

**AN ANALYSIS OF HIV/AIDS POLICY
FORMULATION & IMPLEMENTATION
STRUCTURES, MECHANISMS & PROCESSES
IN THE EDUCATION SECTOR IN KENYA**

July 2006





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AND IMPLEMENTATION STRUCTURES,
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LIST OF ABBREVIATIONS

ACU	AIDS Coordinating Unit
CBO	Community Based Organization
CfBT	Centre for British Teachers
DASCO	District AIDS Coordinating Office
DEO	District Education Officer
DFID	Department For International Development
FBO	Faith Based Organization
KESSP	Kenya Education Sector Support Programme
KIE	Kenya Institute of Education
MoE	Ministry of Education
MoGSCSS	Ministry of Gender, Sport, Culture and Social Services
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
MOL	Ministry of Labour
NACC	National Aids Coordinating Council
NASCOP	National Aids Coordinating Programme
NGO	Non Governmental Organization
O.P.	Office of the President
OVCs	Orphans and Vulnerable Children
PACC	Provincial Aids Coordinating Council
PASCO	Provincial AIDS coordinating Office
PDE	Provincial Director of Education
PLWHAs	People living with HIV/AIDS
PMO	Provincial Medical Officer
PSABH	Primary School Action for Better Health
PTA	Parent Teachers Association
RAPID	Research and Policy in Development
TSC	Teacher Service Commission

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EXECUTIVE SUMMARY

Context

After a slow start, Kenya has made great strides in the fight against the HIV/AIDS pandemic. Since the discovery of the first AIDS case there has been investment in a variety of interventions including treatment, management, care and support. A need for a clear policy to support the various interventions was felt soon after the government of Kenya declared HIV/AIDS as a national disaster in 1999. In 2000 the government put in place a comprehensive multi-sectoral strategy to guide the various stakeholders in their participation in the war against the disease. Notably, Kenya is one of the few African countries to register a sustained decline in the HIV/AIDS infection rate (from a high of 10% in the '90s to 7% in 2003) as a result of the large investment in various interventions against the HIV/AIDS pandemic.

Drawing from the national HIV/AIDS strategy, the Ministry of Education (MoE) has taken the initiative to prepare for implementing a Ministry-specific HIV/AIDS policy. The MoE has also put in place a sector wide support programme through which to implement all its education programmes: the Kenya Education Sector Support Programme (KESSP). HIV/AIDS is one of the major multi-sectoral programmes that will be supported and implemented through the KESSP. The KESSP has adopted the *Primary School Action for Better Health* (PSABH) programme as a model for the implementation of HIV/AIDS programmes in schools in Kenya. PSABH is an HIV/AIDS education awareness and prevention project funded by DFID and managed by the British education services company CfBT.

The Study

The specific purposes of this ODI-Merck study were:

- To compare the Kenyan experience of working within existing government systems to achieve behaviour change in the area of HIV/AIDS with that of other countries in Sub-Saharan Africa
- To gather information from key stakeholders in Kenya on the formulation and implementation, structures, mechanisms and processes of the Kenya Education Sector HIV/AIDS Policy
- To comment upon the process of formulating and disseminating the policy
- To prepare evidence from the successful implementation of PSABH, in response to the findings of a RAPID assessment, in order to support the MoE to better lead the scaling out of HIV/AIDS activities under the KESSP and to work in conjunction with other Ministries in cross-cutting areas.

Drawing from the experience of the implementation of PSABH by CfBT there is research evidence to support the view that large-scale school-based education programmes can bring about behaviour changes that reduce the risk of HIV/AIDS infection amongst youth. (For a detailed analysis of the positive impact of PSABH upon school youth please refer to Appendix 1.) PSABH has been implemented in 5,000 primary schools with significant positive behaviour changes demonstrated in school youth, as reported in independent evaluations. These findings indicate that large-scale sustainable HIV/AIDS education programmes hold the key to behavioural change in youth.

In order to strengthen the implementation of such programmes there is need for a clear and easily implementable HIV/AIDS education-sector-specific policy. The Ministry of Education is to be commended for creating such a policy, and praised for the clarity and functionality of the finished policy document. However, issues remain that need to be tackled in order to enable effective national implementation:

- The Education Sector HIV/AIDS policy lacks clear and detailed policy interpretation and implementation guidelines.

- According to the findings of this study, a structure for implementing the policy has not been created.
- There is a lack of capacity in terms of knowledge, skills, information and attitudes for the interpretation and implementation of the policy on the part of stakeholders.
- The findings of this study indicate that teachers, headteachers and other key stakeholders at the grassroots level:
 - Were generally not familiar with the HIV/AIDS policy
 - Did not have access to copies of the policy document
 - Were not sensitised and trained on the interpretation and implementation of the policy
 - Did not know their mandate, duties and responsibilities in the interpretation and implementation of the policy.

The study also revealed that there are few coordinated implementation processes and activities among the stakeholders and partners, and that there is urgent need for a monitoring and evaluation mechanism for quality assurance of the policy implementation process.

We conclude that:

- There need to be clear guidelines on the access and utilization of resources for the distribution, dissemination, interpretation and implementation of the HIV/AIDS education policy
- There should be well-coordinated approaches for the interpretation and implementation of the policy
- There should be a monitoring and evaluation system for the implementation of the HIV/AIDS policy and curriculum for quality development and maintenance
- Within schools, the HIV/AIDS education syllabus should be harmonized through complete integration into all the subjects in the curriculum for easy and effective implementation
- The *Primary School Action for Better Health* (PSABH) programme provides a successful model for the implementation of HIV/AIDS programmes in schools in Kenya and as such has been incorporated into the KESSP. (Over the next two years (2006-2008), CfBT will complete the transfer of management of the entire programme to the Ministry of Education.)

The Ministry of Education should put in place a strong system that flows smoothly from the national, provincial, district, zonal, village and school levels for distribution, dissemination, interpretation, implementation, AND monitoring and evaluation of the HIV/AIDS policy and school-based education activities. In order to put this comprehensive system in place the Ministry of Education should involve key stakeholders and partners in the process, facilitating a dialogue with them in order to identify the best way forward for the enhancement of the policy and associated programmes to cater for all key stakeholders - pupils, teachers, parents, headteachers, the community, employers and employees in the education sector and partner ministries, departments and institutions.

The dialogue should involve identification, access and sharing of resources among the key implementers of the policy and the interventions drawn from it. It should involve discussions on collaboration and partnerships. It should lead to self-evaluation, peer evaluation and collaborative evaluation. Under the leadership of the MoE, the stakeholders should determine what resources are available for effective implementation of the HIV/AIDS policy and related interventions, what needs to be strengthened, and what structures need to be put in place. The stakeholders will variously contribute information, knowledge and technical support. There should be a national steering and coordinating committee appointed for the task. *The Ministry has both the mandate and the responsibility to take the lead in facilitating the interpretation and effective implementation of the Education Sector HIV/AIDS policy and associated education activities. And the need is urgent.*

CHAPTER 1

BACKGROUND TO THE STUDY

Kenya has invested significantly in the fight against HIV/AIDS since the discovery of the first AIDS case in the early 1980s. But HIV/AIDS continues to be a major health, economic and social concern in the country today. Many people are living with the disease, many have died, and the rate of infection continues to be high. Of an estimated 15 million Kenyan children, over 1,700,000 are orphans, a third of whom are under five years old. 650,000 have lost their parents to AIDS. The number of orphans and other children (OVCs) made vulnerable by HIV/AIDS is projected to grow beyond 2 million by 2010. 500,000 of these children will have lost both parents, mostly due to HIV/AIDS. The suffering in the Kenyan community, particularly among the poorest, is considerable, and there is literally no-one in Kenya who has not been affected by HIV/AIDS.

A need for a clear policy to support the various interventions was felt soon after the Government declared HIV/AIDS a national disaster in 1999. In 2000 the Government put in place a comprehensive multi-sectoral strategy to guide the various stakeholders in their participation in the war against the disease. Since then there has been significant investment in treatment, management, care and support for the infected and affected, and in the development of education and awareness campaigns, particularly for youth.

The main goal of this study was to determine the HIV/AIDS programme implementation policy context. It was designed to discover whether the intervention environment is adequately supported by user-friendly and readily implementable policy guidelines.

The primary objectives of the study were:

- To gather information from the key ministries of Education and Health in Kenya on the formulation and implementation, structures, mechanisms and processes of the Education Sector HIV/AIDS Policy.
- To assess the level of awareness of the HIV/AIDS Education policy among the key stakeholders.
- To analyse the HIV/AIDS Education policy formulation process in terms of structures, mechanisms and processes.
- To analyse the issues, concerns and attitudes of some of the key stakeholders in the formulation and implementation of the policy.
- To outline the Kenyan experience of working within existing government systems to achieve behaviour change in the area of HIV and AIDS among the under 16s and combine it with relevant experience from other countries in Sub-Saharan Africa.
- To recommend the way forward in enhancing the awareness, formulation and implementation of the HIV/AIDS education policy.

A case study and survey approaches were used in the conduct of this study. The case study is based on the *Primary School Action For Better Health* (PSABH) project, funded by the Department for International Development (DFID) and implemented by CfBT. The project, which commenced in pilot form in 2000 and since 2005 has been reaching 5,000 schools per year, seeks to bring about positive behaviour changes in the sexual relationships of upper primary school pupils in targeted areas such that the risk of HIV/AIDS transmission will be reduced.

The researchers carried out a literature search and analysis of related materials, with internet searches revealing relevant materials that have been reviewed and presented here. A mixture of casestudy and

survey designs were used. Key informants from various Ministries, departments and institutions were involved in the study. Data was collected from key informants through face-to-face interviews. A one-day stakeholders' data gathering workshop was organised in Rift Valley for in-depth guided group discussions with a cross section of stakeholders representing various ministries, departments and institutions (See Appendix 7 for the list of participants). The workshop participants analysed the policy formulation and implementation structures, mechanisms and processes of the HIV/AIDS education policy and made recommendations for improving policy dissemination, interpretation and implementation.

Considerable data was gathered through site visits to the Ministry of Education Headquarters and key institutions and departments of the MoE. Interviewees included senior staff in the Ministry who participate in policy formulation and make key decisions in policy implementation, monitoring and evaluation, Kenya Institute of Education ACU staff, the MoE ACU staff, and staff in the Ministry of Home Affairs and the National AIDS Coordinating Council (NACC).

Interview schedules, observation schedules, focused group discussions guides and content analysis guides were used to collect the research data (see Appendices for the research instruments). Both quantitative and qualitative data were coded and analysed manually by the researchers.

The anticipated outputs of the study were a paper that included:

- the experience acquired from PSABH in Kenya, and the experiences of other African countries in their policy and programming response to the HIV/AIDS pandemic
- a RAPID assessment of the Kenyan Education Sector HIV/AIDS policy and its formulation and implementation structures, mechanisms and processes at all levels of the hierarchy - local (school and community), district, provincial and national
- a way forward for the effective implementation of the education sector HIV/AIDS policy, ensuring appropriate response programmes from all the key stakeholders
- evidence from the implementation of PSABH in response to the findings of the RAPID assessment, in order to support the MoE to better lead the scaling out of HIV/AIDS activities under the Kenya Education Sector Support Plan and to work in conjunction with other Ministries in cross-cutting areas
- recommendations on the steps needed to further embed lessons derived from implementation into the policy making process.

CHAPTER 2

LESSONS LEARNED FROM HIV/AIDS POLICY FORMULATION IN SUB-SAHARAN AFRICA

Sub-Saharan Africa is the part of the world most affected by HIV/AIDS. With just over 10% of the world's population, the area has the highest rate of HIV/AIDS infection, reaching 60% by the end of 2005. The region has an estimated 25.8 million people living with HIV/AIDS, with 3.2 million new infections and an estimated 2.4 million dying from the epidemic by the end of 2005. Among young people in the 15-24 years age bracket an estimated 4.6% of women and 1.7% of men are living with the disease. The challenge of controlling HIV/AIDS is overwhelming. Less than one-fifth of the people at risk of getting infected with HIV/AIDS have access to basic prevention services (UNAIDS 2005 Report). Among people living with HIV, only one in ten has been tested and knows that he/she is infected.

Like many other African countries Kenya has struggled in the past 20 years to get the best, most effective and responsive programmes, strategies, policies and approaches of tackling the menacing HIV/AIDS pandemic. The effects range from villages being wiped out to severe loss of employees within organizations and government ministries as well as the private sector. Many families, institutions and departments have over the past decade lost valuable sons and daughters, earnings and their best-trained workers at the prime of their working lives. The disease has not spared any country. It has affected both rich and poor countries. The only difference is in the way each country responds, depending on their social-economic and political environment.

Within Sub-Saharan Africa, **Southern Africa** is viewed as the epicentre of the HIV/AIDS epidemic. AIDS was first recognized in South Africa in 1982. South Africa is a well-endowed country with comparative wealth. However, South Africa did not see HIV/AIDS as a major problem at the start since the rate of infection remained low and its growth slow for over ten years. In the early days the country was not under pressure to make big investment in the HIV/AIDS campaign since the spread was almost unnoticeable. Then in the 1990s there was an explosive growth in the epidemic. In response to this sudden increase in the rate of infection the AIDS Coordinating Unit (ACU) of MoH and the ANC worked together to establish a multi-sectoral Steering Committee that included representatives of business (three national Chambers of Commerce), trade unions (two national union federations), churches (South African Council of Churches), civic organizations (South African National Civic Organization), political parties and the government (MoH). The Minister of health formally adopted the Strategy and Plan in July 1994. In the last 10 years South Africa has made great strides towards containing the HIV/AIDS pandemic, although often hampered by confusing messages from the country's leadership.

