Kenya Network of Positive Teachers (KENEPOTE)

HIV and AIDS Planning Workshop REPORT

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HIV and AIDS Planning Workshop REPORT
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The POLICY project recognizes the role played by its strategic partner, the Kenya Network of Positive Teachers (KENEPOTE), in advocacy for the reduction of stigma and discrimination against and protection of the rights of and access to care and treatment for, HIV-positive teachers. Special thanks go to KENEPOTE office bearers, especially Chairperson Margaret Wambete and Executive Director Elsa Ouko, for initiating KENEPOTE and having the vision to convene the first national workshop for HIV-positive teachers in Kenya. POLICY project is proud to be associated with this innovative initiative. The Workshop has created strategic partnerships and alliances between POLICY Project, Ministry of Education, Science and Technology (MOEST), Teachers Service Commission (TSC), Kenya National Union of Teachers (KNUT) and USAID. The Workshop will be revelation to all teachers and other education and HIV and AIDS stakeholders in Kenya and beyond. The Workshop owes its special success to the HIV-positive teachers who worked tirelessly to develop KENEPOTE’s National Vision, Mission and Strategic Objectives, thereby effectively addressing the challenge HIV and AIDS are posing to teachers in Kenya.

Particular gratitude goes to the workshop participants who gave testimonies on their experiences with HIV and AIDS, especially on stigma, discrimination and abuse of their rights. Their testimonies gave much credence and legitimacy to issues that might otherwise have been treated purely conjecturally. POLICY Project looks forward to working with KENEPOTE and other stakeholders to bring positive change towards an environment free of abuse, stigma and discrimination in the education sector work place. Sincere gratitude goes to the Workshop co-ordinator and main facilitator, Millicent Obaso, for her tireless efforts and determination in generating maximum team spirit among the participants, resulting in the production of a focused report and action plan within a remarkably short time. The output of the Workshop provides a basis for future action on the challenges facing HIV infected teachers and the entire education sector.

POLICY Project is grateful for the excellent work done by the resource persons and those who facilitated the implementation of the workshop. Special thanks go to Jeremiah Okuto for his technical input and excellent photographs, TSC’s Alice Waweru and Laban Aigro of MOE ST for providing guidance on policy issues throughout the workshop. Special thanks also go to POLICY Project’s Esther Gatua, Nancy Ombega and Salim Kassim who all worked tirelessly and diligently for overall success.

USAID provided workshop resources under its HIV/AIDS program, while Cheryl Sonnichsen provided invaluable technical inputs.

Finally, our thanks go to Elijah Leiro and Sylvia Oduori for their tireless efforts in editing this report and to Grace Akengo and Winnie Oyuko for working on the design and layout.
This is a report of the first workshop ever held in Kenya for HIV-positive teachers, between 13th and 18th December 2004. It was organised by the Kenya Network of Positive Teachers (KENEPOTE) and the POLICY Project with support from USAID. The 60 HIV-positive teachers attending came from all Kenyan provinces. The top leadership of the Ministry of Education, Science and Technology (MOEST) and Kenya National Union of Teachers (KNUT) participated in the opening and closing ceremonies of the Workshop while the Director of the Teachers Service Commission/AIDS Control Unit (TSC/ACU) attended throughout. USAID officer responsible for its HIV and AIDS programs in Kenya attended the closing ceremony.

KENEPOTE

KENEPOTE was formed in 2003 as a network to unite HIV-positive teachers in their fight against HIV and AIDS and their negative impacts. It would also promote positive living with the virus in order to ensure continued productivity and prolonged life.

The roles of teachers

The Workshop recognised that the Teachers Service Commission (TSC) is the largest single employer in Kenya with 235,000 teachers stationed across the country. Teachers have diverse roles, including teaching children during their character forming years. Teachers are also counsellors, role models and parents; and they lead in religious institutions and hold many other responsible positions within their communities. These invaluable roles accord them high credibility; to the extent that Peter Piot, Executive Director of UNAIDS, argues that a teacher can save more lives than a doctor.

Teachers and HIV/AIDS

In the context of HIV and AIDS, teaching falls in one of the hardest hit employment sectors. Infected teachers have experienced stigma, discrimination and rejection by their families, fellow teachers, students and school associations. Because of stigma and discrimination, many HIV-positive teachers have lost their means of livelihood and cannot afford medicines to treat opportunistic infections (OIs), anti-retroviral (ARVs) or necessary balanced diets. Consequently, many such teachers are insecure and experience diminished productivity. This undermines their students’ education and character formation. Today’s children are the leaders of tomorrow, meaning that the absence of a good education and strong foundation for their characters threatens the future of our Nation.

The overall goal of the workshop

The December 2004 workshop’s goal was to sensitise HIV-positive teachers and important education sector stakeholders on KENEPOTE Goals, Vision, Mission and Objectives. The Workshop further hoped to get HIV-positive teachers to share their workplace and life experiences and to explore ways in which they could unite to address the challenges facing them, given their great potential as Kenyan agents of change.

Workshop Objectives

The Workshop Objectives were to:

- create awareness among and to sensitise potential KENEPOTE partners—such as TSC, MOEST and KNUT—on KENEPOTE’s Goals, Vision, Mission related to the needs of HIV-positive teachers;
- encourage HIV-positive teachers to share their experiences and concerns as lessons to others;
- increase awareness and knowledge of Workshop participants on facts about HIV and AIDS, care and support for Teachers Living With HIV and AIDS (TLWHA) and orphans and other children made vulnerable by HIV/AIDS (OVC) issues;
- identify key issues, challenges and needs of HIV-positive teachers and determine
how to address them;
• explore stigma and discrimination and determine how to reduce them in order to promote positive living with the virus;
• discuss the education ministry’s HIV and AIDS policy and the legal rights of infected teachers and come up with strategies for protecting such rights; and
• develop a one-year action plan for KENEPOTE.

Participant’s expectations about the workshop
Participants verbalised the following expectations that overlapped with the Workshop objectives and were incorporated into the overall agenda. Participants’ expectations included:
• getting tips on how to get treatment for OIs and how to access ARVs;
• elaboration of pre-requirements for treatment;
• participants to compose AIDS songs; and
• Workshop proceedings should be documented.

All the objectives and expectations were met as described below.

Workshop Methodology
In order to realize the Workshop objectives, various resource persons were invited to present papers and conduct sessions. The following topics were covered: Facts on HIV and AIDS, HIV/AIDS Management, Adherence to ARV Treatment and Care, Nutrition and HIV/AIDS, Principles of Care, Home Based Care, Disclosure, Stigma and Discrimination, Spiritual Care and Support, Positive Living with HIV/AIDS, Psychological and Social Needs of TLWHA, Principles of Psychotherapy, Behaviour Change, The Legal Rights and Inheritance Rights of TLWHA, Education Sector Policy on HIV and AIDS, and The Challenges for HIV Positive Teachers.

Participatory methodologies were used during the sessions to ensure the achievement of the objectives and expectations. To heighten awareness and memory retention, illustrations, pictures, diagrams, demonstrations and return demonstrations were used. Additionally, lectures, discussions, group discussions, questions and answers and public debate in plenary were used. In between sessions, icebreakers were used to remove tension and to build team spirit and trust. Each day started with prayers for spiritual reinforcement, followed by a recap of the previous day’s work to ensure continuity and linkage with the new day’s sessions. The day closed with a prayer. Over 10 participants gave testimonies to put a human face to HIV and AIDS.

