their employer to do much more especially in assisting teachers to cope with the challenges of HIV and AIDS. For instance, they recommended that TSC and schools should liaise with other stakeholders to ensure that the HIV and AIDS policy is well implemented. They especially singled out the code of regulations on stigma, which needs to be adhered to. Reiterating their request to the MoE, respondents recommended for an increase in their salaries in addition to improving the terms and conditions of service for all teachers affected by HIV and AIDS. To manage teacher absenteeism in schools, the TSC was urged to employ more teachers, including those who are HIV positive. As a measure of curbing HIV infections, the TSC was asked to allow spouses to work in the same stations or geographical locations, a practice that was confirmed to be operational. Respondents recommended that deploying professionally qualified counsellors in all learning institutions will be a more effective strategy of managing HIV and AIDS in the education sector. It was reported that some of the teachers undertaking counselling and guidance services were not only unskilled, but had no adequate time to provide counselling services in schools. Some teachers suggested that the physical locations of counselling within school premises was an issue because teachers as well as learners were not comfortable being seen going there. This is partly because of the stigma associated with HIV and AIDS.

Teachers in all the sampled districts emphasized that, for greater success in the fight against HIV and AIDS in schools, they must be directly involved. It is for this reason that it was recommended that the TSC's ACU and other stakeholders should train teachers to equip them with the skills of managing HIV and AIDS in schools. The need for such training was confirmed by AEOs and Teachers' Advisory Centre (TAC) coordinators who confessed that, although they were well trained on HIV and AIDS, they did not have adequate time and opportunity for imparting relevant skills to teachers who required them. Owing to the reported countrywide shortage of education administrators, the study found that TAC coordinators were busy doing the work of quality and standards assurance officers, leaving them with little or no time to provide counselling services.

Most study respondents suggested that the TSC's ACU should be provided with an enhanced budgetary allocation so as to strengthen the activities of support groups in order to reach more teachers. They also suggested that more skilled personnel (including those who are HIV positive) should be deployed at the ACU to professionally handle HIV positive teachers. It was felt that KENEPOTE should be more involved in workshops for teachers where its members are used as facilitators.

#### **4.3.3 School Communities**

Respondents suggested a number of ways in which school communities could get involved in the management of HIV and AIDS challenges. These include establishing health clubs/support groups and providing financial and material support to the infected and affected teachers in schools. By collaborating with other stakeholders for partnership in managing HIV and AIDS challenges, school communities should be empowered to adopt sustainable programmes to meet the needs of AIDS orphans in their schools. Mobile theatres were reportedly to be highly effective in communicating HIV and AIDS messages and as a strategy for addressing stigma and discrimination within school communities.

#### **4.3.4 Kenya National Union of Teachers**

The study found that KNUT's ACU is concerned with the welfare of its members in the sampled districts. Whereas teachers appreciated the effort of their trade union, they felt that it would be more effective if those affected by HIV and AIDS were to be given financial assistance to help them cope with increasing medical expenses and other needs. In addition to lobbying for more support and advocacy for the management of HIV and AIDS challenges facing its members, including stigma and discrimination, KNUT should conduct HIV and AIDS awareness campaigns and strengthen teacher welfare structures in schools.

#### **4.3.5 Educators**

As stakeholders, teachers and lecturers in the sampled schools and institutions recommended that their role should be more prominent than previously. They said this could be achieved by establishing more effective support or welfare groups to be able to



reach more teachers. This was because such groups were reportedly effective in providing psychosocial help to teachers living with HIV. They challenged each other to be working more actively with other stakeholders as appropriate in eliminating stigma and discrimination, which affected their colleagues. This will undoubtedly encourage disclosure among their affected colleagues. It was also recommended that by forming lobby groups for the infected and affected teachers, they will become effective role models in managing HIV and AIDS challenges that affected their schools.

#### **4.3.6 National AIDS Control Council**

As a national organization coordinating HIV and AIDS programmes, some of teachers in the sampled districts felt that NACC was not visible on the ground. They suggested that NACC should spearhead the formulation and implementation of a separate policy to enhance the care and support of People Living With HIV and AIDS (PLWA). It was felt that given appropriate support, teachers living with HIV would be made more effective in their duties. By directly getting involved in creating awareness of NACC in schools, teachers would understand its role and be able to support its programmes. Teachers who were interviewed recommended that NACC should mobilize more resources for HIV and AIDS programmes at the grassroots especially in schools. A need was clearly felt for NACC to monitor and evaluate all HIV and AIDS activities by various community-based organizations (CBOs), faith-based organizations (FBOs) and home-based organizations (HBOs) so as to effectively manage the challenges of HIV and AIDS in schools.