Tanzania's experience is quite similar to that of South Africa. While the first AIDS case was diagnosed in 1983 there was little in the way of a comprehensive long-term response to the pandemic. Between 1985 and 1986 the MoH developed a Short Term Plan that governed early activities to control the epidemic. Apparently the seriousness of the disease was not yet fully appreciated at this stage and it was treated as a short-term problem. Between 1987 and 1991 Tanzania implemented the first Medium Term Plan, but it was not until 1992 that a more complete set of interventions and the first steps to decentralize the programme were put in place. Tanzania implemented the Second Medium Plan between 1992–1996, which adopted a multi-sectoral approach. For the first time the country focused on reducing HIV transmission and mitigating the personal and social consequences of the epidemic. In 1991, a review of the National AIDS Control Program (NACP) called for the development of a national policy that would provide guidelines for dealing with AIDS. The review identified the following major issues: care of people with HIV/AIDS; HIV counselling; caring for AIDS orphans; and AIDS education in schools. In

1998, the NACP prepared a new five-year strategy for 1998-2002, developed with broad participation. The strategy was approved and implemented.

Tanzania has implemented many HIV/AIDS programmes. The rate of infection has declined significantly in the last 10 years. Among pregnant women the rate of infection was as high as 36% in 1994 in some regions and 20% in others, but this has declined and a recent study estimated that 7% of the adult community in rural mainland were HIV positive. In the cities prevalence ranged between 5.8% and 11.5% in 2005. Despite all these gains, the Tanzanian government cannot relax and needs to reduce the rate of infection, using in particular school-based programmes for behavioural change.

Zambia has been one of the most adversely affected countries in the African continent. The first AIDS case was identified in 1984; however, because of its commercial orientation based on the rich diamond mining industry with money flowing freely in the market, the devastating impact of the disease at the early stages of the invasion in early 80s was little noticed as the economy was very vibrant at that time. Most young men worked in the diamond industry and had lots of money to spend. Thus the country experienced a very rapid spread of the disease among the most productive members of its society - the workers, their spouses and friends.

Early government responses to the epidemic focused on the prevention of HIV transmission through the protection of blood supplies and the dissemination of information to the public on how to prevent HIV infection. A broader multi-sectoral approach later replaced the initial biomedical response. The National AIDS/ STD/ TB and Leprosy Programme (NASTLP) began broad-based and extensive consultations with the government and other stakeholders in 1993 to build consensus and collaboration on the future of the multi-sectoral programme. In May 1993, the National Consensus Workshop of stakeholders brought together donors, government ministries, local and international NGOs, church organizations, traditional practitioners, trade unions, private business organizations and students, and this multi-sectoral approach appears to have been an important contributory factor in containing prevalence rates.

The case of **Malawi** is similar to Zambia although their economic and political structures are quite different. Malawi was a one party (almost a one man) system in the political arena. The president controlled all the decision making structures, systems, mechanisms and to a large extent the processes. The response then was highly bureaucratic and tightly controlled by the government; it was far from being multi-sectoral and inclusive. HIV/AIDS was viewed as a medical problem that needed medical and biomedical interventions. This is best illustrated by a chronology of the government's response to the invasion of the HIV/AIDS pandemic. The first AIDS case in Malawi was diagnosed in 1985. In 1986, the government established a Technical Committee within the MoH to set guidelines for blood screening and other medical issues. The MoH developed a Short Term Plan in 1987 and a Medium Term Plan in 1988. In 1989, the government established the National AIDS Committee to organize the response to the epidemic. The Second Medium Term Plan was implemented in 1993. Between 1993 and 2005 Malawi put in place policies and programmes to fight the impact of HIV/AIDS.

A key issue for Malawi has been organization of a multi-sectoral approach. Initially, the government established a National AIDS Committee parallel to the MoH that made the environment unnecessarily complex and collaboration and coordination difficult. They have, however, implemented many interventions to prevent and control the rates of infection while caring for those infected and affected.

It is interesting to note that Malawi has registered a steady increase in HIV/AIDS prevalence in some of the regions. And the national figure does mask the differences. In Malawi, HIV/AIDS prevalence is shown as 7% in Central Malawi and as high as 13% in the Northern tip of the country. Prevalence among young pregnant women in the age range 15-19 stood at 15% and in the age 20-24 was 20% in 2005.

Prevalence among rural folk increased from 12% in 1999 to 14.5 % in 2005. The rural population need to be protected against HIV/AIDS

Uganda was one of the first countries to experience an AIDS epidemic. HIV prevalence reached extremely high levels in some parts of the country in the mid-1980s. The Ugandans used to call it the 'slim disease'. Uganda's response to the epidemic was early and relatively well organized. The first policies dealt with blood transfusion and testing. Uganda also developed one of the first multi-sectoral programs when it established the Uganda AIDS commission within the office of the President in 1991. Other countries copied Uganda's model of a multi-sectoral approach, developed in an effort to increase participation in the fight against AIDS. Uganda's approach has been effective in involving all sectors of government and in demonstrating a strong commitment, despite some implementation hitches. At times, the extra layer of bureaucracy has proven to be inefficient. To ease the bureaucratic problems the government of Uganda moved some of the functions of the commission back to the AIDS Control Program in the MoH. Uganda has made great strides since the discovery of the first AIDS patient and the initial responses in the late 80s. A recent study in Uganda, at Rakai in Southern Uganda has shed more light in understanding the country's progress in mitigating the negative impact of the pandemic.

AIDS infections declined sharply among women in Uganda from 20% in 1994 to 13% in 2003, and among men from 15% in 1994 to 9% in 2003. From the findings of the Rakai studies it is difficult to attribute the decline in HIV/AIDS infection to any one particular factor. It has to be a combination of factors. Sexual behaviour does not seem to have changed for the better but the use of condoms did increase; for example, in 2005 35% of teenagers indicated that they had more sexual non-marital partners compared to 2003 when the figure was less than 25%. This has happened despite the implementation of the Uganda's HIV/AIDS policy for over a decade, so it is hard to speculate what the future holds for Uganda.

Zimbabwe has experienced a severe HIV/ AIDS epidemic during the last 10 years. In response, the country has implemented several short and medium-term plans and established the National AIDS Coordination Program. The effort to develop a comprehensive national policy began in 1994 with the establishment of a Steering Committee to plan the process and provide leadership. The Steering Committee solicited inputs and opinions from experts through a series of consultations and brainstorming sessions. The inputs formed the basis of the first draft of the policy, which the committee then circulated widely (200,000 copies printed and distributed). The draft policy was also used as the focus of discussions with several national, provincial and district groups. More than 4,500 people participated in discussion forums held in conjunction with seven provincial workshops. The draft policy was serialized in the national newspaper to make it accessible to larger portion of the general population.

Although the final policy took a long time to be officially approved, many of its administrative policies had already been implemented by the time approval came. In addition, the extensive participation created widespread awareness of the policy and many of the advocacy and support-building objectives had already been achieved at the time that the policy was approved. Zimbabwe has registered declining numbers of infections and, if this data is reliable, is the first country in the Southern Region of Africa to achieve a reduction in prevalence.

It is interesting to note that the **Ethiopian** government responded to a potential AIDS epidemic before the diagnosis of the first case in 1985. The government established a national task force for the prevention and control of HIV infection and AIDS. The task force issued the first AIDS control strategy by the end of 1985. In 1987, Ethiopia developed short and medium-term plans in accordance with guidelines from the Global Programme on AIDS. In September 1987, the government established an HIV/AIDS department within the Ministry of Health (MoH). The department developed the Second Medium Term Plan in 1991. The Council of Ministers gave final approval to the policy on August 14, 1998. Ethiopia

thus was one of the fastest and most responsive countries in Africa in the fight against the HIV/AIDS pandemic.

Ethiopia's infection rate remains low to date at 4.4% with the epidemic concentrated in urban centres. However, countries with high rates of infection surround the country, so the challenge is how to protect its people from getting infected from across the borders in territories where prevalence is high. Between 2000 and 2003 the rate of HIV/AIDS infection among the rural population rose from 1.9% to 2.6% in 2003; by the end of 2004 Ethiopia had approximately 1.5 million people living with HIV/AIDS and about 500,000 orphaned children, and the rate is raising in both rural and urban centres. AIDS was responsible for 30% of all the deaths among adults in Ethiopia in 2004-2005. Less than 10% of those who needed antiretroviral treatment were receiving it.

Ghana established medical guidelines for treating and preventing AIDS in 1987. In 1994, participants at a national workshop identified the need for a comprehensive national AIDS policy. At the same time, a review of the accomplishments of the Medium Term Plan for AIDS pointed to the need for a comprehensive policy to support prevention and care efforts. By 1996, public health specialists and government officials agreed that enough was known about the epidemic but there was an urgent need to develop a comprehensive policy to guide the national response. Two consultants were commissioned to develop the first draft of the policy. They conducted key informant interviews with health officials, people living with HIV and AIDS (PLWHA), NGO representatives, legal experts and others. They also reviewed policy documents from other countries and the recommendations of various UN organizations and international conferences. The consultants identified the following topics as key sections of the policy: testing, care, information, education and communication, condoms, youth, women, funding and research.

The completed draft was reviewed by members of civil society at several regional meetings later in 1999 and the revised policy was taken to parliament for approval. The policy process in Ghana originally included little participation outside the MoH. However, a review of the draft policy and discussions with other countries about their policy development processes convinced the AIDS Control Programme that the draft policy could be strengthened by expanding participation in the drafting and review process, and this was undertaken.

Kenya has trodden a similar path to many African countries in the struggle to come up with an HIV/AIDS strategy and policy guidelines for effective response to the pandemic. Kenya's participation and ratification of many recommendations for finding appropriate, relevant and responsive interventions to the HIV/AIDS pandemic are well known. However, like most other African countries the shock of that came with the discovery of the first case of HIV/AIDS sent many stakeholders looking for medical solutions to the pandemic first and foremost. The fact that HIV/AIDS is a multi-faceted, multi-sectoral problem was not understood and appreciated in the initial responses to the pandemic. It was much later that the need for a comprehensive policy was recognised and addressed seriously. The first AIDS case in Kenya was diagnosed in 1984. In 1985, the government established the National AIDS Committee to advise the MOH on matters related to HIV/AIDS control. In 1986, the MOH formulated policy statements and guidelines on safe blood supply. The First Medium Term Plan was developed in 1987. Because the government viewed AIDS primarily as a health issue, it did not then see the need for a comprehensive policy.

The rate of infection peaked among urban dwellers in the mid 90s and the overall HIV prevalence among the adult population peaked in the late 90s. A 1991 government-led review of the accomplishments of the First Medium Term Plan found government officials and donors seriously concerned about the lack of a national policy and clear guidelines on HIV/AIDS. The National AIDS Control Programme and the Kenya AIDS NGO Consortium (KANCO) made efforts to increase senior officials' understanding of the

seriousness of the epidemic and its multi-sectoral nature. The Ministry of Planning and National Development initiated efforts to integrate HIV/AIDS into national planning efforts.

The Kenyan process was characterized by substantial technical input from experts and a high degree of multi-sectoral participation in the review of the draft policy. Although it took some time to get the process organized, policy development moved quickly and smoothly once technical subcommittees were established. By the time the Sessional Paper reached Parliament, it had undergone a thorough review. As a result, Parliament approved the paper quickly and with little dissent. The Sessional paper was passed in 2005 and with its passing came a new enthusiasm to undertake long term planning. The government ministries most actively involved in HIV/AIDS programmes were ready for sector specific HIV/AIDS policies for their ministries, departments and institutions.

As is evident from this review, Kenya was slow to come up with proper guidelines and considerable time was lost with many stakeholders using the approach that HIV/AIDS is a medical programme, thus failing to recognize the need for a policy to guide the national response. Fortunately the education sector took the initiative to lead the way to the development of a sector-specific HIV/AIDS policy. The sector embarked on the process of developing a sector policy on HIV/AIDS issues as they affect the whole education and training areas in 2004 and the policy was launched in July 2005.

Kenya reported a decline in the rate of infection among adults from the high rate of 10% in the 90s to a significant reduction to 7% in 2003. Kenya is only the second recorded case in Sub-Saharan Africa where a sustained decline in infections has been achieved. The most noticeable drops in HIV prevalence were recorded among pregnant women in Busia, Meru, Nakuru and Thika where HIV prevalence plummeted from approximately 28% in 1999 to 9% in 2003. Other significant declines were reported in the towns of Garissa, Kajiado, Kisii, Kitui, Nyeri and the capital city Nairobi. There is evidence in Kenya's case that behaviour change has contributed significantly to the decline of the rate of infection. In 2003 about 24% (23.9%) of the population said they used condoms.