Take–Home Messages
Treatment Care and Adherence
The workshop gave knowledge for participants to take home. More importantly, it gave practical information and guidance to HIV-positive teachers on how to manage their status. The take-home messages included principles of ART treatment, adherence and care. Participants were advised on how to overcome barriers by going for proper adherence assessment before initiation of drug therapy. The teachers taking ARVs were encouraged to be deeply committed to taking the drugs as prescribed and on time; and to remain in close contact with the person providing treatment to support them and ensure counselling and follow up.

Nutrition
The nutrition take home message was a simple menu, based on local foods (see page 16). The importance of nutrition in the management of HIV and AIDS was underscored because malnutrition in HIV patients fuels AIDS that in turn aggravates malnutrition. Malnutrition reduces immunity and increases susceptibility to infections.

Opportunistic Infections
Participants were informed about opportunistic infections (OIs) and action to take when they occur. Signs and symptoms they should look for to identify opportunistic infections were also highlighted. For example they should look out for the following: for respiratory infections (TB, pneumonia), gastro-intestinal infections (candida, diarrhoea), head complications (meningitis), skin infections (herpes zoster, fungal infections) and genital infections (viral, fungal). Participants were given tips on
the management and treatment of the same. Emphasis was placed on TB since 75% of its victims in Kenya are HIV-positive.

**Positive Living**
Participants were introduced to the concepts of positive living as a mechanism for healing. These concepts embraced fighting self-stigma and stigma from outside; spiritual support; exercise; crying; expressing oneself; joining support groups; talking to other HIV-positive people; sharing experiences; having fun and taking responsibility to avoid re-infection or infecting others; and going for continuous counselling.

**HIV Status Disclosure**
The participants were encouraged to consider self-disclosure in order to overcome self-stigma and accept their status and find it easier to go for care, treatment and the support they require. It was concluded that disclosure promotes responsibility and respectability. Disclosure was described as a mechanism that creates an environment where women are able to negotiate protected sex.

**Social needs of positive teachers**
The session concluded that the psychological needs of teachers must be seen as fundamental since the state of mind manifests itself in the physical being, which in turn influences the state of mind. For HIV-positive teachers to heal both physically and psychologically, it is necessary to increase access to psychosocial therapy and counselling.

**Stigma**
Participants identified two major sources of stigma to include ignorance and the fact that HIV is contracted through sex. In the words of one participant: “Stigma and discrimination are killing teachers faster than HIV and AIDS; therefore if we do not kill stigma and discrimination, even ARTs will be null and void.”

Due to stigma, some head teachers fail to respect or honour requests by infected teachers for leave to attend treatment clinics, deny such teachers rest when feeling tired, make no plans to reduce their workloads when necessary and breach confidentiality about the teachers’ infection. For example, teachers’ infection is revealed to students who broadcast the information through songs, classroom and toilet graffiti and suggestion boxes. Students refuse to submit assignments for marking by infected teachers (ostensibly fearing their books will return with the virus). Some students refuse to take instructions from HIV-positive teachers, who some Parents and Teachers Associations (PTAs) insist on being transferred on trumped up disciplinary grounds.

The Workshop’s group reports captured stigma as follows: “The HIV-positive teacher is perceived to be a failure, immoral, untrustworthy, irresponsible, foolish, dishonest, incompetent and infectious”. Participants described their feelings arising from these perceptions as ones of “shame, isolation; fear, rejection, marginalisation, devaluation and segregation.”

**Way Forward**
The Workshop participants concluded that KENEPOTE must immediately address the following three priority objectives:

- reduce stigma and discrimination against teachers living with HIV and AIDS;
- intensify advocacy and lobbying for protection of the rights of teachers living with HIV and AIDS; and
- strengthen the capacity of KENEPOTE as a network acting in the best interests of HIV-positive teachers to ensure implementation of these objectives in an efficient, effective and transparent manner.

Attached to this report are national and regional one-year action plans developed by Workshop participants based on the revised KENEPOTE thematic areas, Vision, Mission and Strategic Objectives. The three objectives to be addressed in Year One were derived from the revised KENEPOTE operational framework developed by the participants. The Action Plan is attached as Annex I and contains the Mission, Vision Strategic Objectives, activities and expected results. The list of Workshop participants and the program are attached.
HIV and AIDS Planning Workshop Report

Introduction

The Kenya Network of Positive Teachers (KENEPOTE) was formed by two HIV-positive teachers: Elsa Ouko and Margaret Wambete. The need to form KENEPOTE emerged from their real life experiences in which they faced stigma, discrimination and rejection. They realised that many other teachers were facing similar challenges within their families, communities and work places. For example, teachers had been denied permission off work to attend HIV/AIDS clinics when sick, to get treatment for opportunistic infections, or to access anti-retroviral (ARV) drugs. Others had been interdicted while others still had been dismissed because of their HIV status. Such discriminatory and punitive actions against teachers have far reaching consequences, such as loss of livelihoods, inaccess to health services and early deaths.

KENEPOTE’s objectives are to unite HIV-positive teachers against stigma and discrimination; advocate for prevention, care and treatment; protect their rights; and promote their living positively with the virus in order to prolong their active lives.

Background

HIV and AIDS are ravaging Kenyan families and communities, infecting and killing many. Current estimates place the number of orphans at 1.6 million. Within employment, the teaching profession is among the worst hit sectors. Infection among students is also high, undermining completion of education cycles. These realities negatively influence the supply of teachers who normally make important contributions to the balanced development of children and are critical change agents within their communities. Infection, stigma and discrimination against them undermine their concentration on and productivity in their various roles.

Younger people have been disproportionately affected by the HIV/AIDS pandemic. Levels of infection peak in 15-24 age group many of whose members are still in education.

Kenya’s Education Sector Policy on HIV and AIDS specifies the rights and responsibilities of every person involved directly or indirectly in the education sector concerning HIV/AIDS. The document identifies the groups targeted by the policy, including teachers and students in:

✓ Early child care and education
✓ Primary education
✓ Special needs education
✓ Secondary education
✓ Teachers vocational education training
✓ Adult and continuing education
✓ Higher education
✓ Non-formal education
✓ Skills training

The policy also applies to semi-autonomous government agencies and all other stakeholders in the provision of education, such as Teachers Service Commission (TSC).

The KENEPOTE workshop was among the first ever to be held for HIV-positive teachers from Kenyan primary and secondary schools with participants drawn from all the eight provinces. KENEPOTE approached POLICY Project for technical support for the workshop, which was subsequently sponsored by USAID.

Workshop Objectives

KENEPOTE drafted the following seven (7) workshop objectives in consultation with the POLICY Project:

1. Sensitise potential KENEPOTE partners (such as TSC, Kenya National Union of Teachers (KNUT) and Ministry of Education, Science and Technology (MOEST)) about KENEPOTE’s Goal, Mission, and Activities;
2. Encourage HIV-positive teachers who attend the workshop to share experiences and concerns;
3. Increase workshop participants’ awareness and
The Workshop fulfilled its objectives and the participants’ expectations as presented in the following chapters. The Workshop program is presented in the appendices to provide topics covered.