#### **4.3.7 Locally Based Organizations**

It was felt that although there were many locally based organizations, which were involved in HIV and AIDS programmes, their effectiveness was not evident. To revitalize them, teachers suggested that these organizations should initiate income-generating activities for PLWA within the school communities, including teachers. These would economically empower them to meet their financial obligations. In addition to providing financial support to the affected teachers, these organizations should train more people in home-based care skills such as personal hygiene and nutrition, especially in schools. Given that they are strategically located, if these organizations formulated better strategies for addressing HIV and AIDS, they could become more effective in their work.

For instance, it was suggested that they should reach out to the school communities as a whole instead of merely concentrating on those homes with persons living with HIV.

#### **4.3.8 Education Institutions**

Teachers expressed their displeasure at the manner in which some of their colleagues who were living with AIDS were being treated outside their schools. They revealed that their colleagues who were living with HIV only found refuge in their schools. During the study, it emerged that schools were effective centers around which HIV and AIDS programmes should be organized. For instance, by using wall drawings to pass information on HIV and AIDS to learners and the school community at large, schools were found to be the most cost effective and efficient centres of reaching young people.

## **5.0 CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 Summary of Key Findings**

From practice and what was proposed, the study found that managing the education human resource impact of HIV and AIDS can be categorized into two main areas. The first one involves the provision of social support for teachers through strategies such as HIV and AIDS workplace policy, demystification of HIV and AIDS, appropriate and adequate medical care, other care and support as well as enhancing VCT. The second one is by strengthening human resource management system through appropriate teacher allocation deployment and motivation systems. Major findings in specific areas include the following:

#### **5.1.1 HIV and AIDS Data Collection and Management**

The study found that accurate, up-to-date data on HIV and AIDS-related teacher attrition absenteeism and impact projections are acutely lacking. Such data would enable the TSC and other relevant agencies to monitor what is happening to educational staff force for appropriate action. For instance, if appropriate arrangements were made, the MoE can request the MoH to computerize all data on patients visiting hospitals. Hospital records have useful details, which can be used to estimate the precise HIV prevalence among teachers. Relevant staff in the MoE should be well trained on data collection and management so as to create reliable data banks at all levels. The use of appropriate information and communication technology should be enhanced for easy access to such data banks. For instance, it was reported that there were huge amounts of data in government offices (including TSC), which could not readily be accessed during the survey because they were kept in paper form. Continuous collection of accurate data was, therefore, recommended to develop data banks so as to build the best and promising practices on HIV and AIDS challenges in education institutions.

#### **5.1.2 TSC's AIDS Control Unit**

Although the study confirmed that the ACU played a significant role in the management of challenges facing teachers living with HIV, it was under funded and under staffed as well. Teachers were reportedly taking a long time to travel to the TSC headquarters to seek assistance. Therefore, there was need to increase budgetary allocations to the ACU

and decentralize its activities to lower levels where more professionally qualified staff should be deployed in order to assist teachers more effectively. Such staff should include teachers who were living with HIV and who were skilled in the management of HIV and AIDS. Greater involvement of teachers is an effective strategy of fighting against HIV and AIDS in schools.

### **5.1.3 Stigma and Discrimination**

The study found that stigma and discrimination were the major hindrances in the fight against HIV and AIDS among teachers. There was a strong feeling that not much was being done by relevant stakeholders to minimize stigma and discrimination among teachers. They felt uncomfortable with the insistence that couples produce HIV status certificates before they could be allowed to have a Christian wedding in church when public personalities such as members of the clergy and other leaders have not openly declared theirs. The study found that more efforts are required to minimize stigma and discrimination to make teachers living with HIV feel more acceptable within their communities, including schools.

### **5.1.4 School-level HIV and AIDS Specialists**

Respondents in the survey felt that relevant personnel in schools and existing health facilities did not adequately attend to teachers living with HIV. The study found that as a result of lack of full time specialized HIV and AIDS personnel, there was a disjoint between policy and practice in the sampled schools. Guidance and counselling teachers were reportedly not skilled enough to manage issues associated with HIV and AIDS. They were also unable to cope with their teaching workloads in schools. A strong desire was expressed that the government hires school-level specialists to be in charge of the school-level response, framework, dissemination of current and new information, and curriculum. Here they could coordinate clubs and activities around HIV and AIDS in schools, which are open to students, staff, and community members. These specialists should be trained in confidentiality measures, disclosure, individuals' rights, use of policy frameworks, and AIDS curriculum issues. Trained in socio-psychological counselling, these specialists should also be able to conduct school-level training for teachers and

other staff. Such personnel will ensure that HIV and AIDS policy becomes practice in schools.