But it is worth noting that Kenya moved very fast in the implementation of HIV/AIDS education programmes across the board. The last decade has seen many school based and community based education and training programmes in Kenya. Kenya was also among the first African countries to adopt a multi-sectoral approach to dealing with the HIV/AIDS pandemic in Africa. In fact Kenya has been slow in providing the medical treatment and care and support interventions but quick in putting in place and implementing educational programmes.

The other problem Kenya has had is quality control in HIV/AIDS programmes. With so many NGOs and CBOs participating in the implementation of a large diversity of community-based programmes, quality and accountability has been an issue. Accountability has been a problem at all levels and aspects of programming in the quality of outputs and outcomes and in the utilization of available resources.

At the school level Kenya has invested in a national HIV/AIDS curriculum. The HIV/AIDS curriculum was launched in 2000. Since 2000 all the primary and secondary schools were expected to implement the curriculum through infusion method. Teachers were expected to infuse HIV/AIDS messages as they teach their regular subjects. In 2004 the Kenya Institute of Education revised the national curriculum. The HIV/AIDS curriculum was integrated in the revised curriculum for both primary and secondary schools. All the teachers are expected to teach using the revised curriculum. Arguably as they teach the integrated curriculum they are going to pass the HIV/AIDS messages. In order to effectively teach the integrated curriculum the teachers should have been in serviced.

The MoE made efforts to provide in-service training to teachers for the revised curriculum but these have largely been unsuccessful, mainly because of the very large numbers of teachers that needed

training before the commencement of the implementation, which gave only a very short timeframe. In-service training is thus being done in phases. The Quality Assurance Directorate and KIE (the curriculum development centre) are charged with the responsibility of ensuring that teachers are adequately trained.. KIE has an ambitious teacher in-service programme that is expected to reach at least three teachers per school for all the schools in the country.

The majority of the respondents in this study agreed that although the Kenya Government and its development partners have invested in a diversity of programmes, there is still serious weaknesses, particularly in disseminating the education policy to schools. One of the priorities must be to make a set of comprehensive and all-inclusive policy guidelines at the national level. The formulation of such a policy should be multi-sectoral, and the processes should capture the divergent issues facing society in relation to the HIV/AIDS pandemic. The focus should be on the prevention of infection through behaviour change among all Kenyans, especially youth in the 11-25 age bracket where high prevalence of infections occur, as Kenya's youth are the foundation as well as the future of the nation. However, equal attention must be paid to young adults in the 26-39 years age bracket, who are the most economically as well as the most sexually active and hence at highest risk.

Summary

Kenya's experience with the invasion and the impact of the HIV/AIDS pandemic is very similar to and comparable with those of many African countries. The initial response for all the countries reviewed was slow, limited to the government ministries, highly bureaucratic and non-inclusive. HIV/AIDS then was viewed as a disease that required a medical and biomedical responses. It was not until much later (for some countries up to 15 years later) that a more comprehensive, multi-sectoral response was put in place. Some countries are still tackling the pandemic without a clear focus nor adequate policy guidelines; some are still operating from a strategic plan without a policy. The examples of Kenya, Uganda, and Zimbabwe, which have declining rates of HIV/AIDS infection due to the implementation of multi-sectoral, concerted and sustainable programmes, are thus not only encouraging but a challenge to the rest of the African continent and other developing countries to invest more significantly in order to intensify their programmes and to adopt multi-sectoral approaches.

There is adequate supportive research evidence that HIV/AIDS yields to determined, concerted and well-implemented interventions. There have been well sustained successful preventive programmes in diverse settings in the world. For example in western countries there is evidence that sustained quality information campaigns have helped decrease the infections among home sexual men in Western countries, among sexually active young people in Uganda, among sex workers in Thailand and Cambodia and among drug users in Spain and Brazil. There is also evidence that prevention programmes initiated some time ago and which were seen in the past to be slow in producing results are currently helping to bring down HIV prevalence in Kenya, Zimbabwe and urban Haiti. From the existing evidence, it seems probable that comprehensive prevention and treatment packages would avert at least 50% of the new infections that would otherwise be expected to occur up to 2020.

CHAPTER 3

HIV/AIDS EDUCATION IN KENYA

It is universally agreed that education has a major role to play in preventing HIV and AIDS as well as mitigating its impact on those affected. It is particularly important since the peak of infection is in the 15 to 24 age group who are mainly in the school and college system, and who need to develop the necessary life skills that support the reduction of the risk and vulnerability to HIV infection. The international education community, during the world education forum held in Dakar-Senegal in April 2000, adopted the Dakar framework for action for Education for All (EFA) which drew attention to the urgent need to combat HIV and AIDS if the EFA goals were to be achieved.

HIV/AIDS has been and continues to cause major concerns due to its devastating impact:

- At present there is no known cure or vaccine for HIV and AIDS.
- The only way to stop its spread is through behavioural and attitudinal change.
- The HIV pandemic has impacted very adversely on education sector as a whole
- It has affected quality, access and equity as well as demand and the supply of educational services.

The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) called upon Governments to develop and implement national strategies to reduce HIV infection among the 15 to 24 years old. It called for the vast expansion of access to information and education especially to youth. A similar call for the intensification of educational interventions for youth was made by the Education International First World Congress which asked countries worldwide to be active in promoting a comprehensive school health policy.

Any HIV/AIDS education intervention for youth must address the following issues that directly increase their vulnerability to HIV/AIDS infection:

- Delay their debut/initiation into sexual activity.
- Provide life skills that build and enhance self-esteem, self-worth and self-confidence.
- Impart skills for self-protection from vulnerability to sex and HIV/AIDS infection.

Mainstreaming HIV/AIDS Education into the regular curriculum in Kenya

Kenya has adopted the use of education and training as major tools in the prevention of an HIV/AIDS pandemic since the year 2000 when the first HIV/AIDS national school curriculum was launched. School-based HIV/AIDS education programmes and community-based and workplace education and training programmes have been implemented. There is need to have some common approaches in the implementation structure, mechanisms and process so that quality control can be done across the board, and also to assist replication in order to make the programmes cost-effective.

Since 2000 Kenya has been implementing a primary school and secondary school HIV/AIDS national curriculum through the Ministry of Education. During the first five years an infusion strategy was adopted for the implementation of the curriculum, with HIV/AIDS education content infused in carrier subjects. Teachers were expected to pass HIV/AIDS messages through their regular subjects using the implementation guidelines for the HIV/AIDS syllabus that were provided by the MoE.

The majority of teachers were not adequately trained on the infusion strategy, and this lack of knowledge, skills, attitude and confidence negatively affected the quantity and quality of the implementation of the national HIV/AIDS curriculum. The fact that at the time the national HIV/AIDS curriculum was launched it was a non-examinable subject meant that it was not given prominence and importance in

teaching. Some teachers did not teach it but instead used the time allocated to teach other subjects that they considered important for achieving success in national exams.

The MoE recognised that HIV/AIDS was not getting the attention it deserved on the timetable since it was not an examinable subject. In response the Ministry changed the implementation strategy following the 2003 curriculum review and introduced a dual strategy. The revised syllabi have infused and integrated HIV/AIDS content, information and messages in the majority of subjects, which ensures that HIV/AIDS content will be taught and examined within the carrier subjects just like any other subject. The revised curriculum contains most of the HIV/AIDS content from the old stand-alone syllabus.

The MoE prepared and distributed manuals for guiding the in-service training of teachers for the implementation of the revised HIV/AIDS integrated curriculum. The QASO Directorate used KIE trainers to train teachers at zonal and school levels, but only a small proportion had been trained on the new curriculum at the time of its launch. Since then KIE ACU in conjunction with UNICEF have provided in-service training for teachers in the UNICEF Districts.

Notwithstanding the above, teachers are still expected to cover part of the curriculum through the infusion strategy. This is rather complicated and confusing because the teacher has to use two syllabuses: from the integrated curriculum they are expected to cover the integrated HIV/AIDS education content and from the stand-alone HIV/AIDS education curriculum they are supposed to teach the rest of the HIV/AIDS topics that were left out of the integrated curriculum. This leaves the teacher with the responsibility of interpreting the two syllabi and deciding how much to integrate and the areas that need infusing during classroom hours. This is a great challenge, and considering that most teachers have not been adequately prepared, the effectiveness and quality of the curriculum are undoubtedly being compromised.

Analysis of the HIV/AIDS Education Sector Policy Document

In general, the education sector policy on HIV and AIDS is comprehensive and detailed. However, although attempts were made during its formulation to make it all inclusive, it does not provide the following:

- It does not bring out its implementation framework. It also does not give adequate guidelines on how it will be implemented at all levels.
- It promises education managers skills upgrading opportunities but does not show this will happen.
- It is superimposed on structures which are already overstretched.
- It does not assign specific tasks and responsibilities to individual managers.
- The policy has not created an adequate implementation structure at all levels with specific mandates.
- The policy does not provide an adequate framework for follow up and supervision.
- The policy assumes there are established and well-elaborated management structures at all levels. It also assumes that other ministries and organisations will support MoE in the provision of human resources.
- The Ministry's ACU is mandated to create and facilitate other ACU's but there is no time frame in which this should happen. It also assumes that budgetary support will be provided to the education system to address the issue of teachers who may be HIV positive.
- Although the teacher education curriculum has been revised to include HIV/AIDS, there is no major effort to address the in-service training of teachers.
- As our workshop revealed, there has not been adequate dissemination, sensitisation and education on the policy among the key stakeholders.
- There is need to interpret the policy and re-structure it for it to be understood at the school level.
- It has not taken care of the needs, concerns, issues and problems of people living with disabilities, an omission that needs to be addressed with great urgency.

CHAPTER 4

CONCLUSIONS FROM THE TEACHER QUESTIONNAIRE: IMPLEMENTATION OF THE NATIONAL HIV/AIDS CURRICULUM IN PRIMARY SCHOOLS

Kenya revised the primary school curriculum in the year 2002 and the implementation of the revised curriculum started in 2003. During the revision of the primary syllabus special attention was paid to the coverage of emerging issues, with HIV and AIDS as one of the contemporary and vital issues addressed during the revision process. The old curriculum was phased out at the end of 2005 in both primary and secondary schools.

The new, revised primary school syllabi infused and integrated the HIV/ AIDS content, information and messages. An analysis of the revised primary school curriculum revealed that most of the HIV/AIDS content had been integrated into the various subjects in the revised national curriculum. The new syllabuses indicate that HIV/AIDS content, information and messages have been covered in majority of the subjects although some bring out the issues better than others. In Primary English, the coverage of HIV/AIDS education was judged to be quite adequate. The science based subject areas unsurprisingly have a good number of HIV/AIDS topics. The use of the Kiswahili Lugha to pass information and messages on HIV/AIDS is satisfactory.

The scope and spread of HIV/AIDS education through the various subjects is thus generally quite good, and if implemented well it should pass the necessary skills, knowledge and attitudes to youth to enable them to protect themselves against HIV/AIDS infection. Unfortunately, evidence from the key stakeholders (especially head teachers and teachers) indicated that in the majority of schools the implementation was not effective.

In an attempt to establish how the Ministry of Education sector policy on HIV and AIDS was being implemented in the schools, 80 primary school teachers were asked to respond to a detailed questionnaire on the implementation of the policy in schools. The teachers were drawn from a cohort attending undergraduate education degree course under the School Based Programme Half the teachers were from a public university –Kenyatta University(KU) - and the other half were from a private university - The Catholic University of East Africa (CUEA). Twelve of the respondents did not complete the questionnaire adequately because they lacked the relevant information, since they had neither heard about the policy nor were their schools implementing HIV/AIDS curriculum as required by the MoE. Their questionnaires were disqualified and hence not analysed.

The teachers represented all the provinces of Kenya (except North Eastern) and 32 districts. Each of the teachers represented a schools so the analysed questionnaires covered 68 different schools. Disaggregated by gender the sample comprised 52% females and 48% males, i.e. a good gender mix, and in terms of hierarchy, 22% of them were head teachers, 20% deputy head teachers and 58% assistant teachers.

The questionnaire sought to establish whether the teachers were aware of the existence of the National Education sector policy on HIV and AIDS and whether they had participated in its formulation as well as its implementation. The majority (95%) of the teachers interviewed said that they were aware of the existence of the HIV/AIDS policy but none of them was involved in its formulation, nor familiar with its content. In fact some of the teachers confused the policy with the HIV/AIDS curriculum that has been integrated into the national primary school curriculum. Some of the teachers when asked about the HIV/AIDS policy described the DFID-funded PSABH programme. When probed on how familiar they

were with the policy, most of them said they had never seen a copy of the policy document but they had seen the curriculum and the curriculum support materials (i.e. the syllabus and textbooks).

The teachers’ responses to the questions on how much they were implementing the HIV/AIDS policy indicated that none of them was implementing the policy because their responses referred to the implementation of the Primary School Action for Better Health programme (PSABH). The teachers further indicated that they had neither been given in-service training on the implementations of the policy nor had any funds been made available to support the implementation of the policy. They also lacked any guidelines to help them interpret the policy.

The teachers were further asked questions to establish whether they were actually teaching HIV/AIDS in the school with or without the policy. The majority of them (99%) indicated that they were aware of the HIV and AIDS Curriculum and they were implementing it in their schools.