**Accomplishments of the Workshop Objectives**

**OBJECTIVE 1:** Sensitise potential KENEPOTE partners (such as TSC, KNUT, and MOEST) about KENEPOTE’s Goal, Mission and Activities

Sixty (60) HIV-positive teachers from eight provinces attended KENEPOTE’s workshop designed to sensitise top level officials from MOEST, TSC and KNUT on their plight in the workplace. The sensitisation was carried out during the opening and closing sessions and during two sessions conducted by a Deputy Secretary from MOEST. The Director of the Teachers Service Commission/AIDS Control Unit (TSC/ACU) attended the workshop throughout and was therefore fully apprised of the participants’ sentiments and shared experiences.

Deputy Secretary of TSC attended official opening in the company of the Provincial Director of Education (PDE) for Rift Valley. Other guests at the opening ceremony included Barclays Bank’s HIV/AIDS workplace programme manager for Nakuru and the Director of POLICY Project.

The closing ceremony presented a further opportunity for sensitising top level stakeholders, including KNUT’s Secretary General, Nakuru officials and its Nairobi branch officer in charge of HIV and AIDS. MOEST was represented by the PDE while USAID’s Cheryl Sonnichsen and POLICY Project’s Deputy National Director also attended.

**Remarks by officials and founder members of KENEPOTE**

KENEPOTE founders used the ceremonies to address stakeholders on their network’s goals and objectives and to introduce its members. KENEPOTE officials highlighted the challenges the network has faced since its inception and the accomplishments made. Amongst other things, the Chairperson said:

*The workshop starting today demonstrates our joint commitment to fight HIV/AIDS in this country with particular reference to Education Sector’*

She continued to say that “Our commitment in this workshop is to sensitise potential partners about the HIV-positive teachers’ network and to develop a one year plan. This is the best forum with representation of HIV positive teachers from all...
the provinces. All of you have taken time from your busy schedules to help KENEPOTE come up with the way forward and a plan of action that will address the positive teacher’s issues concerning HIV/AIDS in the teaching profession.”

The KENEPOTE Executive Director adjudged the Workshop “therapeutic (against) one common enemy”.

Remarks by Barclays Bank HIV/AIDS Manager

The Barclays Bank official shared the success story of their strong work-place HIV/AIDS policy and program. The official outlined the services and benefits the Bank provides to infected employees, treating them as any employee with any other disease, providing ARVs and treatment for OIs as they would provide drugs for malaria patients. HIV/AIDS patients have a medical cover (as do other employees), while the sick are assigned duties according to their ability to perform and capacity to continue working.

This presentation raised the participants’ hopes, encouraging them on the scope for improvements at their own workplaces. It also impressed on the TSC and MOEST officials the benefits they could extend to their own employees while also highlighting directions in which KENEPOTE activities could head.

Testimony by one of the Workshop participants on stigma and discrimination in the teaching profession

A Workshop participant who had suffered stigma and discrimination and subsequently lost her job because of her HIV/AIDS status, shared her experiences in a powerful testimony summarised below, that went a long way in sensitising stakeholders.

“I am Jacinta Mulatya, popularly known as Jacinta Mbithe. I am a teacher by profession and I am HIV-positive. I was a practicing teacher until May 01, 2004, when stigma, discrimination, isolation and open hostility and cruelty forced me to ask for an early retirement.

I found out that I was HIV positive in 1998, but lived in self denial until November, 2003 when I opened up to my Head Teacher about my status as I was getting sick too often then.

I was too naive to think that he was going to sympathize with me, and understand my situation and condition especially when I got sick. When I revealed my HIV status to the Head Teacher, I had just lost my younger sister to the HIV scourge. She left me with four orphans to look after. Her death broke my spirit, and physically I was ailing, and my Head Teacher gave me no support. My troubles began then. I developed an allergy to chalk and requested the same Head Teacher to try and get me the dustless chalk as it was better than the other kind and more suitable for me.

Instead of buying the chalk or consoling me, the Head Teacher gossiped about me to the other teachers and they in turn told the parents about my HIV status. The climax came early in the year 2004 when the Head Teacher started inciting both the pupils and teachers against me and telling them not to come to me for anything. I was the Deputy Teacher and one of my roles was to be in charge of the store where books were kept. Teachers and students stopped coming to me for books and instead would go to the Head Teacher for virtually everything. Nobody came to my office anymore, I felt lonely and isolated.

The situation got worse, as the pupils would sing the popular song “Ukimwi mbaya” any time I passed by them or vice versa. The teachers would also use any opportunity to antagonize and humiliate me. My depression got worse.

The Head Teacher said that he was going to make sure that I lose my job and all my years of service hence my benefits. But the District Human Resources Officer (DHRO) of Makueni, a Miss Danison learnt of my case when she was given a copy of the second letter. She took up the matter and nipped what was going to happen in the bud. My salary was stopped in April
and I was left wondering what to buy drugs with.

I went to TSC headquarters one day and found a certain officer who drafted a voluntary retirement letter for me after I had talked to him about my HIV status. Although he helped me, he told me not to mention that in the letter.

They had stopped my salary in April, and it was in August 2004 that I got my April salary before they completely closed my case. There were two ladies in TSC who sympathised with me and helped me. Ms Macau (Pension Officers- Eastern) and Mrs. Mulandi (Pensions overall in charge); the two officers helped me get my April salary. I thank the TSC for they were only ready to help.

Later, I met the two nice ladies of KENEPOTE (Elsa Ouko and Margaret Wambete) in Mukono, Uganda. Both of them talked to me about KENEPOTE and the possibility of going back to active teaching if I so wanted. But I told them that I have started a support group that takes care of both the HIV-positive members and HIV-positive orphans. I therefore do not wish to go back to teaching.

How I was treated and compelled to resign from my job really hurt me in the beginning. But after meeting so many positive people, I am convinced more than before that I made the right decision as far as retirement is concerned. I wish to talk to all positive teachers out there. I get less sick now, as I have known how to live positively with HIV status.

To conclude, I strongly condemn what the Head Teacher did to me, and I feel that I could never ever forgive him, as no one has the right to take away another person’s livelihood. By taking my job away when I was sick is denying me the right to buy medication hence the right to life. People living with HIV and AIDS, and especially a sick one, and even positive teachers have a right to be where they are, doing what they are doing unless proven otherwise by a doctor. Two remaining years of service stigmatized, discriminated and even drove me to desperation and hopelessness.

May KENEPOTE stand for those intimidated like me due to their gender and HIV status.”

The Director of POLICY Project’s powerful presentation characterised HIV/AIDS stigma as follows:

“Denial is one of the outcomes of stigma. Stigma blocks access to treatment and reduces the quality of life, it reduces self esteem, causes despair and depression, reduces planning for families and therefore leaves widows and orphans destitute.”

“Process of devaluation of people living with or associated with HIV/AIDS and discrimination follows stigma. Stigma and discrimination breach fundamental human rights. Society is more fearful of stigma than HIV/AIDS and opportunistic diseases associated with it. People can only admit they have HIV/AIDS when stigma is removed. Therefore we must kill the secrecy that fuels the stigma by breaking the silence.”
The POLICY Project director’s definition of and summary on stigma was an excellent wrap up of Jacinta’s testimony.

**Conclusion of the testimony**
Because of Jacinta’s testimony, TSC Deputy Secretary requested that Jacinta’s case and other similar ones are taken to their offices for immediate follow up and action. He also assured the participants that TSC would ensure teachers are not discriminated against.