#### **5.1.5 Enhanced Terms of Service for Teachers**

Owing to rising costs of living, teachers living with HIV were found to be facing persistent financial crises. Consequently, they were unable to meet the increasing costs of medical attention and other obligations. It was found that most teachers living with HIV spent time wondering about their uncertain future because they could not adequately meet their financial obligations. This evidently reduced effectiveness in the discharge of their school duties. Financial and material support strongly featured as a strategy to mitigate the impact of HIV and AIDS among teachers. There was need for relevant stakeholders such as the TSC and trade unions to consider improving teachers' terms of service and ensure that their rights and access to appropriate healthcare and other benefits are clearly defined to them. It is hoped that if specific provisions were made to offer appropriate financial, emotional and material support to teachers living with HIV, they would be encouraged to declare their status. The cost of these benefits must be weighed against that of losing skilled professional teachers early in their careers. This would be a critical step in an effort to address the challenges of HIV and AIDS especially stigma.

#### **5.1.6 Disseminate and Simplify the HIV and AIDS Policy**

The study found that whereas some teachers were not aware of the HIV and AIDS policy, others did not fully understand it. It is, therefore, recommended that the policy should be well disseminated among all stakeholders especially teachers. Further, all stakeholders should ensure that simple manuals on how to manage HIV and AIDS challenges are available to teachers and learners who should be trained on how to use them. It was disclosed that useful documents were often circulated without training recipients on how to use them.

#### **5.1.7 Developing an Effective Comprehensive Strategic Response**

Lack of effective coordination of all HIV and AIDS-related programmes was evident in the sampled districts. Information gaps, which partly left out many teachers from some of the ongoing support activities and programmes were reported. There was need for an effective comprehensive strategic response towards the HIV and AIDS challenges facing

teachers in Kenya. This study calls for stronger linkages and alliances between teachers' unions, education groups and health groups to create platforms for policy discussions and communicating new information. By being more proactive and systematic, players in the fight against HIV and AIDS among teachers will enhance the adoption of potential mitigations so as to assist all the affected teachers and learners.

#### **5.1.8 Development of Workplace Policies in Education Institutions**

Where workplace policies existed, members of staff were receiving support to cope with the HIV and AIDS challenges. However, there were no structured workplace systems and/policies in all the schools visited during the survey. This showed that teachers living with HIV and those affected by AIDS were not adequately catered for at the workplace. It is, therefore, recommended that schools and other education institutions be encouraged by relevant stakeholders to develop workplace HIV and AIDS policies.

#### **5.1.9 Support Groups**

The study found that psychosocial groups such as KENEPOTE and TESCONEP were playing a critical role in supporting teachers living with HIV. But it was found that there were no clear administrative structures in these groups, causing them to be ineffective in mobilizing new members and attracting funding for capacity building and other operations in schools. For instance the study found that in addition to KENEPOTE being unknown in a number of schools in the sampled districts, it was discovered that there was a splinter group of in Nairobi. Despite a low membership, Teachers Against AIDS (TAA) was an affiliate of KENEPOTE, which was quite effective in Nairobi, where it was supporting a number of HIV positive teachers.

### **5.2 Policy and Programming Recommendations**

- The MoE in consultation with the MoH and relevant agencies such as NACC should develop and implement an effective system of collecting accurate data on HIV prevalence, morbidity and mortality rates on a continuous basis. Such data will enable the TSC and other relevant agencies to monitor what is happening with educational staff for appropriate action to be taken in good time. In particular, education management information systems (EMIS) should be

strengthened in order to capture accurate data on teacher absenteeism and mortality as a result of AIDS.

- Given its critical role in assisting teachers living with HIV, the TSC's ACU should be enhanced with increased budgetary allocations, decentralize its activities to lower levels and engage more staff who are professionally qualified, some of who should be teachers living with HIV. It is hoped that these measures will make the management of HIV and AIDS challenges more effective.
- To overcome stigma and discrimination among teachers, all stakeholders should agitate for the demystification of HIV and AIDS by urging churches not to insist on a status certificate before marriage and encouraging prominent personalities in the society such as members of clergy and other leaders to openly declare their HIV status. This will encourage more teachers to declare theirs too.
- Owing to lack of full time specialized HIV and AIDS personnel and the subsequent disjoint between policy and practice in the sampled schools, this study recommends that school-level specialists should be hired and deployed and put in charge of the school-level response, framework, dissemination of current and new information, and curriculum.
- Persistent financial crises contribute to reduced effectiveness of teachers living with HIV. To enable them meet their obligations that include increasing medical bills and household expenses, relevant stakeholders such as the TSC and trade unions should improve the teachers' terms of service. At the same time, efforts should be made to ensure that their rights and access to appropriate healthcare and other benefits are clearly defined to them. This would be a critical step in an effort to address challenges of HIV and AIDS.
- As a result of unawareness or inadequate understanding of the HIV and AIDS policy among some teachers, it is recommended that it should be well disseminated among all stakeholders, especially teachers. The policy should be simplified and user-friendly manuals developed to guide all stakeholders on its implementation.
- Due to lack of coordination of HIV and AIDS-related programmes, there were reported information gaps, which partly left out teachers from some of the

ongoing support initiatives. It is recommended that all HIV and AIDS stakeholders including teachers' unions, education groups and health groups adopt a proactive and systematic approach in addition to forging stronger linkages and alliances in sensitizing teachers on policy issues and new information so as to empower them.