The teachers’ responses on how they were implementing the HIV/AIDS Curriculum in their schools indicated that they were using both the old and the revised syllabuses. This was noticed when some teachers indicated that they were teaching HIV/AIDS during the one lesson allocated to it and during Physical Education (PE) classes, while others (42%) were able to indicate that HIV and AIDS information had been infused and integrated in the revised syllabus with curriculum support materials providing a necessary back-up support.

The majority of teachers, in response to a question on how they how they ensured that appropriate and accurate information on HIV/AIDS was communicated to learners, indicated that they were given books from KIE, while some had been supplied with the curriculum both by KIE as well as through the PSABH Programme. Thus they were using the approved textbooks and other HIV/AIDS materials provided by the Ministry of Education and additional ones from PSABH. Some of the teachers indicated that they used resource persons to teach some of the HIV/AIDS topics in the curriculum.

The primary school revised syllabus was shown to be the most important guide in the planning and teaching of the HIV/AIDS content in the schools for both the integrated curriculum and the stand alone HIV/AIDS syllabus.

To cross check whether teachers actually taught HIV/AIDS content they were asked to indicate in what subjects and classes they taught HIV/AIDS issues in the revised curriculum. Their responses are summarized in the following table. The teachers thought that youth who had been taught the revised syllabus were able to identify HIV/AIDS content and messages as brought out in the syllabus.

Table: Content in the Revised Curriculum where HIV and AIDS messages are integrated, and the class in which it should be taught in primary schools

Content/topic	Class
1. How HIV is spread	5
2. Taking care of those infected	6
3. Causes of HIV and AIDS	5
4. Prevention of HIV and AIDS	5
5. Meaning of HIV	5
6. Social problems in CRE	8
7. Sarafi - Ufahamu na msamiati	7

Most of the policies at school level are developed around the creation of HIV/AIDS awareness. There seems to be very poor support to the children infected and affected by HIV and AIDS. At the school level there are no framework and structures created to support both teachers and parents infected and affected by HIV and AIDS. When the teachers were asked how they dealt with the stigma among the HIV/AIDS infected and affected members of the school community, the only intervention that appeared common to students, teachers and parents was guidance and counselling. However, it is not easy to know those infected or affected at the school level unless the individuals come forward with the information.

The respondents presented the following suggestions when they were asked for their views on policy implementation:

- Build structures at the school level to implement the policy.
- Provide adequate financial support at all levels to facilitate implementation.
- Train key HIV/AIDS teachers in each school and retain them in the school.
- Use all strategies possible to mobilize the communities on HIV/AIDS
- Pay those teachers in charge of HIV/AIDS in each school some motivation fees.
- Establish strong AIDS Coordinating Units (ACU) at the grass root levels.

Summary

- Most schools were not implementing the Education Sector HIV/AIDS policy and most teachers did not know about the policy. All teachers should immediately be educated on their role in the interpretation and implementation of the policy
- There is an urgent need to make available copies of the Education HIV/AIDS policy documents to schools for familiarization and to promote ownership and support
- Most schools were not adequately implementing the national HIV/AIDS curriculum
- There is urgent need for teachers to be sensitised on the Education Sector HIV/AIDS policy. All teachers should be given in-service training on the effective infusion and implementation of the HIV/AIDS curriculum
- There is urgent need for head teachers to be sensitised on the Education Sector HIV/AIDS policy. All head teachers should be trained on the supervision, monitoring and evaluation of the implementation of the national HIV/AIDS curriculum for effective quality control

CHAPTER 5

PSABH: KENYA'S EXPERIENCE IN IMPLEMENTING A LARGE-SCALE SCHOOL-BASED HIV/AIDS EDUCATION PROGRAMME

Between 1999 and the present, CfBT in partnership with the Ministry of Education and the Ministry of Health has been implementing a sustainable, successful school based HIV/AIDS education programme - the *Primary School Action for Better Health* (PSABH) programme, with remarkable success. PSABH uses a multi-sectoral approach to reach school children in the age range 11-16 years with appropriate HIV/AIDS education.

PSABH started in 1999 with financial support from DFID, with a pilot project in 250 schools in one of the most HIV/AIDS adversely affected district - Bondo in Nyanza Province. Following positive findings, the project was expanded to more schools in the Nyanza Region to test the potential impact of a large scale school based HIV/AIDS education intervention on pupil knowledge, attitudes and behaviour. Due to the success of this initial pilot phase the programme was expanded to more schools and districts in the following four years. Between 1999 and 2003 the project was piloted in 2000 primary schools, while in the 2004-2005 financial year the programme was expanded to 5,000 schools in seven of the eight provinces in Kenya.

PSABH works within the existing educational structures and system to provide in-service training for teachers, community representatives and peer supporters (teachers and pupils) to effectively deliver HIV education in primary schools. The project is founded on best practices developed under two earlier national programmes in Kenyan primary schools: the Strengthening of Primary Education Project Phase Two (SPRED II) and Primary School Management Project (PRISM). The programme aims at providing accurate information on prevention, promoting abstinence and delaying the onset of sexual activity. The objectives of the programme are to:

- Improve knowledge of the transmission and prevention of the HIV/AIDS
- Influence students' attitudes about sexual activity and the risk of infection
- Delay sexual debut
- Empower students with appropriate knowledge, skills and attitude to enable them to control their sexual lives
- Enable young people to adopt safer sexual practices in their youth as well as in their later future lives as adults
- Provide effective communication about HIV/AIDS through access to accurate information ("telling it as it is")
- Use life skills to increase students' self esteem/self worth
- Help adults to better understand the way young people think, feel and act (bridging the generation gap).

It is envisaged that PSABH will be a long-term permanent programme that will become embedded within the Kenyan education system. It is expected to permeate the education system and influence the formulation and implementation of the HIV/AIDS education policy. PSABH will positively influence other key stakeholders in their efforts to plan and implement effective HIV/AIDS education programmes in Kenya and beyond.

The programme uses the following approaches:

- Is implemented within the existing education systems.
- Uses integrated training teams from MoE and MoH
- Uses the Government of Kenya's HIV/AIDS schools' curriculum
- Provides schools with the KIE HIV/AIDS learning and teaching materials
- Uses a living values and life skills approach to peer education and behaviour change
- Identifies, selects, procures, generates and distributes a wide variety of relevant HIV/AIDS education materials
- Provides peer support for teachers and pupils
- Gives special emphasis on empowering pupils, especially girls, to protect themselves from vulnerability to HIV/AIDS infection.

The response of the MoE has been very positive, and the PSABH programme has been fully adopted by the ministry. PSABH aims at sensitising and building training capacity within the MoE at all levels, while lecturers from the participating Primary Teachers Colleges have been trained in the PSABH approach. Some of the PTTCs are part of the training teams, enabling the programme to utilize the developed capacity within MoE. Similarly, provincial education officers provide representatives to coordinate PSABH activities and District Education Officers select trainers from their officers, who train the teachers and thereby build trust and truly practical partnerships. The trained education officers monitor school level implementation in a systematic and documented manner.

The programme is implemented through the following strategies:

- Uses a two-cycle training programme to ensure the message 'sticks' and is sustainable
- Incorporates the development of a School Action Plan for Better Health
- Has a Peer Support Component that is directed at pupils
- Offers strong capacity building programme for schools, DEOs, zonal QA officers and primary teacher training college lecturers
- Trains zonal inspectors to empower them with knowledge, skills and attitudes to be able to monitor school level implementation
- Capacity building among the zonal school inspectors to carry out programme based action research
- Integration of the HIV/AIDS curriculum in the regular curriculum for classroom teaching: uses capacity building component that trains teachers to incorporate HIV/AIDS knowledge and awareness within the normal curriculum through the use of:
 - Improved resource materials especially that are self-generated
 - Innovative teaching methods
 - Teacher planning
 - Creative forms of student self expression
- Inclusion and training of lecturers of Primary Teacher Training Colleges
- Use of a wide variety of public activities such as inter-school and inter-zone competitions in drama, music, dance, public speaking, recitations, creative writing, thematic sports and games, exhibitions
- Creation of a supportive environment for students
- Inclusion of HIV/AIDS messages in and out of class time with activities including:
 - School assemblies
 - Class teacher time
 - Question boxes
- Includes extra curricular activities (school health clubs, information corner).
- Use of enhanced training cascade model for wider reach.

The Role of Research, Monitoring and Evaluation in PSABH

Evaluation is an integral part of the programme and the programme has a distinctive research component, designed by Dr Eleanor Maticka-Tyndale, Professor of Sexual Health and Social Justice at the University of Windsor, Ontario. It has been able to effectively respond to the challenge of appropriateness through well-targeted action-based research and day-to-day monitoring of the project implementation process. The programme researchers collect data, analyse it and give regular feed back to the programme implementers on an ongoing basis.

Major evaluations were carried out on the PSABH Programme after 18 months of implementation, and again at the end of 30 months. The findings are important as they relate to the expected outputs of this study and its intended use, namely to recommend a way forward for the enhancement of the HIV/AIDS education policy and programme formulation and implementation. The key findings at two benchmark periods 18 months and 30 months are:

- Lower sexual debut/initiation among girls and boys
- Fewer boys and girls reporting that they had ever played sex
- More boys reporting that they avoided some situations because they made them more vulnerable to having sex
- More girls and boys convinced that they do not have to play sex with their boy friend/girl friend i.e. believe that they can have a boy/girlfriend without having to have sex with them (or “play sex” as it is referred to in Kenya)
- More girls and boys felt that they could tell their boy friend and girl friend to wait till they get married in order to play sex
- More girls feeling they can say “NO” to sex
- More girls determined to proof that “NO” to sex means “NO”
- Fewer girls and boys reporting they played sex in the last three months
- More girls reporting forced sex (whereas they would previously have remained silent)
- More girls and boys reporting that a condom should always be used when engaging in sexual intercourse
- More girls reported condom utilization during their last sexual encounter
- Ability of girls and boys to describe the concrete and realistic methods and strategies that they used to avoid or to refuse to engage in sex
- Possession of accurate and broad knowledge about HIV/AIDS during the impact evaluation compared to the pre-program pre-test, that showed possession of inaccurate information based on myths and misinformation.

On the basis of these findings, the MoE and the funder, DFID, have extended the PSABH programme. The strengthened cascade training model has enabled wide coverage. The cascade-training model has been ideal for scaling up the programme and continues to be a success story. The use of continuous training has been a great strength of the programme because as new schools are recruited they are quickly inducted into the programme without delay or loss of the programme momentum. This approach has ensured that the capacity, pace, quality and coverage have been steadily maintained.

CHAPTER 6

THE WORKSHOP

A great part of this study was implemented through holding a representative stakeholders' workshop in the Rift Valley province. This province was used as a casestudy to carry out an in-depth analysis of the structures, mechanisms and processes used for the HIV/AIDS policy formulation process. The Rift Valley province is the largest of the eight provinces in Kenya by land size, economic productivity and demographic distribution. It has the highest agricultural potential, which leads to it often being referred to as the granary of Kenya. Rift Valley hosts some of the largest ranches and farms owned by some of the richest farmers and business people in Kenya. In strong contrast the province contains some of the poorest, most economically marginalized people who work and live in their masters' farms and ranches as squatters. Rift Valley is also one of the most multi-cultural, multi-racial and multi-ethnic provinces in Kenya.

Experience with the implementation of the PSABH school-based HIV/AIDS programme has shown Rift Valley to be a very responsive province in the implementation of projects and programmes. It has also emerged as a province where a multi-sectoral approach works well. The provincial, district and zonal education offices in the province work collaboratively with other government departments and stakeholders. During a pilot study of financial support for OVCs that was conducted by CfBT in 2005, Rift Valley distinguished itself in its ability to mobilize community resources and rally support for the implementation of activities beneficial to its OVCs at the school and community level.

The stakeholders' workshop took the structure of plenary presentations and group discussions. The discussions brought together stakeholders in related and collaborating departments, ministries and organizations with similar objectives. Such organisations tend to have similar clients, strategies and structures, such that it was easier for them to come up with relevant recommendations and action plans for implementing the policy in their own institutions.

The workshop had the following purposes:

1. To gather information and share ideas, attitudes and opinions among key stakeholders on HIV/AIDS policy formulation and implementation in Kenya.
2. To analyse issues concerning the formulation and implementation of HIV/AIDS policy in Kenya.
3. To analyse the extent to which the HIV/AIDS policy affects the implementation of HIV/AIDS education, using the PSABH project as a casestudy.

The workshop presentations were guided by the objectives of the study and the expected outputs. A set of key questions guided the responses and reactions of the participants. The participants were asked to share their experiences on the involvement of stakeholders in the policy formulation process.

The results of the workshop were combined with results gained from interviews with informants. In addition sixty-eight teachers from randomly selected schools responded to a detailed questionnaire that asked about their individual and institutional involvement in HIV/AIDS policy formulation and implementation. The use of a variety of data collection methods helped to triangulate the information gathered for validation purposes.

Key Responses from the Workshop Participants

The findings in this section are drawn from the responses of the key stakeholders at the data-gathering workshop and are presented in two sections in a thematic manner. The first section presents findings on

the policy formulation structure, mechanisms and process at the school, district, provincial and national level. The second part presents the policy implementation structures, mechanisms and processes at the school, district, provincial and national levels.

The following are the responses of the key stakeholders to the key question: to what extent are the various key stakeholders familiar with the education sector HIV/AIDS policy?