**The major highlights of the key note address**
The Director, TSC, assured participants of his organisation’s continuing concerns with the teachers’ management of HIV/AIDS for sustained productivity. He noted that the workshop had brought together HIV-positive teachers to discuss stigma and address their needs at the workplace. The majority of teachers fall in the hardest hit age bracket of 15-49. AIDS is affecting the fundamental rights of teachers at the workplace particularly with respect to discrimination and stigmatisation. The illnesses associated with HIV/AIDS and the subsequent death has enormous impact on the education sector. It is increasingly feared that teachers are at greater risk of HIV/AIDS than other professionals of similar education in sub-Saharan Africa. Some factors elevating the risk of teachers contracting HIV/AIDS include frequent transfers, teachers’ comparatively higher and steadier incomes in the rural areas, and their power especially over students. The risks within the education sector are not limited to teachers alone, but include others, such as administrators and managers.

Teachers interact with many people as they perform their many and varied roles in classroom and at school as teachers, counsellors, role models and parents. They are also leaders in the Church and the community, holding responsible positions and are held in high esteem. Their countrywide distribution enables them to effectively advocate behaviour change since HIV/AIDS is a behavioural disease.

Teachers’ roles in Kenyan development make them a special group that deserves attention. According to Peter Piot, Executive Director of UNAIDS, a teacher can save more lives than a doctor. Significant deaths and illnesses among teachers as we see in Kenya, can erode gains made in educating the labour force, and thereby reverse hard won economic and development achievements.

The major role of TSC in providing teacher management services is being constrained by the impact of HIV/AIDS pandemic, which is affecting the health and performance of teachers. TSC desires to protect its uninfected members and to support the infected. Consequently, the Commission has developed an HIV/AIDS in-the-workplace policy, which is awaiting ratification by stakeholders. The policy spells out the rights and responsibilities of employers and employees and is intended to provide a framework for collective action. It addresses concerns such as stigma, discrimination, human rights, job security, prevention, confidentiality, employee benefits, recruitment procedures, performance management, discipline and dismissal among others. The policy stipulates that there will be no compulsory HIV/AIDS testing as a requirement for employment or continued service.

TSC is aware that stigma and discrimination surrounding HIV/AIDS are barriers to prevention, care, support and treatment. Shame and stigma have hampered open discussions of both the causes of and appropriate responses to the scourge. Stigma has caused the infected and affected to feel guilty and embarrassed, unable to express their views, fearing they will not be taken seriously or will be dismissed from their jobs.

The TSC director concluded: “I wish to assure you that, TSC shall not discriminate teachers and other job applicants living with HIV/AIDS against access to, or continued employment, training, promotion or employee benefits. They shall be protected against discrimination as well as stigmatisation. All infected teachers have the
“TSC does not, and will not, use the HIV status as a reason for refusing a teacher promotion, training or career development. Career progression of teachers is based on the individual’s merit and ability to perform the job safely and effectively. Infected teachers are entitled to the same benefits enjoyed by the non-infected employees. An expenditure incurred by the teachers as a result of inpatient medical treatment, should be claimed from the Commission for reimbursement by submitting to the Commission an application form TSC/MED/3.”

Ministry of Education Science and Technology’s Statement on HIV and AIDS

The MOEST Deputy Secretary’s purpose at the Workshop on Day Three was to introduce his ministry’s policy on HIV and AIDS to the infected teachers. Distributing copies of the policy to the participants, he asked them to take the documents to their schools and communities and become agents of change. He commended KENEPOTE’s bold move in breaking the silence over its members’ HIV status, which was a major step towards changing the environment of the family, school and community in which to address the issues of stigma and discrimination. The Secretary described KENEPOTE as an organization with an opportunity to examine the environment, values and resources concerning teachers and HIV/AIDS, and a potential strategic partner for MOEST. KENEPOTE could pioneer a database on teachers with HIV/AIDS and a monitoring and evaluation framework for assessing the disease’s impact in the education sector. Noting MOEST’s need for OVC data, the Secretary was particularly impressed by the Workshop’s all-province coverage, with 10 participants each from Rift Valley, Central and Western, 3 from Coast, 4 from North Eastern, 2 from Nairobi, 6 from Eastern and 15 from Nyanza. The presentation of the MOH policy on HIV/AIDS involved a very intense interaction with participants who were asked to subsequently become ambassadors in their respective work places.

Conclusion on objective One

The Workshop illustrated the network’s usefulness to TSC, MOEST and KNUT, which in turn assured KENEPOTE officials of their support and cooperation. The deliberations resulted in 21 teachers declaring their status openly for the first time ever, and giving their names and employment details for TSC to intervene with their Head Teachers concerning stigmatisation and general workplace support. The Workshop noted teachers with outstanding issues to be resolved, including wrong dismissals, transfer refusals, problems with Head Teacher over compassionate leave, etc., which TSC promised to address immediately.

OBJECTIVE 2: Encourage HIV positive teachers at the Workshop to share experiences and concerns

At the beginning of the Workshop, reservations among the HIV-positive participants threatened the prospects of attaining the stated objectives of the exercise. Many participants said they were not sure of their HIV status, but suspected something was wrong with their health. Workshop facilitators, POLICY Project staff and KENEPOTE officials had to work very hard to get the participants to be forthcoming. Fear dominated the room in which spirits were low.

However, John 9, vs. 1 to 4 inspired: “His disciples asked him, Rabbi, who sinned, this man or his parents, that he was born blind. Neither this man nor his parents sinned, but this happened so that the work of God might be displayed in his life.”

Participants sang and gave one another assurances that all revelations would remain confidential. The participants’ stories showed that their spirits had differed on getting the news on being HIV-positive. Some had gone into denial, while others planned to disclose their status. While some came out in the open and disclosed their status, others had decided they would never share their status with anybody. The Workshop therefore found some more ready than others to share experiences.
KENEPOTE’s founder members broke the ice by detailing their experiences to Workshop participants and talked of the benefits they had enjoyed by going public. This helped to build trust among the rest of the participants. The second day of the workshop started with participants exalting KENEPOTE for lifting their spirits and giving them hope.

The Chairperson of KENEPOTE then asked for willing participants to share their experiences. Three people came forward to narrate how they knew they were HIV positive, the circumstances that led to seeking VCT and how they felt after they were told they were positive. They described the support they had received, how and where they accessed drugs and the difference this has made into their lives. The testimonies—including one from a discordant couple—brought other participants to tears and were the beginning of trust building and participants opening up and bonding together. With participants sharing experiences, the Workshop turned into a group therapy activity. The participants would confess that coming to the Nakuru workshop to share experiences with fellow HIV-positive teachers had given them a new life and courage and lifted their spirits. They expressed joy by composing and learning new songs and dancing to them, overcoming barriers of language, tribe, religion and gender. For example, a Kikuyu participant taught his colleagues a Luo song. They also coined and learned the “KENEPOTE song” whose words are as follows:

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KENEPOTE Song “United Against AIDS“

| United against AIDS, Unite and be safe                      |
| Get the facts and get to know what AIDS is all about (repeat twice) |

Verse 1
We want to thank all those who give in their lives
They stand firm to fight AIDS but not people with AIDS

Verse 2
Every body! Together we stand and fight the AIDS
Until we reach the end

Verse 3
We use to be together as dear friends
But now you reject me and run away when I need you most
Repeat verse 2

OBJECTIVE 3: Increase awareness and knowledge of the workshop participants on HIV/AIDS facts, care and support People Living With HIV and AIDS (PLWHA) and OVC issues

Various experts presented papers on different HIV/AIDS-related topics to increase the knowledge and awareness of Workshop participants. The following topics were covered: Facts on HIV and AIDS, HIV/AIDS Management, Adherence to ARV Treatment and Care, Nutrition and HIV, Principles of Care, Home Based Care, Stigma and Discrimination, Spiritual Care and Support, Positive Living with HIV/AIDS, OVC Issues, Psychological and Social Needs of PLWHA, Principles of Psychotherapy, Behaviour Change, The Legal Rights and Inheritance Rights of PLWHA, Education Sector.