- The absence of structured workplace systems and/policies in all the schools visited during the survey is an indication that teachers affected by HIV and AIDS are not being adequately catered for in their workplaces. These institutions should therefore be given necessary technical and financial support to develop and effectively implement appropriate workplace policies.
- The TSC should support and strengthen psychosocial groups particularly KENEPOTE by developing functional collaborative links with them as well helping them to establish clear administrative structures. This will enhance their status and increase their ability to attract funding for capacity building and other operations.
- The TSC should employ reserve/volunteer teachers in schools to ease the teaching workload whenever teachers those living with HIV were unable to effectively perform their duties. This will enhance the quality of education being offered in schools.



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## APPENDICES

### Appendix 1: Group Discussion Guide For Learners

#### A. PREVALENCE & IMPACT OF HIV and AIDS

- A1. What are the common illnesses among teachers in your institution? And **for most common diseases**).
- A2. How has the institution been affected by the HIV and AIDS in terms of **through death, sick teachers not effective in class, absenteeism of te**
- A3. How has HIV and AIDS affected your learning and academic performar terms of concentration, absenteeism, attitude, stigma? (**Probe for death teachers/lecturers, fellow learners, classmates, schoolmates, orphan relatives, and community members**).

#### B. EXISTING MITIGATION STRATEGIES

- B1. How does your institution solve challenges associated with HIV and AIDS? (**Probe for teacher/lecturer absenteeism due to funerals, attending to sick at home, being sick; stigma and discrimination; supporting sick teachers/lecturer; unattended classes**).
- B2. How are learners involved in solving challenges of HIV and AIDS in your institution? (**Probe for what goes on when teacher is absent, or is in class but sick/weak, etc**).
- B3. Which organizations are involved in solving challenges of HIV and AIDS in your institution? (**Probe for specific support or assistance provided by each organization**).
- B4. In your opinion, how supportive is the head teacher/principal/director of your institution in handling challenges related to HIV and AIDS in your institution? (**Probe for specific support of head teacher, other teachers too**).

#### C. POTENTIAL MEASURES AND STRATEGIES

- C1. Other than what your head of institution, teachers and yourselves are doing in the institution, what else do you think can be done to solve the challenges of HIV and AIDS? (**Probe for infection, transmission of HIV, stigma and discrimination, support to infected/affected teachers/lecturers, and existing workplace policy/guidelines?**).
- C2. What can the Government do to minimize challenges of HIV and AIDS in your institution? (**Probe for transmission of HIV and AIDS, stigma, specific support to affected/infected teachers/lecturers, workplace policy/guidelines**).
- C3. Apart from what you have already said, what other comments and suggestions can you make towards the management of HIV and AIDS in your institution?

## Appendix 2: Group Discussion Guide for Teachers

### A. PREVALENCE & IMPACT OF HIV and AIDS

- A1. What are the common illnesses among teachers in your institution? And what of learners? (**Probe for most common illnesses**).
- A2. How has your institution been affected by the HIV and AIDS? (**Probe for teacher absenteeism, teaching, effects on learners, support staff, school performance**).
- A3. As an individual, how have you been affected by HIV/AIDS? (*Death/sickness of colleagues, learners, spouse, parents, relatives, community members*).

### B. EXISTING MITIGATION STRATEGIES

- B1. How does your institution manage challenges associated with HIV and AIDS? (**Probe for teacher absenteeism due to funerals, attending to sick at home, being sick; stigma; supporting sick teachers; unattended classes; etc**).
- B2. As individual teachers, how are you managing the challenges of HIV and AIDS in this institution and at home?
- B3. Which organizations (CBOs, FBOs, Govt agencies, NGOs, etc) are involved in managing HIV and AIDS challenges in your institution? (**Probe for specific support or assistance provided by each organization**).
- B4. As individual teachers, how are you involved in the activities of these organizations? (**Probe for specific roles, benefits and duration of involvement**).
- B5. Have you received any training on HIV and AIDS? (**Probe for purpose of & content of training, trainer, where, when, how you have benefited from training**).
- B6. What workplace policies or guidelines does your institution have on managing HIV and AIDS challenges? (**Probe for support of infected, affected, transmission of HIV and AIDS, and stigma and discrimination**). Any other?
- B7. How supportive is the head of your institution in handling challenges related to HIV and AIDS?