The majority of the respondents at grassroots level were not aware of the education sector HIV/AIDS policy. Only a few head teachers who had attended the secondary schools heads association annual meeting had received a copy each of the policy document in 2005. However, those who received the policy documents said that no information, guidelines or sensitisation was done following the distribution of the policy documents. They confessed that they had not made use of the document since they were not given any information on its content, their role in disseminating the information and their role in its implementation. So they said they had made hardly any use of the booklets.

A few of the participants said that they were aware of the existence of the policy through MoE information and guidance-circulars and other avenues such as in-service workshops but the majority had not seen the policy booklet.

Stakeholders at the higher levels (district, provincial and national) were aware of the policy, but even at these levels not everybody had a thorough knowledge of the policy content. Some stakeholders were aware that the policy existed but have had no access to the actual document. This was true of key Ministry departments like the Kenya Institute of Education (KIE), the examinations council and teacher training colleges. In KIE, which is an implementing agent for the school curriculum, there were many officers who had not yet seen the HIV/AIDS policy document.

In response to the question, “who are the key HIV/AIDS policymakers in education?”, the participants answered that they were the policymakers who have the legal mandate to direct and steer policy formulation, namely senior government officers, but they should also include people at grassroots level, thus:

- Director, Permanent Secretary and Politicians from MoE and MOH.
- AIDS Control Unit in the MoE.
- Teachers, Heads Association, KNUT, Children’s officers, Special Needs officers, parents, NGO’s, faith based organisations, community elders, heads of department, politicians, other experts, women’s groups, civil societies, and youth.

In developing the policy, attempts were made to make the most appropriate and clear policy statement choices from the available alternatives. This was done through engaging stakeholders in consultations and discussions. Reference was made to countries in Africa and elsewhere where HIV/AIDS policies had been formulated. Expert inputs were sought through the use of national and international consultants engaged in the policy formulation process.

Consultations were held but at the national, provincial and district levels rather than at grassroots levels; this led to a lack of ownership and support by the ultimate implementers and beneficiaries. The process included the full cycle of policy approval structures, mechanisms and processes. Policy dissemination was carried out only at a high level during the launching ceremony; fuller implementation was expected to commence soon after the launch but this did not happen due the inadequate involvement of key stakeholders in both the formulation process and the dissemination functions. However, according to the KESSP Programme, adequate resources had been allocated for policy dissemination, sensitisation, stakeholder mobilization and implementation.

The key structures used in policy formulation in Kenya were the ACUs. The National ACU in the MOE headquarters coordinated the process. The KIE ACU and TSC ACU supported it in coordination. The ACU collaborated with the other departments in the Ministry including the Provincial Education Officers and their staff and the District Education Officers and their staff.. The MOE worked in partnership with other ministries including:

- The Ministry of Health (representatives from the Ministry Headquarters and National AIDS Control Programme - NASCOP).
- The Ministry of Home Affairs
- The Ministry of Culture, Sport and Social Services
- The Office of the President (represented by the National AIDS Coordination Council)

The MOE brought on board development partners and other key partners including Non-Governmental Organizations and Community Based Organizations.

The workshop respondents viewed the ACUs at the National Level and Provincial levels as representatives of the top-down approach. By using the ACU structure, the process excluded other structures and departments who are key to the formulation, dissemination, interpretation and implementation of the HIV/AIDS policy in education. This kind of structure does not allow for the involvement of stakeholders at all levels. Evidence adduced at the stakeholders workshop supported the view that very few representatives from the provinces and districts, and none from the lower levels, participated in the formulation of the education sector HIV/AIDS policy.

Policy dissemination was limited and not done in an organised, formal way. It emerged during the workshop and the interviews with informants that copies of the policy and information on its content were only given to those who were invited and participated in the launching ceremony. This is evident in the limited circulation, readership and use of the document among stakeholders two years since its release. Dissemination continues to be done in a haphazard manner by the ACU. Since the launch of the document by the MoE there have not been specific sensitisation and training workshops held to educate stakeholders on the content of the document, their role and the role of other key stakeholders in its dissemination and implementation. This is a serious omission that needs to be addressed immediately to allow for effective implementation of the policy and encourage widespread support for effective interpretation. Key stakeholder institutions were not empowered through training to draw from the general sector policy to formulate their own institutional policies; this needs to be addressed so that institutions can be empowered to draw up their own institution-specific policies. Finally, the policy itself lacks guidelines on the role of each stakeholder on the dissemination, interpretation, implementation of the policy, while no attention was given to who should monitor and evaluate the policy implementation process.

CHAPTER 7

CONCLUSIONS

A. Key Findings:

- Kenya only declared HIV/AIDS as a national disaster in 1999 – some 15 years after the discovery of the first AIDS case in 1984.
- Kenya took up to a decade to recognise and act on the need for a comprehensive, multi-sectoral strategy and policy since the discovery of the first AIDS case in the early 80s; however, the end result was positive: the development of the HIV/AIDS NATIONAL STRATEGY 2000-2005
- Kenya is one of the few African countries that adopted a multi-sectoral approach for dealing with the HIV/AIDS pandemic
- Kenya is one of only 3 African countries that has achieved sustained decline in the rate of HIV/AIDS infection, and this can be attributed to its multi-sectoral approach, and aggressive, concerted education programmes along with other interventions such as VCTS and ARTVT
- All HIV/AIDS programmes in Kenya should draw their implementation framework from the multi-sectoral HIV/AIDS response strategy
- The Ministry of Education has developed and is implementing a sector specific HIV/AIDS policy for education
- The Education Sector HIV/AIDS policy formulation process took the conventional policy formulation scientific model
- The policy formulation process did not involve all the key stakeholders who should have been involved, especially at the provincial and district levels that are critical for effective implementation
- The National ACU did make an attempt to prepare policy implementation guidelines for the policy but the attempt was overtaken by the adoption and launch of the KESSP in 2005 as the new MoE programme implementation guideline
- The KESSP recognizes the need for comprehensive, large-scale, school-based HIV/AIDS programmes in the model of PSABH, and allocates resources accordingly
- Kenya has a national HIV/AIDS curriculum that uses two syllabi making its implementation complex and difficult
- The implementation of the national HIV/AIDS curriculum is not as effective as it should be, due to lack of capacity and training among the key implementers (teachers and head teachers).

B. General Conclusions:

1. Ownership and Support for Education Sector HIV/AIDS Policy

- There was lack of ownership of the policy
- The HIV/AIDS Education Sector policy lacked adequate support among the key stakeholders

2. Dissemination

- Distribution and dissemination of the policy has been limited and fragmented.
- There is no evidence of a strategy for ensuring that all the stakeholders are adequately briefed on the content and use of the policy.
- The policy has not been adequately popularised among the stakeholders at the various levels - national, provincial, district and zonal
- Most teachers who participated in this study had heard and were aware of the policy's existence but were unfamiliar with its content

- There is an urgent need to make available copies of the Education HIV/AIDS policy documents to schools for familiarization
- 3. Assumptions**
- That there are established and adequate management structures for policy implementation
 - That there will be adequate financial support for the implementation of the policy
 - That other ministries and organisations will support MoE in provision of human resources
- 4. Strengths of the Policy Document**
- The policy is well summarized
 - The document is written in a simple language that is easily understood
 - It is consistent in terms of information and approach
 - It is non-discriminatory in terms of language and illustrations
 - It is balanced in terms of coverage of the various levels of education from primary through to secondary and higher education
 - The design of the document is attractive and it is user-friendly in size, design, font type, language and readability
 - The document is relevant to the needs of the various key stakeholders
 - The policy encourages collaboration and partnership
 - The policy is appropriate, balanced and valid for the education sector and its partners
 - The policy is adequately comprehensive, broad and inclusive.
- 5. Inadequacies and Weaknesses**
- A major weakness is that it does not address the needs, concerns, issues and problems of people living with disabilities
 - The statements are too broad to be interpreted meaningfully without detailed guidelines, clarifications, mandates and responsibilities
 - The policy lacks legal backing as it has not been entrenched in the Kenyan constitution
- 6. Interpretation and Implementation**
- There is need for clear guidelines for the interpretation and implementation of the policy
 - There is no adequate framework for follow up and supervision
 - There is no clear mandate for the interpretation and implementation of the policy
 - None of the schools represented in the study sample were fully implementing the policy
- 7. Capacity Building**
- There is a general lack of capacity for the interpretation and implementation of the policy among the key stakeholders
 - The key stakeholders need information, knowledge and skills for the interpretation and dissemination and implementation
 - The key stakeholder institutions were not adequately empowered through training to learn to draw from the general sector policy to formulate their own institutional policies
- 8. Resource Allocation**
- It is not clear from the policy document where and how the resources for the implementation will be drawn from
 - There is need for strategies for identification and allocation of adequate resources for the implementation of the HIV/AIDS policy implementation at all levels - national, provincial, district and zonal.

APPENDICES

APPENDIX 1

CASE-STUDY OF KENYA'S EXPERIENCE IN IMPLEMENTING A LARGE-SCALE SCHOOL-BASED HIV/AIDS EDUCATION PROGRAMME: PSABH

MEETING NATIONAL GOALS

The PSABH (Primary School Action for Better Health) programme began in 1999 as a pilot project in only 250 schools in one Kenyan District. In 2000 the project was expanded to more schools in Nyanza Province. In the next three years (2000 to 2003) the project was implemented in 2,000 primary schools. Between 2004-2005 the coverage was expanded and successfully implemented in 5,000 primary schools in seven provinces through out the country demonstrating its capacity, flexibility, and versatility to scale to the national level.

The aim of the project designers had been to develop an HIV and AIDS behaviour change intervention that could be delivered by the Ministry of Education, Science and Technology (MoE) at a national level, i.e. in all the 18,500 Kenyan primary schools. To be effective at this large scale an intervention has to be delivered using robust management structures and systems than can be replicated in the scaling up process and still achieve success. It is vital that such an intervention operates within the existing policy framework while bringing new information and experience to contribute to the development of new ideas with minimum or no disruptions in the system.

In order to support a national ministry in realization its educational goals across a whole country any programme needs the internal flexibility to adapt to many different contexts. Responsive is essential in reconciling traditional practices and modern behaviour or solving conflict between professional roles and personal beliefs. Much of the experience gained relates to two main areas: a) managing change activities at a scale large enough to be relevant to a national ministry
b) operating in a responsive manner such that the intervention can inform change processes from within.

WHAT PSABH OFFERED THE MINISTRY OF EDUCATION

The project had a strong management and research base. These can be attributed to the following:

- Experience - CfBT the managing NGO had had 10 years experience of managing national programmes in partnership with the MoE and had a good reputation.
- Research base- the research component was lead by extremely experienced people who were able to synthesize and present the findings in ways appropriate to many different audiences.
- Commitment and result based management-all parties, the managing NGO, the researchers, the funding agents and other development partners of the MoE were committed to delivering results on the ground, not just on paper.

The experience with PSABH generated the following benefits:

- Confidence that primary schools could play a significant role in HIV/AIDS education.
- Proof of the training capacity within both the MoE and Ministry of Health (MoH) to deliver the intervention.
- Effectives strategies for reconciling teacher concerns with pupil needs.
- Evidence that research can play a valuable and integral part in implementation
- Prevention messages that separated objective information from moral education.
- Institutionalisation of a new and optimistic attitude towards HIV education.

THE PURPOSE OF THE PROGRAMME

The purpose of the project is to bring about positive behaviour changes in the sexual relationships of pupils in government primary schools in Kenya. It aims to provide accurate information on prevention to promote abstinence and delay the onset of sexual activity.

MAIN PROGRAMME ACTIVITIES

- Week-long training workshops for: Head teacher, 3 teachers and 1 parent per school
- Capacity building of the same to address HIV/ AIDS through
 - School Action Plans
 - Participatory teaching (i.e. question boxes, health clubs)
 - Forms of student self-expression
 - Use of resource materials
- Integrated training teams from MoE and MoH
- Distribution of, and training in use of, Kenya Institute of Education (KIE) materials public activities such as inter-school competitions in areas of drama, music, art, etc.
- Sensitisation and mobilization of District and Provincial level education and health officers
- Training education officers to monitor schools' HIV/AIDS education
- Training representatives from pre-service Teacher Training Colleges
- Integrated quantitative and qualitative research using control schools

IMPACT RESULTS

Evaluation of PSABH after 30 month's implementation were:

- Lower sexual initiation among girls.
- Fewer girls reporting they ever played sex.
- Fewer girls and boys reporting they played sex in the past 3 months.
- More girls and boys reporting a condom should be used when engaging in sexual intercourse.
- More girls and boys who believed that 'no' means 'no'
- Increased likelihood of pupils receiving a passing grade on knowledge tests
- Sustained programme implementation at school level.
- Some fall off in pupil participation after 18 months' implementation.