In order to meet the above objective, the participatory methodology of teaching was used. The presentations were illustrated by pictures, diagrams, demonstrations and return demonstrations. Lecture, discussion, as well as question and answer, were used. Group discussions and plenary discussions were held to maximize participation after each session, while the facilitator highlighted key points and summarised the session.

In between sessions, there were icebreakers, such as composing and learning AIDS songs. Dancing fostered team building, which helped the group members to bond and build trust.

Before starting each morning’s sessions, a recap of the previous day’s work was done to make sure everybody understood what had been done previously and to link it with the day’s impending sessions to ensure continuity. Papers presented at the Workshop are highlighted below and are attached in a bound copy to provide details.

Session: Facts on HIV and AIDS

The objective of the session was to provide basic facts on HIV/AIDS, its current status in Kenya and the national response to it. Key areas covered included distinguishing the prevalent type of HIV in Kenya, viz. HIV Type 1, with sub-types A, C, D, Z and E. Avoiding contracting other strains of the HIV virus was discussed as a way of living long with the virus. Prevention and treatment of sexually transmitted infections (STIs) was discussed as one of the ways of preventing HIV/AIDS infection because the virus usually gets into the bloodstream through open cuts or sores, such as those found during an STI.

POLICY Project gave the participants a copy of Lawrence Marum’s paper, HIV/AIDS prevalence and trends in Kenya 1990-2004: Implications for strategic planning, which had been presented at the National AIDS Control Council (NACC) strategic planning meeting in October 2004. The paper provides information on risk groups, AIDS cases in Kenya, methods of measuring trends and catalogues prevalence by age and sex. The paper reports that those at highest risk of HIV infection in 2005 are young girls (especially in pregnancy), married men and women, infants and children. The report also presents some explanations for why some couples remain discordant, such as inefficient transmission due to low viral loads and couples living apart from each other.

The report also identifies people needing attention in the wake of the HIV/AIDS pandemic, including:

- TB patients of whom 40-80 % are infected and all are eligible for antiretroviral therapy (ART).
- Women (1.9:1 female ratio) most female ARV candidates will be 20-29.
- Sexually active adults who need to know their HIV status and need repeat testing at critical points in life.
Kenya’s significant achievements against HIV/AIDS in the last five years are highlighted in Marum’s report as:
• Prevalence is declining;
• Risk behaviour is reduced;
• VCT is widely available;
• PMCT coverage is over 10%;
• ART is available in urban locations; and
• Blood supply is safer though supplies are still not adequate.

Challenges to look out for and control include:
• Young girls remain vulnerable;
• More than 400,000 married couples are discordant. Faithfulness without knowledge of status, including that of partner, will not protect one from contracting HIV. Great risk may be at home; and
• Only 20% of the infected know their status.

**Session: HIV/AIDS Management**

The presentation focused at length on TB and HIV intergration and terms of management. 75% of TB cases are HIV-positive with pneumonia and fluids in the lungs. They might also have oral thrush.

**Symptoms of TB**
• Cough for more than two weeks;
• Swelling of the neck;
• Convulsions and sometimes meningitis;
• Skin rash;
• TB affects everything except hair and teeth.

By treating TB, HIV and AIDS-related complications may be reduced while treating OIs improves the quality of life and enhances increased survival.

**Characteristics of TB**
• HIV is a chronic viral infection with NO known cure.
• HIV multiplies inside the CD4 cells that play a critical role in the immune system.
• CD4 cells are destroyed by HIV and gradually decrease in number.
• As the CD4 cell count decreases, the immune defences are weakened and the HIV-infected patient becomes vulnerable to opportunistic infections.
• Without treatment, the HIV-infected individual progresses predictably to symptomatic disease and AIDS.

Participants were showed slides of various forms of clinical presentations in HIV/AIDS patients, including genital warts, genital herpes, herpes zoster, TB, mouth/throat infections and candida. It was emphasised that TB is a common opportunistic infection in patients with HIV disease. If one is not sure whether he or she has TB, one should go for a chest X-ray. Since TB is associated with increased mortality, its treatment at an early stage is important.

After determining that the patient is HIV-positive, the patient’s readiness for treatment has to be assessed. Thus, it is important to check the following:
• Has the patient disclosed HIV status to anyone?
• Does the patient have support at home or through friends?
• Does the patient have a place to live where they can be found regularly?
• Does the patient understand the expected outcomes of ARV and its potential side effects?
• Does the patient appreciate the needs for intensive monitoring and follow up?
• Does the patient recognize the need to take ARVs for life, even when they have no symptoms or feel better?
• Does the patient understand the impact of non-adherence on his or her future care?

**The Principles of ARV Treatment**
• Never take ARVs in the absence of adherence counselling and support.
• Never take a monotherapy treatment for a chronic HIV infection.
• If ARV medications are to be discontinued, stop all the drugs as instructed.
• ARVs are never an emergency measure.

Additionally, participants were shown slides on the types of antiretrovirals used in Kenya
First line of Treatment
STAVUDINE/ZERIT/D4T
a) Formulations: capsules of 15mg, 30mg, and 40mg
b) Side effects: headache, peripheral neuritis

LAMIVUDINE/EPIVIR/3TC
a) Formulations: tablet of 150 mg; syrup of 50mg/5mls
   and combination of AZT/3TC (= COMBIVIR)
b) Side effects: very rare

NEVIRAPINE/VIRAMUNE/NVP
a) Formulation: tablet of 200mg; syrup of 50mg/mls
b) Side effects: Hepatitis (up to 10% of patients), skin rash (up to 20% of patients in the first 2-8 weeks of use)

Session: Adherence to ARV Treatment and Care

Adherence counselling was defined as: “Preparing the patient for treatment; making practical decisions and negotiations as well as supporting the patient through the care period.”

Adherence was defined as the engagement of a patient in a plan for care, understanding what care means, getting consent of the patient and partnership between the patient and the caregiver. It is a broader term than compliance because it includes drug therapy, the drugs, and follow up, health enhancement behaviour and food restrictions.

Adherence assessment is necessary before starting the client on treatment because learning that one has HIV is quite depressing. Patients and relatives need time to absorb the information and to adapt to the bad news, benefiting from as many discussions and further clarifications as necessary. Taking drugs daily is not easy even for simple prescriptions; therefore everyone is vulnerable to non-adherence for ARTs. Near perfect adherence is required to achieve treatment success. Thus, long-term care therapy requires commitment from the patient and support from providers of treatment (counselling and follow up), as illustrated in the diagram below.

Adherence in Kenya is 59% compared to 88% in Uganda and 89% in South Africa. We have a challenge to deal with the low adherence rate in Kenya, whose causes are explained above.