### III. POTENTIAL MEASURES AND STRATEGIES

- C1. What do you think can be done differently in your institution to manage the challenges of HIV and AIDS? (**Probe for infection, transmission of HIV and AIDS, stigma and discrimination, support to affected/infected teachers, workplace policy/guidelines?**).
- C2. What do you think stakeholders such as MOE, MOH, KENEPOTE, NACC, KNUT, can do differently to manage the challenges of HIV in your institution? (**Probe for transmission of HIV, stigma and discrimination, support to infected/affected teachers, policy/guidelines**).
- C3. What **other comments and suggestions** can you make regarding the management of HIV and AIDS challenges in your institution?

### Appendix 3: Questionnaire for Headteacher - A

1. Name of institution-----Province-----District-----Division-----

Please state type of institution and sponsorship (**Please tick** all options that apply appropriately):

PRIMARY		b. SECONDARY			c. TECHNICAL	
Type of institution	Sponsorship	Category	Type of institution	Sponsorship	Type of institution	Sponsorship
1. Mixed Day	1. Public Government	1. National	1. Mixed Day	1. Public Government	1. Men Boarding	1. Public Government
2. Mixed Day and Boarding	2. Religious Government	2. Provincial	2. Mixed Day and Boarding	2. Religious Government	2. Women Boarding	2. Religious Government
3. Mixed Boarding	3. Other (specify):	3. District	3. Mixed Boarding	3. Other (specify):	3. Men Day and Boarding	3. Other (specify):
4. Girls Day and Boarding		4. Other (Specify)	4. Girls Day and Boarding		4. Mixed Day	
5. Boys Day and Boarding			5. Boys Day and Boarding		5. Mixed Day and Boarding	
6. Girls Boarding			6. Girls Boarding		6. Mixed Boarding	
7. Boys Boarding			7. Boys Boarding		7. Girls Day and Boarding	

3. Age of institution (years): **a.** 0-4. **b.** 5-9. **c.** Over 10.  
 4. **a.** Highest class (1, 2, 3, 4, 5, 6, 7, 8) **b.** Highest form/year (1, 2, 3, 4). **c.** Number of streams per class/form (1, 2, 3, 4, 5, 6). **D. Other** .....  
 5. Total number of learners for the years shown:

Year	Total Number of Learners	
	Male	Female
2001		
2002		
2003		
2004		
2005		
2006		
2007		

6. Please indicate in figures the number of teachers in your school for each of the categories as shown in the table below:

1. Teacher Employer:	2001		2002		2003		2004		2004		2005		2006		2007	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
a. TSC																
b. BOG/PTA																

7. Please indicate teaching workload for your teachers.

Total no. of lessons per week	No. of teachers
0 – 10	
11 – 20	
21 – 30	
31 – 40	
Above 40	

8. Indicate the employer and number of teachers who **have left** your institution in the past one year, their teaching subjects and the reasons for leaving.

9. Please give the number of teachers who were **ABSENT for at least half a day** from your institution during the first term of 2007 and their teaching subjects. **(Enter the number of teachers in the blank cells of the table below as appropriate).**

Reasons for absence	Duration of absence in days										Teaching subjects of absent teachers				
	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40 and more	Languages	Maths	Humanities	Science	Technical	
Further training/studies															
Desertion															
Discipline															
Compassionate leave															
Attending official function															
Attending funeral															
Cultural/religious															
Maternity															
Sick leave															
Weather problems															
Transport problems															
Drug or substance abuse															
Other reasons (Specify):															
1.															
2.															
3.															
4.															

10. Please give the number of teachers who have died in your institution during the past one year and their teaching subjects. **(Enter the number of teachers in the blank cells of the table below as appropriate).**

Causes of death	Professional qualifications of teachers who died										Teaching subjects of teachers who died				
	Phd	Masters degree	Bachelors degree	S1	Diploma	P1	P2	P3	P4	Languages	Maths	Humanities	Science	Technical	
Malaria															
Road accident															
TB															
Cholera															
Pneumonia															
Meningitis															
Typhoid															

HIV & AIDS																		
Cancer																		
Diabetes																		
High Blood pressure																		
Other causes (specify)																		
Other reasons (Specify):																		
1.																		
2.																		
3.																		
4.																		