SUSTAINABLE INTERNAL TRAINING CAPACITY FOR THE DELIVERY OF LARGE SCALE TRAINING PROGRAMMES FOR HIV/AIDS EDUCATION

The origins of development projects are often external to the implementing government bodies, for example, donors fund project design consultants; best practice models are adopted from other countries or training programmes are acquired in a published package to be delivered in a new region or sector. It was an advantage that the PSABH project was designed in country by a group of resident people who had substantial experience of working in the Kenyan education sector already. Their experience was not in HIV and AIDS itself but they were seasoned in delivering change interventions on a national scale through existing MoE systems. This meant that the infrastructure necessary support a large-scale activity was already familiar:

- A body of experienced trainers who could work together as a team;
- Financial administration systems for use in the field;
- Efficient but lean reporting and monitoring structures;
- A network of training venues that could accommodate large groups
- Experience of managing. An improved model of cascade training.
- All of the outlined existing capacity had been developed in conjunction with MoE and much of it was resident within that ministry.
- The significance of this internal capacity lies in being able to meet the often-conflicting demands of high volume training and sustained responsiveness.

BUILDING SUSTAINABILITY IN CAPACITY FOR CONTINUOUS LARGE SCALE TRAINING

As there is normal movement within ministries due to factors such as relocation, promotion or retirement and demise it is critical that the long-term management and development of the training team is seen as a core part of the intervention.

Maintaining quality in training requires a constant minimum ratio of trainers to trainees. As long as this ratio is kept it matters little how many groups or classes are being delivered at any one time, as long as the administrative and management structure can keep pace.

The windows for the in-service training of teachers in a normal education calendar are limited and often restricted to the 12 annual weeks of school vacation.

The logistics of affecting any significant change in body as large as 18,500 schools requires a large replenishable and effective team of trainers. In order to achieve these balances the following measures are imperative:

- Rely on the ministry's own selection processes for identification of potential trainers
- Develop general criteria for trainer selection such as job position, training ability, level of education reached, commitment
- Plan to train trainers with varying entry levels in terms of knowledge and training ability.
- Manage a strengthened cascade model in which senior trainers train alongside less experienced trainers and maintain a key monitoring and mentoring role at all levels.
- Imitate the management structures of large schools during training events to maximize use of known roles
- Incorporate approaches for 'training for succession' amongst trainers.
- Use MoE institutions for training, for example Teacher Training Colleges

SUSTAINED RESPONSIVENESS

In reality the best-laid plans sometimes go awry. There are always unexpected gains and disappointments as plans become actions. The inclusion of an effective and well-targeted research plan can help either pre-empt some of the disappointments or provide insight into alternative approaches and remedies. However, mechanisms need to be included in the implementation plan to respond to proven impact and researched issues as they are encountered. Support for these changes also needs to be nurtured.

- Make researchers available to the MoE and include the most senior level officers possible in first-hand presentations of research results.
- Present research findings or lesson learned at all levels and in forms, from PowerPoint presentations in meeting rooms to flipcharts at training events.
- Incorporate expertise in the development of trainers and the management of training teams within the programme delivery
- Build in both monitoring and mentoring systems to track quality of training delivery and rectify weaknesses.
- Budget for multiple trainer development sessions and refresher training.
- Keep the knowledge, attitude and behaviour level of the trainers' one step ahead of the people they are expected to train.

THE NEED FOR MULTI-SECTORAL APPROACH - INTERDEPARTMENTAL AND INTER-MINISTERIAL

At a field level government officials are endowed with tremendous authority in local communities. When ministries are seen to work together in joint for the impact can be even more powerful. In PSABH, integrated teams of trainers from MoE and MoH are formed to deliver the training at school and

community level. MoH staff carry more authority when talking on the technical aspects of HIV and people are more comfortable asking questions of a sexual nature with a health worker than an educationist. MoE staff, however, hold the authority when it comes to how schools can respond and what is both realistic and permissible in a school setting.

CHALLENGES OF USING THE MULTI-SECTORAL APPROACH IN IMPLEMENTATION OF HIV/AIDS POLICY AND PROGRAMMES

- Despite multi-sectoral approaches being supported at a policy level, there is little experience in doing so at a field level.
- At the beginning there is likely to be competition and mutual mistrust as staff from different ministries try to establish their own authority and understand the hierarchal positions in the integrated team.
- Once it is understood that both ministries have valuable technical contributions to make to a common goal integrated teams work well together.
- PSABH witnessed tremendous progress in the training skills of health workers and the technical confidence on HIV and AIDS in educationists.
- PSABH witnessed tremendous progress in the technical confidence on HIV and AIDS in educationalists.

The biggest challenge in combining two ministries is the difference in expectations and work practices. Unfortunately donor-funded activities have become associated with payments for being a trainer or trainee in the form of per diems or sitting allowances. In PSABH trainers receive modest payments to cover additional expenditures incurred by being away from home and trainees only receive travel refunds and full-board accommodation. There is constant friction on this issue and every training activity includes demands for allowances from trainers and trainees.

In an ideal world, ministries working together would agree certain work procedures and practices at a senior level in advance:

- Comparable selection criteria for trainers
- Level of time commitment from trainers and general schedules of key training periods.
- Minimum length of time the officer will stay with the programme
- Commitment to quality and the mechanisms necessary to uphold that quality
- Valid reimbursements of travel and accommodation for trainees and guidelines on per diems for trainers
- Agreement of the use of different budget lines to support the travel of non-MoE staff to visit schools

THE SCHOOL ENVIRONMENT SUPPORT SYSTEMS AND ENVIRONMENT

School-based HIV and AIDS interventions are seen as necessary because of the unique characteristics of schools; they are widely spread in countries lacking other strong communications network; they are long-standing centres of their community; their hours and mode of operation are known and regulated. They have established mechanisms for the introduction of new programmes; they often house a large proportion of the administrative capacity of a community and teachers are frequently the most educated members of that community.

To become more receptive and responsive to change schools need to change the ways in which they do business. They need to change the way they interact with the host communities. They need to adopt more flexible and changing character. They need to be in themselves agents of change. In doing so schools have to change or shade some of their characteristics of longevity, authority and common regulation.

Most of these characteristics need to be challenged in order for schools to become environments that can support change for HIV and AIDS education as it relates to sexual behaviour.

In the case of PSABH it was recognized from the very beginning that clearly there was critical need for detailed qualitative and quantitative research was needed to encourage and reassure schools about leading change. The key research to support change included:

- Knowledge of age at first sex
- Insight into the way in which sex was happening
- Further understanding of the nature of forces leading to sex
- Clarifying the dilemmas that teachers faced in dealing with HIV AND AIDS education
- First hand accounts of how pupils interpreted what they heard

TEACHERS' CONCERNS AND PUPILS' NEEDS:

Teachers' Concerns

Teachers face complex challenges in delivering HIV and AIDS education in areas that relate to sexual behaviour. The majority truly want to prevent the spread of HIV among young people and willingly teach most aspects of prevention. However, on the topic of the efficacy of condoms they face a dilemma as many believe that by acknowledging that correct and consistent use of condoms and reduce HIV transmission they are encouraging early and frequent sexual activity. They also fear reprisals from either MoE, the parent body or the sponsors of their schools, who are often religious. This leads to them either being silent on the condom, or delivering the information in a biased way such as “condoms are not 100% effective”. PSABH used its research to help teachers resolve this conflict through:

- Reporting back to teachers the many conflicting messages young people were hearing
- Reporting back to teachers requests from young people for
 - the truth about condoms
 - strategies to abstain
- Revealing the most common scripts underlying sexual intercourse
- Providing teachers with strategies to separate objective information from moral education in their teaching
- Dealing with moral issues through Life Skills and Living Values education
- Over time the MoE has gradually produced policy documents that can be used to support this position of objective information.
- The Education Sector Policy states that HIV and AIDS information must be: ‘current, accurate, factual and comprehensive and presented in a manner, language and terms that are understandable, acceptable and contribute to positive behaviour change’.
- For the majority of the evaluation period of this project the ministry’s position can best be described as silent.

Pupils' Needs

- Information, even if incomplete, inaccurate or contradictory in nature, reaches young people far more easily than services.
- Adults control their days, they have little access to the money to travel and are constantly answerable to adults so it is hard for them to do anything with confidentiality.
- Pupil relationships with teachers are complex as teachers know their parents, are as likely to discipline them as they are to provide counsel or may even in some cases be the source of abuse.

- The solution in PSABH has been to use the model of integrated training teams to encourage schools to invite trained health workers in to talk with pupils to provide access to other referral services.
- Ministries still need to do more to endorse this and provide for such staff travel in planning and budgeting.

RECOMMENDED FEATURES FOR SUCCESSFUL HIV/AIDS EDUCATION PROGRAMME IMPLEMENTATION

Success comes for many reasons either consciously as a planned part of the programme, in response to changes in the environment or simply through good fortune. PSABH has benefited from all these. Each programme must recognise and establish what works best in its context to bring about success or to enhance the benefits of the programme. Recommended features include:

- Creation of a Lead Team of trainers known to CfBT as experienced trainers and training managers. This team has been an integral part of all planning and training revision.
- Inclusion of all KIE materials – HIV/ AIDS syllabus and books – in development of the training content
- Identifying appropriate entry points in the school system to carry HIV/AIDS education work. E.g. the national goals of education, guidelines for assessing competitions, existing school planning tools, the pattern of the school day, recognized roles of different teachers and adults.
- Including representatives from key parts of the Ministry in planning including: inspectorate, teacher services commission, policy and planning, AIDS Control Unit, examinations council.
- Training pupils as Peer Supporters, although this proved to have significant challenges in sustainability
- Training Deans and Tutors from pre-service teacher training colleges.
- Training Ronal Inspectors to monitor the programme as well as trainers
- Developing the capacity of teacher training colleges to be long-term training venues for the programme
- Developing and using appropriate and responsive feedback mechanisms. It was critical to develop and use appropriate mechanisms to feedback research findings at regular and relevant intervals at all levels of the MoE.
- Regular feedback was critical in securing support, especially in sensitive areas such as prevention messages. Only with self-adjustment could the programme achieve positive impact.
- Much as the project aimed to lead change it recognized the need to listen to both teachers' concerns and pupils' needs and worked hard to reconcile the two.
- Due to its capacity to listen to, appreciate and empathise with students and teachers concerns and issues PSABH was retained in trained schools and non-targeted schools worked hard to get into the training.
- Creating and maintaining sustained enthusiasm for the programme was critical to the sustained impact.

EMERGING EXPERIENCE

Some things can be recognized only with hindsight and may have been simply fortuitous.

- CfBT's reputation as a partner in education to the MoE was critical in the earlier phases of PSABH. At that time the policy framework was not as advanced and many steps were taken in good faith by officers who had worked with CfBT previously.
- The combination of characters active in management of the project was extremely productive and included;
 - NGO managers who were willing and able to create an operating environment that was flexible enough to accommodate necessary changes and strong enough to protect quality of the programme.

- An exceptional Kenyan educationist who was able to manage large numbers of trainers and a sensitive training programme effectively.
- A highly experienced lead researcher who was able to not only combine quantitative and qualitative findings but was able to present and explain these findings effectively to the audiences in country.
- People who were engaged in developing policy framework that a response to HIV/AIDS education required led the MoE. Although the structure of ACUs was new and the roles of officers unfamiliar, officers were willing to become involved in the programme and take part in working groups at Provincial and District levels.

APPENDIX 2

ANALYSIS OF THE KENYAN HIV/AIDS EDUCATION SECTOR POLICY DOCUMENT

As a pre-requisite for this study, the researchers analysed the education sector HIV/AIDS policy document in advance of the discussion with the key stakeholders invited to the workshop. From our analysis it was noted that the following are some of the key stakeholders addressed by the policy document:

- Learners.
- Employees
- Managers
- Employers
- Other providers of education and training in public, private and non-formal learning institutions at all levels.

The policy stipulates that it is the responsibility of all learning institutions to address HIV and AIDS through education, developing skills and values and changing attitudes to promote positive behaviours that fight the scourge. The policy anticipates that each institution will be able to mobilise different stakeholders such as local communities, religious groups, leaders, parents, caregivers and guardians to support and ensure success of the HIV and AIDS prevention and control programmes within the learning institutions. It endorses a curriculum with content guidelines that address HIV and AIDS but is sensitive to cultural and religious beliefs and appropriate to age, gender and special groups. It describes how life skills will be mainstreamed into the existing curriculum and co-curricular activities at all levels. It requires Higher Education institutions to develop a common framework for teaching HIV/AIDS. The policy encourages all learning institutions to use co-curricular activities such as clubs, drama groups and sports events to inform and educate on HIV and AIDS. All heads of education institutions are to ensure that appropriate supervisory systems and measures are in place to ensure a safe teaching and learning environment with particular reference to hostel accommodation.

The policy states that relevant and suitable teaching and learning materials for HIV prevention will be developed for use by all institutions and workplaces. It requires pre-service and in-service programmes for teachers to prepare teachers/trainers to respond to HIV/AIDS within their own lives, and as professionals to build positive attitudes and skills for HIV/AIDS prevention and control among learners. The policy also requires that learning institutions will create rape and sexual harassment awareness through sensitisation of girls, boys, men and women to enhance safety and protection. The policy requires that research on levels of HIV prevalence, orphanhood, vulnerability, access to education and other relevant areas will be undertaken, and managers at all levels in the education sector should put in place mechanisms for monitoring and evaluating the quality of HIV programmes and all other strategic interventions. Nevertheless, the policy recognises that ultimately, behaviour changes in minors rests with their parents, guardians and caretakers.

The policy statements in this area are broad and all-encompassing and relate to all learning institutions. However, the statements are often non-committal rather than authoritative, for example it appears to suggest that institutions of higher learning should implement HIV/AIDS intervention, rather than requiring them to. The policy also does not comment upon the availability of resources.