Patient based factors include other medical conditions like oral sores, diarrhoea and depression. Regimen based factors could be complexity of regime, taking other drugs at the same time such as TB drugs. Side effects of ARVs or combined drugs can also discourage adherence. Lifelong commitment to taking the drugs daily and at a particular time is not easy, and one can get tired of the routine.

Provider based barriers range from attitudes, inadequate patient preparation, and inaccessible providers for urgent routine and urgent visits, long waiting in clinics/missing files or shortage drugs, drugs being out of stock and uncoordinated clinic visits (all these are logistical inadequacies).

Patient education is critical in adherence. Every client needs to know facts about HIV and disease progression, professional advice, and relationship between adherence and disease...
progression. The education and intervention has to be tailored to the clients needs. Clients must be given time to ask questions and where necessary simplify instructions.

The cultural factors and beliefs towards HIV and ARVs have to be tackled, providers must advice on consequences of drug and alcohol abuse, sleeping overdose and say NO to sharing of drugs. Discuss with the patient how patient can tailor therapy to their routine and above all to be honest.

The session was concluded by advising the teachers and the communities to work in partnership with PLWHA as a means of achieving maximum viral suppression towards improved livelihoods since leaving a patient in the charge of a doctor alone is insufficient.

Caregiver must discuss with the patient the importance of nutrition while on therapy, psychological effects of the disease to the patient and the need for the patient to discuss concerns with people patient trusts.

Session: Nutrition and HIV

Malnutrition fuels HIV/AIDS, which in turn aggravates the rate of malnutrition. Therefore, good nutrition plays a major role in the management of HIV/AIDS since it helps build the immune system.

Malnutrition in HIV patients is caused by muscle and tissue catabolism, fever, nausea, vomiting, diarrhoea and weight loss. Difficulty in swallowing can also contribute to malnutrition. Other contributory factors include dehydration, macronutrient deficiency and loss of muscle mass.

Malnutrition presentation includes weight loss up to 10% body weight, reduced immune competence and increased susceptibility to infection. Sometimes it is accompanied with vitamin and mineral deficiencies and loss of muscle tissue/subcutaneous fat.

Components of nutrition care are; nutrition education and counselling; water, hygiene and food safety interventions to prevent diarrhoea; food for work programs; and food preparation. Entrepreneurship for income generation will help to generate the income required to buy some of the foods required for balanced nutrition.

The goal of nutrition support for PLWHA is to:

- Prevent food borne illness;
- Prepare diets which pay attention to AIDS related symptoms;
- Provide nutritious foods for HIV affected households living with food insecurity;
- Improve or develop better eating habits and diets;
- Prevent or stabilise weight loss; and
- Preserve muscle mass.

### General nutrient allowance required

#### Calories/Energy
- Maintenance: 35 to 40 Kcals/kg/Bw.

#### Protein
- Maintenance: 1.0 to 1.4 gm/kg
- Repletion: 1.2 to 1.5gms/kg/Bw or 100 to 120 gms per day. 1.5 – 2.0kg/Bw for repletion.

#### Carbohydrates
50 – 60% of total Kcals or 4– 6gm/kg/Bm

#### Fats
- 20 – 30% of total Kcals.(less of saturated fat e.g. butter, ghee, cheese, lard)
- Use polyunsaturated fats e.g. canola olive oil.

#### Fluids
- Encourage 2500 mls per day.
- Select enriched soups, porridge or fresh juices

#### Fruits
- At least a fruit a day.

#### Vegetables
- 2–4 servings per day.

#### Fat Malabsorption
- Eliminate oils e.g. butter, margarine, and foods prepared with fat.
- Eat lean meat.
- Cut or remove physical fat from meat.
- Eat fruit, vegetable, and other low fat foods.
Fatigue lethargy
- Have someone pre-cook foods to avoid energy and time spent in preparation.
- Eat fresh fruits that do not require preparation.
- Eat snacks food often throughout the day.
- Drink high-protein liquids.
- Set aside time each day for eating.

Nutrition Guidelines
- Keep track of your nutrition status: eat a well balanced diet.
- Take small frequent meal and snacks 5–6 per day for easier digestion and high nutrient intake.
- Food should be high in calories and proteins. Select foodstuffs that are nutrient dense e.g. meat, fish, poultry nuts, cheese, soups, milk and puddings.
- The diet should include food rich in vitamins and minerals.
- Take plenty of fluids, i.e. 6–10 cups. Monitor water loss through sweating, diarrhoea, vomiting etc. If one chooses to gain weight, take fluids that contain calories, e.g. juice, milk, soups and enriched porridge.
- Observe personal/food hygiene and environmental cleanliness, the food should be safe to boost the immune system.

Simple Menu

**Breakfast**
- Bread/sweet potatoes/arrowroots 2–3 pieces
- Weetabix/pancakes
- Ginger tea or tea with milk 1–2 cups
- Eggs/sausages
- Papaws/oranges/bananas 1 slice or 1 medium size

**10.00am**
- Bread/biscuits 1-3 pieces
- Porridge (enriched) 1 cup

**Lunch**
- Rice/potatoes/spaghett/ugali 1 cup
- Chapati 1 large size
- Vegetables of all kinds 1 cup
- Beef/poultry/fish/pork 10 pieces
- Legumes: bean/ndengu/peas 1 cup
- Milk 1 cup
- Fruit 1 piece

**4.00 pm**
- Porridge enriched 1 cup
- Tea & milk 1 cup
- Bread/biscuits/cakes 2 pieces
- Fruit 1 piece

**Supper**
- Ugali/rice/potatoes 1 cup
- Chapati 7 Pieces
- Legumes e.g. beans/ndengu 1 cup
- Vegetable of any kind 1–2 cups
- Milk 1 cup
- Fruits of choice 1 piece

**Bed Time**
- Tea or any other beverage with a snack of any choice.

Management of common HIV/AIDS symptoms and ways to maximize food intake

If you have a sore mouth or throat, avoid acidic foods like tomatoes and spices. Drink high protein fluids and use a straw when possible. Avoid hot foods and eat vegetables, fruits and thick smooth food e.g. porridge.

In case of fever or loss of appetite

Drink high energy/high protein liquids and fruit juices. Eat small portions of soft preferred food with a good aroma or flavour. Also drink fluids often and eat nutritious snacks whenever possible e.g. sandwiches.

Nausea and vomiting

Eat small snacks throughout the day. Eat plain dry foods, such as toast, and avoid food with a strong smell. Drink diluted fruit juice and other liquids and soups. As much as possible, eat simple boiled foods e.g. porridge, potatoes and beans. Eat bananas, mashed fruits, soft rice or porridge. Eat smaller meals frequently. Avoid the kitchen during food preparation, but do not skip meals. Drink ginger tea, ginger ale and plenty of non-carbonated beverages. Avoid caffeine, alcohol and nicotine. *Maziwa mala* will help; but avoid dairy products. Sniff lemon edges. Avoid fatty foods, apple juice, high sugary foods and food with roughage. Take medication for nausea.
Examples of locally available resources were displayed for participants. For example, millet flour combined with pounded yams and ground groundnuts could be used to provide a balanced meal. Some of the herbs used to boost immunity and suppress OIs were also displayed and discussed.