11. Please indicate **school mean grade** for the years shown (for primary schools only):

Year	School Mean Grade	
	Primary school (KCPE)	Secondary school (KSCE)
2001		
2002		
2003		
2004		
2005		
2006		



## Appendix 4: Questionnaire for Headteacher - B

### A. TEACHER INFORMATION

A1. Name of institution-----Province-----District-----  
Division-----

A2. a. Gender: Male-----Female .....b. Your highest academic level (1. KCSE. 2. A-level. 3. Bachelor degree. 4. Masters degree. 5. PhD 6. Other (Specify).....). **(Please tick as appropriate)**

A3. Your professional qualification (a. PhD. b. Masters degree. c. Bachelors degree d. Approved teacher. e. P1 f. P2.g. P3.h. P4. i. Untrained teacher j. Other (Specify).....). **(Please tick as appropriate).**

A4. Your teaching subject(s): (1. Maths. 2. Languages. 3. Humanities. 4. Sciences. 5. Technical)

A5. Your job group (1. Below G. 2. G 3.H 4. K. 5. L 6. M. 7. P. 8. Q. 9. R. 10. Other (Specify).....). **(Please tick as appropriate).**

A6. Number of years you have been in this institution (a. 1-4 Yrs. b. 5-10 Yrs. c. over 10 Yrs.) **(Please tick appropriately).**

### B. PREVALENCE & IMPACT OF HIV and AIDS IN YOUR INSTITUTION

B1. What are the common illnesses among the teaching staff in your institution? **(Tick as appropriate, multiple responses are allowed).**

Type of illness	Male (age in years)			Female (age in year s)		
	20-30	31-45	46 and above	20-30	31-45	46 and above
Malaria						
TB						
Cholera						
Pneumonia						
Meningitis						
Typhoid						
HIV and AIDS						
Cancer						
Diabetes						
High blood pressure						
Other (specify):						

B2. In your opinion, to what **extent** has each of the following been affected by HIV and AIDS in your institution? **(Please circle an appropriate scale).**

	Very low	Low	Moderate	High	Very high	
Institutional administration		1	2	3	4	5
Teachers' effectiveness	1	2	3	4	5	
Teachers' attitude towards work	1	2	3	4	5	
Teachers' class attendance	1	2	3	4	5	
Teachers' professional growth	1	2	3	4	5	
Teachers' participation in community affairs	1	2	3	4	5	
Teachers' conduct		1	2	3	4	5
Learners' ability to concentrate on studies	1	2	3	4	5	
Learners' overall academic performance	1	2	3	4	5	
Teachers' attitude their HIV and AIDS positive colleagues	1	2	3	4	5	
Teachers' relationship with their HIV and AIDS positive colleagues	1	2	3	4	5	
Other (specify):						
a	1	2	3	4	5.	

b.	1	2	3	4	5
c.	1	2	3	4	5
d.	1	2	3	4	5

**C. EXISTING MITIGATION STRATEGIES**

C1. Please indicate the strategy (strategies) you have employed to address each of the HIV and AIDS challenges (teacher abstenteeism, teacher sickness, stigma & discrimination, HIV transmission, Death of teachers or teachers’ spouse, child, and parent due to HIV and AIDS, teacher shortage).

C2. Provide details of HIV and AIDS programmes/activities in which your institution is involved.

C3. Indicate which programmes in C2 are effective and, if **not effective at all, please** give reasons.

C4. Have you received any training on HIV and AIDS? (1. Yes----- 2. No-----).

C5. If your answer to Q. C4 is **Yes**, please indicate the extent to which the training was beneficial to you: (1. Not beneficial at all, 2. *A little beneficial*, 3. *Moderately beneficial*, 4. *Beneficial*, 5. *Highly beneficial*).

C6. If the training received has not beneficial to you at all, please give reasons (1. Information obtained did not match my expectations. 2. Difficult to implement what was taught. 3. Conflicts with cultural beliefs. 4. Not interesting. 5. Other Specify-----).

C7. Please state whether your institution has a work place policy to address the following HIV and AIDS, challenges. (1. Yes. 2. No).

**D. POTENTIAL MEASURES AND STRATEGIES**

D1. State what you think can be done differently in your school to manage the challenges of HIV and AIDS concerning each of the following: (Infected teachers, Affected teachers, Transmission of HIV, Stigma and discrimination, Others (specify)).

D2. What do you think the following stakeholders can do differently to manage the challenges of HIV and AIDS in your institution [Ministry of Education; Ministry of Health; Teachers’ Service Commission (TSC); Kenya National Union of Teachers (KNUT); Kenya Network of Positive Teachers (KENEPOTE); Non-governmental organization (NGOs); National AIDS Control Council (NACC); District Aids Control Committee (DACC); FBOs – Faith based organisations; Home-based Organizations (HBOs); home based care (HBCs); school community; Educators].

D3. What **other comments** can you make regarding HIV and AIDS in your school?