In terms of access to health services, the policy indicates that the education sector will:

- Establish partnership with other line ministries and service organisations to facilitate access to treatment and related services for employees and learners.

- Facilitate access to information on health, as well as indicating when and where employees and learners should seek treatment for sexually transmitted infections, tuberculosis and other opportunistic infections.
- Promote the role of nutrition and food security for positive living as well as promote feeding programmes at the learning place, workplace and home.
- Facilitate training of educators and other institutional employees and learners in the safe management of bleeding or other injuries, as well as the application of universal infection control precautions.

To provide adequate psycho-social support, the policy requires that learning institutions and workplaces will:

- Create an enabling environment free of stigma and discrimination.
- Initiate an on-going professional counselling process for the infected and affected persons or refer them to a professional service.
- Facilitate access to support and counselling services.

To promote community mobilisation, the policy encourages educational institutions to:

- Mobilise communities for material and moral support and to seek funds and technical support from development partners, civil society and private sector for management of HIV/AIDS for the affected and infected.
- Create a regular forum to mobilise resources, monitor and evaluate the impact of interventions and address the challenges in collaboration with the Ministry of Education.

In terms of Orphans and Vulnerable Children (OVC), the policy requires that all learning institutions:

- Take the responsibility to identify and assess learners with special needs as well as identify resources that can support them.
- Make flexible programmes whenever possible to accommodate the needs of children who are infected, affected, vulnerable or with special needs.

APPENDIX 3

TEACHERS' AND HEADTEACHERS' QUESTIONNAIRE

INTERVIEW SCHEDULE FOR HEADTEACHERS AND TEACHERS

**AN ANALYSIS OF MOEST HIV/AIDS POLICY DEVELOPMENT AND
IMPLEMENTATION IN RELATION TO THE IMPLEMENTATION OF THE
PSABH PROJECT**

CfBT

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Dr. Jacinta K. Ndambuki

Introduction

ODI/CfBT IN CONJUNCTION WITH MOEST IS CARRYING OUT AN ANALYSIS OF HIV/AIDS POLICY DEVELOPMENT AND IMPLEMENTATION STRUCTURES, MECHANISMS AND PROCESSES

You have been identified as a key stakeholder in the HIV/AIDS Policy development and implementation process.

Please respond to the questions in this interview schedule honestly and to the best of your knowledge.

Thank you for your cooperation.

God bless you.

Date of Interview _____

Name of Interviewer _____

SECTION A
RESPONDENT PROFILE

Institutional Data

Province

- 1) _____
- 2) _____
- 3) _____
- 4) _____

2) District

- 1) _____
- 2) _____
- 3) _____
- 4) _____

3) Institution

Primary

Secondary

Education Office

Other Ministries

- ◆ _____
- ◆ _____
- ◆ _____
- ◆ _____

4) Employer

- ◆ _____
- ◆ _____
- ◆ _____
- ◆ _____

ii) **PERSONAL DATA**

1) Age

- > 50
- 40 – 49
- 30 – 39
- < 30

2) Sex

- Male
- Female

3) Academic qualifications

- i) _____
- ii) _____
- iii) _____
- iv) _____
- v) _____

4) Highest professional qualification

- i) _____
- ii) _____

5) Post held/designation

6) Professional Grade

7) Years of experience:

> 35

26 – 35

16 – 25

6 – 15

> 6

SECTION B

POLICY AND PROGRAMME FORMULATION, CONTENT, IMPLEMENTATION AND EVALUATION

1. Are you aware of the existence of the National HIV/AIDS Policy in education?

Yes

No

2. In what ways did you participate in its formulation?

3. What guideline does the policy provide you to facilitate its implementation?

4. What institutional framework have you put in place to implement the policy?

5. Who are spearheading the implementation of the HIV/AIDS policy in your school?

6. What training have they undergone?

7. What financial resources (if any) have been provided to support the implementation of the policy?

8. What guidance do you get from the education supervisors in the implementation of the Policy?

9. How do you involve other stakeholders in the implementation of the Policy?

10. What programme(s) do you have in the school for the implementation of the HIV/AIDS Policy?

11. Are you aware of the HIV/AIDS curriculum

12. Are you aware that the HIV/AIDS curriculum has been integrated into the revised curriculum?

13. How are you implementing the HIV/AIDS curriculum in your school?

14. How do you ensure that appropriate and accurate information on HIV/AIDS is being communicated to the learners?

15. What guides in the planning and teaching the HIV/AIDS content and information in your school?

16. How are HIV/AIDS issues handled in the:-

a) staff room?

b) classroom?

17. What content and in which class have you handled HIV/AIDS issues in the revised curriculum?

<i>Content/Topic</i>	<i>Class</i>

18. How do you compare the guidelines provided on HIV/AIDS Content and information in the phase out curriculum and in the revised curriculum?

<i>Phase out Curriculum</i>	<i>Revised Curriculum</i>

19. What is your school policy in handling HIV/AIDS?

20. How do the approved textbooks on the revised curriculum cover HIV/AIDS content?

21. What support is available for children who are infected by HIV/AIDS?

22. What support is available for children whose guardians are infected by HIV/AIDS?

23. What support is available for teachers who are infected by HIV/AIDS?

24. What support is available to parents who are infected by HIV/AIDS?

25. How do you identify and handle:-

- a) Orphaned children in your school?
- b) Vulnerable children?
- c) Special children?

26. How do you deal with the stigma among the HIV/AIDS infected and/or affected members of your school community?

- Students
- Teachers
- Parents
- Other (*please specify*)

27. What else would you want to say about HIV/AIDS Policy in education.

Comments:-

APPENDIX 4
OBSERVATION SCHEDULE

A CHECK LIST FOR THE HIV/AIDS EDUCATION AND TRAINING MATERIALS

Check whether the respondent has any of the following materials:

(Please Tick as Appropriate)

- | | | |
|--|----------|---------|
| 1. The Education Sector HIV/AIDS policy | Yes----- | No----- |
| 2. The HIV/AIDS curriculum for schools
And colleges | Yes----- | No----- |
| 3. The National HIV/AIDS Strategic Plan | Yes----- | No----- |
| 4. The KESSP Document | Yes----- | No----- |
| 5. The Sessional Paper No 1, of 2005 | Yes----- | No----- |

APPENDIX 5

PART A

KEY GUIDING QUESTIONS USED FOR DATA GATHERING AT THE WORKSHOP

1. To what extent are the various key stakeholders familiar with the HIV/AIDS policy in education?
2. Who are the key HIV/AIDS Policy makers in education?
3. What is the HIV/AIDS policy formulation process in education?
4. What are the key structures that are used for HIV/AIDS policy formulation in education?
5. Who are the key stakeholders in HIV/AIDS policy making in education?
6. Were all the key stakeholders adequately involved in HIV/AIDS policy formulation in education?
7. Who are the key partners in HIV/AIDS policy formulation in education?
8. Who else should be involved in policy formulation in education at the
 - Local level
 - District level
 - Provincial level
 - National level
9. What are the key strengths of the HIV/AIDS policy in education?
10. What are the key weaknesses of the HIV/AIDS policy in education?
11. What suggestions and recommendations can you make for the improvement of the HIV/AIDS policy in education in terms of the following:
 - Relevance
 - Appropriateness
 - Clarity
 - Validity
 - Practicability
 - Implement ability
 - Availability of resources
 - Comprehensiveness
 - Inclusiveness
 - Encouraging collaboration and partnerships

APPENDIX 5

PART B

WORKSHOP FOR ANALYSIS OF HIV/AIDS POLICY FORMULATION AND IMPLEMENTATION STRUCTURES IN EDUCATION

POLICY IMPLEMENTATION QUESTIONS

Who are the key policy implementers in education at the

- Local level
- District level
- Provincial level
- National level

Who are the key stakeholders in HIV/AIDS policy implementation in education at the

- Local level
- District level
- Provincial level
- National level

Who are the key partners in HIV/AIDS policy implementation in education at the

- Local level
- District level
- Provincial level
- National level

Who else should be involved in HIV/AIDS policy implementation at

- Local level
- District level
- Provincial level
- National level

What resources are available for HIV/AIDS policy implementation at the

- Local level
- District level
- Provincial level
- National level

How responsive have the various key stakeholders been in the implementation of the HIV/AIDS policy in education

- Students
- Parents
- Teachers
- Head teachers
- Community leaders
- Faith Based Organizations
- Community Based Organizations
- Non Governmental Organizations
- Community Members

Who should be involved in monitoring and evaluation of the implementation of the HIV/AIDS policy in education at the

- Local level
- District level
- Provincial level
- National level

What are the challenges implementers of the HIV/AIDS policy face at the

- Local level
- District level
- Provincial level
- National level

What opportunities are there for the effective implementation of the HIV/AIDS policy in Education at the

- Local level
- District level
- Provincial level
- National level

What are the key issues/problems facing the implementation of the HIV/AIDS policy in education at the

- Local level
- District level
- Provincial level
- National level

What is the best way forward in the implementation of the HIV/AIDS policy in education at the

- Local level
- District level
- Provincial level
- National level

APPENDIX 6

**WORKSHOP FOR ANALYSIS OF HIV/AIDS POLICY FORMULATION & IMPLEMENTATION STRUCTURES IN EDUCATION
DAILY REPORT FORM**

<p>COURSE: ANALYSIS OF HIV/AIDS FORMULATION & IMPLEMENTATION STRUCTURES IN EDUCATION</p>	<p>DISTRICT/REGION: NAKURU</p>
<p>DAY: 2</p>	<p>DATE: 19 JANUARY 2006</p>
<p><u>SESSIONS</u></p> <ul style="list-style-type: none"> • Climate setting • Workshop purpose, Objectives, Expected output & process • Programme rules and regulations • Welcome remarks • Official opening • Policy formulation • Policy implementation 	<p><u>FACILITATORS</u></p> <ul style="list-style-type: none"> • JN/PO • MG • JK/JN/MG • HN • EM • J.Kitunguu, Deputy PDE • JK/MG/JN/PO/JO • JK/MG/JN/PO/JO
<p><u>DAY'S PROCEEDINGS</u></p> <ul style="list-style-type: none"> • Climate setting – Participants drew a hut in pairs and joining of dots. • Purpose of the workshop • Objectives • CfBT mission, vision, objectives and operations • Brief introduction of ODI • Brief preview on PSABH & SSABH • Expected outputs • Introduction of the policy document. • Discussion on policy formulation and implementation • All participants were thanked for attending the workshop. • The DPDE made the following remarks. <ul style="list-style-type: none"> ○ Action must be done, everything is possible. ○ It is our responsibility to pass on factual and accurate information. ○ The workshop was very important and whatever comes out of the workshop would be useful to the country. • Policy formulation – group discussion & report back. • Policy implementation. Group discussions and report back. 	<p><u>EMERGING & INTERESTING FEATURES</u></p> <ul style="list-style-type: none"> • The issue of teamwork and consultation came out very clearly. • Leaders should have an extra rule in management to achieve their set goals. • Teachers are powerful change agents. • Emphasis on intersectoral collaboration in the implementation of HIV/AIDS education policy. • HIV/AIDS policy in education is a user-friendly document, which is guided in accordance with international conventions and regulations. • Hold the bull by the horns. It can be done if each one of us plays our part.
<p><u>CONCLUSION & SUMMARY</u> The day's objectives were achieved. Participants willingly shared information with each other and in the process made contributions on policy formulation structures, mechanisms and processes.</p>	
<p>Report prepared by: Josephine Ondieki</p>	

APPENDIX 7

**WORKSHOP FOR ANALYSIS OF HIV/AIDS POLICY FORMULATION AND IMPLEMENTATION STRUCTURES IN EDUCATION
THE STEM HOTEL, NAKURU WED. 18 JANUARY 2006 – FRI. 20 JANUARY 2006**

CONTACT LIST OF PARTICIPANTS

No.	Name	S	Designation	District	Zone	School/Office	Address	Telephone	Email
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5.	Emily Jangara	F	Ass.Field.Off	Nakuru	Nakuru M.	NACC	14104, Nakuru	051-2217186	-
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APPENDIX 8

GROUPING OF PARTICIPANTS AT THE WORKSHOP DISCUSSIONS

GROUPWORK: RESPONDING TO QUESTIONS ON POLICY FORMULATION

GROUP 1 - **MoH (Health), Children Officers and Provincial AIDS Control Council (Seven members)**

	NAME	DESIGNATION	OFFICE
1.	Josephine Ondieki	DDQASO	Nakuru Municipality
2.	Josephine Oguye	Provincial Children's Officer	Nakuru
3.	Emily Opado	Assistant Field Officer	
4.	Ritah Odhiambo	MoH	Nakuru Municipality
5.	Japheth Okomo	District Children's Officer	Nakuru
6.	Dr. Toromo	PASCO	Nakuru
7.	Nigel Rider	Business Development Director	CfBT, Nairobi

Chairperson - Rita Odhiambo
 Secretary - Nigel Rider
 Mobiliser - Josephine Ondieki

GROUP 2 - **Principals and Teachers (Primary & Secondary Schools) (Seven members)**

	NAME	DESIGNATION	OFFICE
1.	Cecilia Ngetich	Principal	Moi Forces Academy, Lanet
2.	Millicent W. Wahome	Principal	Njoro Girls High School
3.	Muhia Gichuki	Principal	Kahuho Secondary School
4.	Francis Mwangi	Principal	Afraha High School
5.	Sr. Hiltrude Mtaresi	Headteacher	Gogar Primary School
6.	Christine Mayieko	Headteacher	Kaptembwo Primary School

Chairperson - Mrs. Ngetich
 Secretary - Joseph Ngure
 Mobiliser - Mr. Mwangi

GROUP 3 - **MoEST Officers (Six members)**

	NAME	DESIGNATION	OFFICE
1.	Mr. David Kitunguu	Deputy PDE	PDE's Office, Rift Valley
2.	Mr. Joseph M Njuguna	Programme Officer	MEO's Office, Nakuru
3.	Mr. Jacob Sogomo	Deputy DQASO	Nakuru
4.	Mr. Michael Mugawo	SQASO	DEO's Office, Nakuru
5.	Mrs. Phoebe Okango	Lead team	
6.	Mr. Abdulkarim Mohammed	Education Officer	DEO's Office, Nakuru

Chairperson - Kitunguu
 Secretary - Phoebe Okango
 Mobiliser - Mohammed

APPENDIX 9

WORKSHOP FINDINGS PART A

ANALYSIS OF HIV/AIDS EDUCATION POLICYMAKING IN KENYA

THE KEY STAKEHOLDERS IN HIV/AIDS POLICY MAKING IN EDUCATION

Ideally these should be key ministries and departments, NACC, NGOs, CBOs, FBOs, PTAs, PLWHAs, OVCs representatives, students peer supporters, KNUT, Kenya Primary Head teachers Association, Secondary School Head teachers Association and TSC (Teacher Service Commission)

AIDS Control Units at the headquarters and provincial level.