Session: Principles of Care

This session had three objectives:

Objective 1: Introduction to the HIV/AIDS Survival Kit

The kit comprises of:
- Positive living
- Good nutrition
- Prevention and treatment of OIs
- ARTs
- Safe sexual practices

Objective 2: HIV and OIs

This objective covered what HIV does to the body and what to do when common OIs occur. Prevention and treatment of OIs were also covered. Home Based Care and referrals were introduced in this context.

Positive Living was described as ‘the power of the mind’ which makes a big difference if put into action. Positive Living helps in the acceptance of HIV status and the fight against personal stigma. It is important for Positive Living, to seek knowledge and understanding of HIV infection in order to manage it effectively. Accepting one’s HIV status changes one’s attitude to life and is liberating. The facilitator advised: “Try to live every second as it comes and enjoy life. It is about the quality of life. Positive Living also helps you to fight stigma from external sources.”

HIV was defined as a virus that depends on human white cells to replicate. Thus, for its survival, the virus destroys the white cells whose CD4 cells are used to gauge an individual’s immune status. A normal CD4 count ranges between 500-1200/mm³.

Reasons for a decline in cell counts are:
- Natural progression of viral infection;
- Bad nutrition including heavy alcohol intake;
- Regular OIs;
- Unprotected sex; and
- Pregnancy.

Opportunistic Infections (OIs)

These are diseases occurring in immuno-suppressed individuals caused by an organism, which would not affect a person with a normal immune system. OIs occur when the CD4 cell count is below 500 cells/mm³ and cause deaths if not treated.

Common OIs

The different types of OIs include: respiratory (TB, pneumonia, PCP); gastro-intestinal (candida, diarrhoea); head (meningitis); skin (herpes zoster, fungal infections, bacterial rashes and boils); genital; (viral, fungal).

Signs and symptoms of OIs

TB manifests in a chronic cough, drenching night sweats, weight loss, sometimes fever and/or haemoptysis. A person with pneumonia often has high fever, cough, chest pain and breathing difficulties. PCP results in shortness of breath and coughing. Oral thrush comes with mouth sores, white patches and pain when swallowing food. Vaginal candidiasis symptoms are a whitish curd-like discharge and vaginal itching. Meningitis patients suffer from severe headache, stiff neck, photophobia, fever and sometimes vomiting.

Prevention of OIs

- Good nutrition
- Hygiene ( Proper food preparation and handling)
- Clean water
- Proper sanitation
- Skin care

Management of OI

- Identify signs and symptoms early
- Seek medical attention early
- Prompt treatment is very important

Treatment of OIs

- Septrin
- Fluconazole
- Isoniazid

Objective 3: Introduction to ART

- What it is/regimen
- The goal of administering ART
Goals of ART

The goals of ART are to reduce viral load, increase CD4 count, increase immunity, prolong life and improve its quality. One should start on ART at the World Health Organisation (WHO) Stage IV of HIV disease (i.e. clinical AIDS), regardless of their CD4 count, or WHO Stage I, II or III of the disease, with a CD4 count below 200/mm3.

Before starting on ART, one should consider willingness to undertake ART, outlook on commitment to therapy, potential barriers to therapy, presence of OIs, the current state of vital organs and the possibility of pregnancy. This will require a blood test to assess the red and white blood cells and the CD4 count. The lab test should also assess liver and kidney functionings while a chest X-ray will also be necessary.

Regimen

ART should always comprise of three (3) drugs, the 1st, 2nd and 3rd lines of treatment etc. (?) These must be taken at set times daily. Each regimen has a lifetime depending on compliance/adherence/resistance. Clinical and lab follow-up is critical. Cost is still an issue; hence the need for more lobbying and advocacy for price reductions.

General side effects

These include reactions in vital organs like liver, kidney, pancreas and blood cells. The patient may also experience skin rash, nausea and vomiting, numbness of extremities and unequal fat distribution.

Adherence

This is the engaged and accurate participation of patient in a plan of care. Adherence is the difference between life and death for the patient, while for the population, it can minimize the emergence of viral resistance. However, for it to be effective, a 95% adherence must be attained.

Other barriers to adherence

These include secrecy and stigma, difficulty in swallowing, side effects, forgetting doses, inadequate access to food and being away from home.

The presentation was concluded with the message that: “It is your responsibility to stay alive. You want quality of life and you deserve it. Be determined. You have a life to live; live it to the fullest. Enjoy every bit. But you must want to stay alive: the opportunity is there because survival kit exists”.

The good news is that success in adherence can be achieved. Key to success is knowledge of ART, its regimens, side effects and conduct of follow-ups. The right attitude of the patient is critical to success.
OBJECTIVE 4: Identify key issues, challenges and needs of HIV/AIDS positive teachers and draw plans on how to address them

Session: Positive Living with AIDS

The facilitators asked the participants to name the stages of healing in the crisis. The participants identified the following as the stages one goes through: -

When the bad news of being positive is released

- Shock and numbness
- Denial follows, then anger and blame
- Bargaining
- Fear
- Self consciousness
- Hope
- Acceptance

What to do to take care of oneself?

- Breathe: take 3 long breaths.
- Refuse to be victimised.
- Don’t say: “I am HIV”, but rather, “I have HIV.”
- Get education on facts and information.
- Get enough exercise.
- Express yourself.
- Get spiritual support
- Think and act positively.
- Cry when you need to.
- Find a safe outlet for your anger.
- Have fun.
- Accept responsibility.
- Talk to other HIV-positive people.

- Meditate and visualise.
- Take one day/one hour at a time to meet your obligations.
- Acknowledge your status.

Voluntary Counselling and Testing (VCT)

VCT was discussed as an important process through which people get to know their HIV status.

VCT can be initiated by an individual or through a referral by a service provider. Informed consent is an important step before testing. Clients should be provided with the information they need to make an informed choice in consenting to VCT.

Who is VCT for?

- Those who wish to know their status.
- Those who want to get married.
- Those who wish to plan their life.
- Those interested in HIV risk reduction.
- Pregnant women attending antenatal clinics.
- Patients who are referred for clinical prognosis.
- Applicants for insurance policies or those who want to migrate.

The above list shows that VCT is for varied members of society and should be a way of life. However, counselling must precede testing.

Session: Psychological Needs of PLWHA

Psychological needs

Discovery of one’s HIV-positive status can be a traumatic experience; therefore counselling is necessary. One’s state of mind manifests itself on their physical being, which in turn influences their state of mind. A good therapy for psychological distress is counselling.

During counselling, the following issues need to be addressed

- Feeling of guilt and neglect;
- Loneliness and depression;
- Spiritual support;
- Fear of death; and
- Making a will.

The process of counselling

There are two types of counselling.

- Individual counselling
- Group counselling

Counselling should be done in appropriate stages, starting with the pre-test, followed by the post-test and the follow up support counselling.

Pre-test counselling

Pre-test counselling is done to help the client deal with emotions, fears and anxieties before the HIV test is done. The counsellor:

- Discusses what is actually done during HIV testing.
• Explains and discusses the implications of knowing one’s HIV status with the client.
• Provides the client with all the information required for making an informed decision and giving consent for testing.
• Explores the client’s knowledge on HIV/AIDS and determines what further information is needed to support the client.
• Assesses anticipated reactions and effects on the client and their relations.
• Prepares the client for the practical consequences of VCT outcomes.
• Advises the client on prevention of infection with, or transmission of, HIV.
• Explains the implications of informed consent and seeks it.

Steps in pre-test counselling

• Discuss HIV test results.
• Provide support.
• Provide referral information.
• Encourage taking preventive measures.