## Appendix 5: Interview Guide for Organizations and Government Departments

### A. BACKGROUND INFORMATION:

- A1. Name of organization/MoE Dept-----  
 A2. Province ----- District -----  
 A3. Your designation.....  
 A4. State nature of support/assistance your organisation provide to the institution (s ) on HIV and AIDS challenges

### B. PREVALENCE AND IMPACT OF HIV AND AIDS IN INSTITUTIONS

- B1. From your experience, what would you say are the common illnesses among the teachers? (**Probe for institutions supported by your organization**).

Type of illness	Male (age in years)			Female (age in years)		
	20-30	31-45	46 and above	20-30	31-45	46 and above
Malaria						
TB						
Cholera						
Pneumonia						
Meningitis						
Typhoid						
Cancer						
Diabetes						
High blood pressure						
Other (specify)						

- B2. How would you describe the **adequacy** and **effectiveness** of the support you give to education institutions on HIV and AIDS challenges?

- B3. What challenges does your organization experience in providing support to the infected and affected in institutions? (**Probe for gender of affected and infected teachers & learners**).

- B4. In your opinion, to what **extent** has HIV and AIDS affected the institutions supported by your organization? (**Probe for data on teachers – how many teachers infected, affected do you support, what about learners?**).

### C: EXISTING MITIGATION STRATEGIES:

- C1. Which HIV and AIDS activities form the major focus of your organization in learning institutions? (**Probe for training, financial, educational, food, medicines, etc**).
- C2. How do your organisational activities benefit the people infected and affected in the institutions that you support? (**Probe for beneficiary school community, teachers/lecturers, learners**).
- C3. To what extent are your HIV and AIDS support activities successful in the institutions? (**Probe for the reasons for success or failure- which ones have succeeded? Why? Which ones have failed and why?**)

### D. POTENTIAL MEASURES AND STRATEGIES

- D1. Suggest what else can your organization can do differently in the learning institutions to manage the following challenges of HIV and AIDS: **Infected teachers, Affected teachers; Teacher absenteeism, Stigma and discrimination, and Teacher morale**.

- D2. From your experience, what can be done differently to manage the challenges of HIV and AIDS in educational institutions? [Ministry of Education; Ministry of Health; Teachers' Service Commission (TSC); Kenya National Union of Teachers (KNUT); Kenya Network of Positive Teachers (KENEPOTE); Non-governmental organization (NGOs); National AIDS Control Council (NACC); District Aids Control Committee (DACC); FBOs – faith based organisations; Home-based Organizations (HBOs); home based care (HBCs); school community; Educators].

- D3. What **other comments and suggestions** can you make regarding the management of HIV and AIDS challenges in the institution (s) that your organisation supports?

## Appendix 6: Questionnaire for Teachers

### A. TEACHER INFORMATION

- A1. Name of institution-----Province-----District-----Division-----  
-----
- A2. a. **Gender:** Male-----Female .....b. **Highest academic level** (1. KCSE. 2. A-level. 3. Bachelor degree. 4. Masters degree. 5. PhD 6. Other (Specify).....). **(Please tick as appropriate)**
- A3. Your professional qualification (a. PhD. b. Masters degree. c. Bachelors degree d. Approved teacher. e. P1 f. P2.g. P3.h. P4. i. Untrained teacher. j. Other (Specify).....). **(Please tick as appropriate)**
- A4. Your teaching subject(s): (1. Maths. 2. Languages. 3. Humanities. 4. Sciences. 5. Technical)
- A5. Your job group (1. Below G. 2. G 3.H 4. K. 5. L 6. M. 7. P. 8. Q. 9. R. 10. ). **(Please tick as appropriate)**
- A6. Number of years you have been in this institution (a. 1-4 Yrs. b. 5-10 Yrs. c. over 10 Yrs.) **(Please tick appropriately).**
- A7. Indicate your employer: [1.TSC 2.PTA/BOG 3. Other (specify) ] -----  
**(Please tick appropriately).**
- A8. Please indicate your current teaching workload (in number of lessons) in this institution. [a. 0 – 10. b. 11-20. c. 21-30. d. 31-40. e. above 40].

### B. PREVALENCE AND IMPACT OF HIV AND AIDS

- B.1. Please indicate the level of prevalence of the illnesses among the teaching staff in these institutions. **(Please choose appropriate levels of prevalence from options in the bracket below).**  
[1. Low prevalence 2. Moderate prevalence. 3 High prevalence. 4. Very high prevalence].

Illnesses Affecting teachers	Prevalence		Affected age-group		
	M	F	20-30	31-45	46 and above
a. Malaria					
b. TB					
c. Cholera					
d. Pneumonia					
e. Meningitis					
f. Typhoid					
g. HIV and AIDS					
h. Cancer					
i. Diabetes					
j. High blood pressure					
k. Other (specify):					

- B2. Please indicate the number of teachers who have died in this institution due to the given causes in the past one year.