Quality Assurance & Standards Officers.

Identify its key stakeholders and partners and work with them effectively to mitigate against the impact of HIV/AIDS on the youth, the community and socio-economic life of the nation, Kenya.

ANALYSIS OF THE ADEQUACY OF INVOLVEMENT OF THE VARIOUS KEY STAKEHOLDERS IN THE HIV/AIDS POLICY FORMULATION

No. Only Involved stakeholders at top level. Up to Provincial and national levels - Provincial ACUs, National ACUs, KIE ACU, TSC ACUs.

The grassroot stakeholders not involved adequately. Only at the level of the representation of Head Teachers Association and Teachers College Principals Association.

Individuals and institutions of learning not adequately represented.

THE KEY PARTNERS IN HIV/AIDS POLICY FORMULATION IN EDUCATION

The Ministry of Education works with many key partners in HIV/AIDS education including the Faith Based Organizations (FBOs), Community Based Organizations (CBOs), Donors, NGOs, the MoH, Children's department, parents and community members, all other ministries concerned with education. Some of the other ministries that use education as a medium of combating the HIV/AIDS pandemic among their key stakeholders include the Ministry of labour (employment and labour) Ministry of culture, Sport and Social Services, the Ministry of Home Affairs the Ministry of Constitutional Affairs-Judiciary and Law enforcement in prisons and rehabilitation centres.

OTHER STAKEHOLDERS THAT WERE NOT INVOLVED BUT THAT SHOULD HAVE BEEN INVOLVED IN POLICY FORMULATION IN EDUCATION AT THE FOLLOWING LEVELS:

Local level

At the local-school and community level the following groups were identified as the key stakeholders in the policy formulation who should have been involved in the process:

- Village elders
- Provincial administration (Chiefs, Assistant Chiefs)
- Local business people
- Councillors
- Community Based Organizations
- Faith Based Organizations
- Local health facilities including Health Centres, Faith Based Organizations Supported health facilities
- Community AIDS Control Council (CACC)
- PLWHAs (Persons Living With HIV/Aids)

District level

- District Commissioner

- District Education Officers (DEO's)
- Non Governmental Organizations
- District Children's Officer
- District Statistics Officer
- District Commissioner

Provincial level

- Provincial Director of Education Officers
- Provincial Police Officer
- Provincial Children's Officer
- Provincial Commissioner
- Provincial AIDS Control Council
- Non Governmental Organizations

National level

- Policy Developers-Lead Ministry
- Ministry of Education
- Ministry of Science and Technology

Partners

- Office of the President
- Ministry of Home Affairs
- Ministry of Culture Sport and Social Services
- Ministry of Health

THE KEY STRENGTHS OF THE HIV/AIDS POLICY IN EDUCATION

- The policy document provides well summarized accurate and valid information
- The document is arranged in a simple, straight forward manner simplicity
- There were no contradictory statements or information. Thus it is adequately Consistent
- Comprehensiveness
- Implementable but needs guidelines for detail and interpretation for implementation purposes
- Fair and equitable to all groups
- Non discriminatory in language and illustrations
- Non-denominational and caters for all education sectors (primary to higher)
- The policy document is well summarised.
- The policy document is well designed.
- The structure of the document is good, beautiful and attractive. Thus it is judged to be well structured.
- Illustrations are good, appropriate big enough size and well set
- The policy document is made from high quality paper.
- Handy – Is a good small enough size that can be easily carried in the pocket or in a small bag
- Encourages gender parity
- Language is simple and clear.
- Guarantees privacy and confidentiality.
- Relevance-The policy is relevant. to the needs of the various key stakeholders
- Appropriateness- The policy is appropriate
- Clarity- The language and structure is simple and clear. It is clear and easily understood.
- Validity- The policy is good and valid
- Encouraging collaboration and partnerships. The policy encourages partnerships and collaboration

THE KEY WEAKNESSES OF THE HIV/AIDS POLICY IN EDUCATION

- Dissemination of the policy has been limited and insufficient even among the key stakeholders
- Lacks ownership- most stakeholders were not involved in its formulation and the policy not yet widely disseminated among them
- No guidelines on how to implement policy.
- Responsibility rests only on the head teacher not the teachers.
- No stated commitment by Government to providing resources both human and financial.
- Availability of resources-Very limited. Not adequate (Need for allocation of resources both human/financial and implementers informed how to assess them)
- No Quality Assurance tools to check head teachers are implementing policy.
- The respondents the policy does not provide adequate direction and motivation to act on the statements. It acts as an awareness creation tool. In their view it presents a statement of intent.
- Does not show how capacity building, education and training will be carried out.
- It is adequately broad but lacks detail for implementation hence the need for detailed guide lines
- The does not motivate you to act. It acts as an awareness tool. Looks like a statement of intent not like an activity oriented policy
- No legal backing. Not yet entrenched into the law-lacks legal backing since it is not institutionalised in the legal framework ie the Education Act
- Practicability-Does not look practical (Need for guidelines)
- Implementability-Several challenges that need to be addressed and interpreted into implementable activities and strategies. Hence the need for guidelines
- Comprehensiveness-Not adequately comprehensive. Left out people with special needs.
- Inclusiveness-Not adequately inclusive left out people with special needs
- Timing-Not timely; should have come earlier than time of launch-A lot of time wasted through the prolonged delay. The need for comprehensive HIV/AIDS policy was not felt by the lead Ministry for a long time but no action was taken to formulate one.

CONCLUSIONS

The policy lacks adequate ownership by key stakeholders and partners especially at the grassroots level where ownership is critical for implementation purposes. Since the majority of the stakeholders and partners were not adequately involved in the policy formulation process they share no ownership of the policy. It is difficult to interpret and implement the policy the way it is. Statements are broad and generalised. It is not clear from the policy document where and how the resources for its implementation will be availed and accessed by the key players-key stakeholders and partners.

RECOMMENDATIONS BY THE WORKSHOP PARTICIPANTS

- It should be made very clear how the policy should be interpreted and implemented
- It should be made very clear to the key stakeholders and partners where the resources for implementation of the policy will come from
- Comprehensive HIV/AIDS policy implementation guidelines should be given
- For Policy implementation the Government should allocate adequate human/financial resources
- The key stakeholders and partners should be sensitised and educated on the policy-its purpose, its objectives, the content, the implementation structure, the roles of the different key players, the resource allocation process, the roles of different key players, the expected outputs, outcomes and impact
- There should be a deliberate aggressive move to disseminate and sell the policy to the various key stakeholders and partners to achieve ownership)
- There should be a comprehensive, clear monitoring and evaluation system. An HIV/AIDS quality assessment tool should be developed and integrated into the quality assurance system
- There should be a clear, comprehensive inbuilt capacity building component of the policy the implementation guidelines should give details and clarifications. Clear implementation instructions,

- procedures and strategies should be given in the guidelines
- Does not motivate you to act. It acts as an awareness tool. Looks like a statement of intent not like an activity oriented policy
 - No legal backing. Not yet entrenched into the law-lacks legal backing since it is not institutionalised in the legal framework ie the Education Act
 - Practicability-Does not look practical (Need for guidelines)
 - Implementability- Several challenges that need to be addressed and interpreted into implementable activities and strategies. Hence the need for guidelines
 - Comprehensiveness-Not too comprehensive. Left out people with special needs.
 - Inclusiveness-Not adequately inclusive left out people with special needs
 - Timing-Not timely; should have come earlier than time of launch-A lot of time wasted through the prolonged delay. The need for comprehensive HIV/AIDS policy was not felt by the lead Ministry for a long time
 - It should be made very clear how the policy should be interpreted and implemented
 - It should be made very clear to the key stakeholders and partners where the resources for implementation of the policy will come from
 - It is difficult to interpret and implement the policy the way it is. Statements are broad

APPENDIX 9

WORKSHOP FINDINGS PART B

ANALYSIS OF EDUCATION SECTOR HIV/AIDS POLICY IMPLEMENTATION STRUCTURES, MECHANISMS AND PROCESSES

INTRODUCTION

It should be noted that the policy has not yet been implemented. Thus the stakeholders who participated in the workshop could not discuss how they had implemented the policy. What they did was to visualize what they should do in their institutions, departments and ministries in order to implement the policy effectively. The following presentation gives their vision on how they individually and corporately were going to put in place programmes and activities through which they would implement the policy. As can be seen from the findings they all agreed that they needed to work with their key stakeholders and partners if they were to effectively implement the policy.

WHAT IS THE BEST WAY FORWARD?

- Strengthen inter Departmental, Inter Ministerial and Inter Sectoral partnership with MoE through regular meetings and consultations
- Increase the number of Subsidy Beneficiaries and Households benefiting from the Cash Subsidy Programme from 3,000 to 10,000 in the next one year-2006-2007
- Reach out and support infected and affected children with ARVs.

CONCLUSIONS

The following conclusions are drawn from the analysis of the key stakeholders and the policy implementation structures. Mechanism and Processes:

- There are only four key ministries in the government who are actively participating in the implementation of large-scale HIV/AIDS programmes in education, especially those targeting the youth aged 11-16 years.
- The four Key Ministries can be termed as the key stakeholders as well as the key partners among them They are led by the Ministry of education, Ministry of Health, Ministry of Home Affairs and Ministry of Gender, Sport, Culture and Social Services.
- The four key ministries have worked together as partners for the last five years collaborating and supporting each other quite well. This collaborative support among the four key ministries has been particularly visible and tangible in the implementation of the PSABH. PSABH encourages collaboration across sectors and ministries through multi-sector approach that is one of the strongest aspects of the programme.
- Collaboration and approach makes programme implantation more effective, efficient and cost effective. Individuals, departments, organizations and ministries make up for each other's areas of weakness and enhance each other strengths through group dynamic synergy.
- Ministries, departments, institutions/organisation ought to realise that they have a social responsibility and a moral obligation to do everything possible within their means to reduce the risk of HIV/AIDS infection among their clients especially the youth, orphans and vulnerable children, people living with disability, women and the community at large,
- There are some very key ministries that should take HIV/AIDS education among the youth and adults as one of their key business since in their day-to-day activities they deal with people whose lives they must influence positively if they are going to be effective.
- The Ministries that are not quite visible as active in HIV/AIDS education among the youth, the adults and the community at large are Ministry of Technical Training, Ministry of Labour, Ministry

of information and Communication, Ministry of Local Government, Ministry of Agriculture, Ministry of Trade and Ministry of Tourism. The work of these ministries are so key and influential in the lives of many youth, adults and community in general that their participation in HIV/AIDS education policy and programme implementation would positively influence a lot of lives for behaviour change to reduce the risk of infection.

RECOMMENDATIONS

- The multi-sectoral approach should be strengthened for effective and efficient HIV/AIDS policy and programmes implementation
- All the key ministries should be required to prepare and implement HIV/AIDS Education policy and programmes that are ministry specific but which influence and bring other ministries to work together collaboratively the effectiveness and efficiency.
- All the ministries preparing and implementing HIV/AIDS policy and programmes for the youth and other groups in the community should be required to use multi-sectoral approach to be able to tap from a larger pool of resources to enhance their capacity and effectiveness.
- Since PSABH has successfully used the multi-sectoral approach despite all the challenges it should be emulated by all the other HIV/AIDS projects and programmes as a model of success.
- Lessons learnt from the implementation of the PSABH Programme should be used to encourage and inform the implementation of other HIV/AIDS projects/programmes in Kenya as well as other countries with similar attributes.

APPENDIX 10

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- | | |
|----------------------------------|---|
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