Causes of death	Number of teachers				
	None	1-3	4-6	7-10	Above 10
a. Malaria					
b. Road accident					
c. TB					
d. Cholera					
e. Pneumonia					
f. Meningitis					
g. Typhoid					
h. Cancer					
i. Diabetes					

j. High blood pressure					
k. HIV and AIDS					
l. Others (specify):					

B3. In your opinion, to what extent have the following challenges affected teaching and learning in your institution. (Circle appropriately using the following ratings): 1. Not at all 2. To some extent 3. Moderately 4. Seriously 5. Very Seriously)

Causes of Problems	Learners' Learning Problems					Teaching problems				
	1	2	3	4	5	1	2	3	4	5
a. Indiscipline										
b. Illness										
c. Hunger/poverty										
d. Absenteeism										
e. Deaths										
f. HIV and AIDS illness										
g. Inadequate learning facilities										
h. Lack of personnel										
i. Lack of clean drinking water										
j. Heavy workload/teaching many lessons										
k. Attending funerals, cultural ceremonies										
l. Paying visits to hospitals, at home										
m. Attending to HIV and AIDS patients										
n. Others (specify)										

B4. Indicate reasons you have been absent from this institution and the number of times it has happened during the first term of 2007.

Reason for absence	Number of Times of absence			
	0	1-4	5-9	10 and more
a. Illness				
b. Compassionate reasons				
c. Transport problems				
d. Caring for/attending to HIV and AIDS patient				
e. Visiting VCT center				
f. Attending official function				
g. Bad weather				
h. Others (specify)				

B5. In your opinion, to what extent has each of the following been affected by challenges of HIV and AIDS in your institution?

	Very Low	Low	Moderate	High	Very high
Institutional administration	1	2	3	4	5
Teachers' effectiveness	1	2	3	4	5
Teachers' attitude towards work	1	2	3	4	5
Teachers' class attendance	1	2	3	4	5
Teachers' professional growth	1	2	3	4	5

Teachers' participation in community affairs	1	2	3	4	5
Teachers' conduct	1	2	3	4	5
Learners' concentration on studies	1	2	3	4	5
Learners' overall academic performance	1	2	3	4	5
Stigma and discrimination	1	2	3	4	5
Teachers' attitude with their HIV and AIDS positive colleagues	1	2	3	4	5
Other (specify):					
a	1	2	3	4	5
b.	1	2	3	4	5
c.	1	2	3	4	5
d.	1	2	3	4	5

### C. EXISTING MITIGATION STRATEGIES

- C1. Please indicate the strategy (strategies) the institution has employed to address each of the HIV and AIDS challenges (teacher absenteeism, teacher sickness, stigma & discrimination, HIV transmission, Death of teachers or teachers' spouse, child, and parent due to HIV and AIDS, teacher shortage).
- C2. Please indicate the level of effectiveness of the following strategies of addressing HIV and AIDS challenges in your institution: Encourage guidance and counselling, Promote psycho-social support groups, Organize HIV and AIDS open days, Promote use of condoms, Encourage staff to visit VCTs, Other (specify) [1. Not effective at all. 2. Effective. 3. Highly effective. 4. A little effective. 5. Moderately effective].
- C3. To what extent are you involved in HIV and AIDS activities in your institution and community?
- C4. Have you received any training on HIV and AIDS? (1. Yes. 2. No).
- C5. If your answer to C4 above is Yes, how beneficial was the training? (**Tick as appropriate the options in the bracket below**). ( 1. Not beneficial at all. 2. *A little beneficial* 3. *Moderately beneficial*. 4. *beneficial*.5. *Highly beneficial*).
- C6. Please indicate whether your institution has developed/adopted guidelines to address HIV and AIDS challenges. (1. Yes. 2. No).

### D. POTENTIAL MEASURES AND STRATEGIES

- D1. State what you think can be done differently in your institution to manage the following challenges of HIV and AIDS [Infected teachers; affected teachers; Transmission of HIV; Stigma and discrimination; thers (specify)].
- D2. What do you think the following stakeholders can do differently to manage the challenges of HIV and AIDS in your institution? [Ministry of Education; Ministry of Health; Teachers' Service Commission (TSC); Kenya National Union of Teachers (KNUT); Kenya Network of Positive Teachers (KENEPOTE); Non-governmental organization (NGOs); National AIDS Control Council (NACC); District Aids Control Committee (DACC); FBOs – Faith based organisations; Home-based Organizations (HBOs); home based care (HBCs); school community; Educators].
- D3. What **other comments** and suggestions can you make regarding HIV and AIDS in your institution?