Purpose of post test counselling if client tests positive

• Helps client understand results.
• Assists with shock and emotional response.
• Provides information on medical care.
• Helps prepare the client for handling personal stigma.

• Resolves whom client should tell about their HIV status and how to go about it.
• Sets up follow up appointments.

Content of post test counselling for negative clients

• Explain window period.
• Consider repeat testing.
• Address the issues of the ‘worried well’.
• Discusses preventive measures.

At all sessions, the counsellor should let the client pour out his/her feelings, doing most of the talking.

Counselling gives some reassurance to PLWHAs with those who are well counselled getting empowerment to continue with their lives normally. During pre-test counselling, a client will talk about what he/she knows about the modes of HIV transmission and prevention and the possible myths surrounding the disease.

The counsellor can therefore correct misconceptions and misinformation and explore the possibility of life after HIV infection. The expected test results should also be tackled at this stage.

Post-test counselling (Individual Counselling)

Part of this stage should be a revision of what was discussed during pre-test counselling. At the same time, the PLWA should be counselled on positive living, paying attention to:

• Avoiding infection/use of condoms;
• Stress management;
• The need for good nutrition and consumption of plenty of water;
• Diversity in opportunistic infections;
• Alternative therapy – immune boosters;
• Acceptance of personal status; and
• The benefits of adequate exercise.

The PLWA will be referred to a support group for further follow up counselling and support counselling.

NB: Some clients may be too confused/distressed by discovering their status for immediate counselling. Reassurance of the possibility of a healthy life can be explored by citing examples.

Follow up counselling

This should vary with time and stage of infection. At the symptomatic stage, a PLWA’s physique may start being deformed, which may be quite demoralizing and can cause much psychological distress. Such patients undergo many psychological and physiological changes and must eat well. Furthermore, they normally have fears about their own future, and those of their children, and a general fear of death.
**Social needs**

Human beings do not live in isolation, but are part of wider society where they need to have a sense of belonging, being loved and loving in turn. For HIV/AIDS victims, loneliness may lead to depression and to a further lowering of immunity. This can be avoided through:

- **Group therapy and sharing experiences** creates a sense of belonging.
- **A supportive environment** which can be realised through:
  - Good relationships within the family, which is quite easy to develop after disclosure.
  - Interacting with the community at large—in the church, work-place etc.
  - Acceptance of status by the self (disclosure), a device that makes the PLWHA yearn to live longer.

The reduction of stigma is important because it makes people feel rejected and isolated. Some strategies for the individual or society for reducing stigma include:

- **Medical care**
  - Use of accessible health care;
  - Ensuring finances with which to buy drugs;
  - The use of accessible drugs;
  - Monitoring the effectiveness of drugs; and
  - Keeping abreast of the new developments in drug research.

- **Nutritional care**
  - Ensuring access to good nutrition;
  - Preferring affordable local (unprocessed) foods, including raw and cooked vegetables.

- **Observation of PLWHA’s human rights**
  - Reproductive rights
  - Right to property ownership
  - Sexual rights
  - Right to a secure livelihood

**Principles for the psychotherapist**

- Be a good listener
- Let PLWHA talk
- Explore PLWHA’s feelings further
- Wait for PLWHA to finish crying and offer some tissue
- Don’t try to solve their problems; instead, provide options
- Don’t decide for them but rather, help them to decide
- Dress appropriately
- Be warm, approachable and honest
- Don’t counsel beyond a 1.5 hour session to ensure concentration

A well-counselled and supported client is better prepared to face the world and is therefore in a better position to consider disclosure.

**The Challenges of HIV Positive Teachers**

- Loss of employment/livelihood;
- Early retirement;
- Rejection and/or isolation by parents, students and fellow teachers;
- Denial of promotion and transfers;
- Failure of Head Teachers to respect and honour requests for time off work, to attend clinics or rest;
- Refusal by Head Teachers to adjust workloads appropriately;
- Breach by superiors of confidentiality over privileged information on status;
- Knowledge that students remain unattended during HIV-positive teacher’s absence;
- Colleagues discussing PLWHA with students and parents;
- Negative, derisive messages through songs, graffiti, innuendo and the refusal for assignments to be marked by HIV/AIDS teachers;
- Students refusing to take instructions;
- Parents seeking children’s transfers away from HIV/AIDS teachers;
- Parents advocating the transfer of infected teachers;
- Parents’ failure to understand HIV-positive teachers’ absence from work;
- Media’s negative portrayal of teachers as among the most affected groups;
- Excessively high expectations of teachers by their communities, especially in rural areas, ignoring the teachers’ human limitations;
- Self-incrimination and denial;
Inability to access good nutrition;
Difficulty in managing treatment costs and failure to consider a waiver system for teachers;
Lack of appropriate education on HIV/AIDS, including information on positive living;
Lack of socio-cultural structures to support infected teachers;
Lack of effective education programmes in schools to build good teacher/pupil relationships;
Fear of death;
Depression and stress based on negative societal interactions;
Attention to making a will and other inheritance issues;
Loss of trust and reliability by society;
Lack of effective networking;
Distances to work stations and other destinations;
Coping with disabilities;
Inability or impediments to furthering careers;
Coping with average professional workload and long-term employment;

How to Address Our Challenges

Acceptance of HIV/AIDS status;
Empowering teachers to kill stigma;
Greater involvement of HIV/AIDS teachers (the GITA Principle);
Improving and exploring Information Education and Communication (IEC) potential;
Exposure to forums;
Establishment and membership of strong support groups;
Strengthening KENEPOTE at the grassroots level;
Ensuring safer sex at all times;
 Ensuring good nutrition;
Encouraging companionship and partnership;
Ensuring access to care, notably ARVs and treatment for OIs;
Networking within and outside own community;
Overcoming self-condemnation;
Disclosure of status;
Encouraging capacity building, such as through peer counselling;
Being positive role models in the community;
Ensuring good grooming and body hygiene; and
Availing adequate exercise, leisure and rest.

Session: Disclosure

This session was conducted by one of the participants who had publicly disclosed her HIV status. She said: “I disclosed my HIV status to prove to my community that there is need to do something about HIV and AIDS. My view is that going public is an important way to reduce stigma. The more we reveal our status, the more difficult it is for society to stick to its negative attitudes towards people living with HIV or AIDS.”

Among her most moving statements was this: “When you disclose and you go completely public, it becomes a fact and it kills the gossip including passed remarks from one person to another such as, ‘Have you heard?’”

Stop stigma

“When (the positive status) becomes a fact, the HIV carrier can concentrate on positive living rather than correcting the rumours and quarrelling with the gossipers who pass the word of ‘Have you heard?’”

Negative Consequences of Disclosure

It is the right of an individual to choose to declare their HIV status, or not to. There are potential negative consequences of disclosing one’s status, including divorce, desertion, isolation and loss of employment. This is why the discovery of infection with HIV presents the difficult decision on whether to disclose it or not. However, one must weigh the
disadvantage of disclosure against its benefits in making a decision.

**Benefits of disclosure**

- Disclosure enhances acceptance of status; reduces personal stigma and the stress of coping on their own. For a problem shared can be a problem halved.
- Disclosure makes it easier for one to seek treatment and care. Knowledge of someone’s HIV positive status elicits support from the community, for “He who conceals his illness cannot be treated or helped!”
- Disclosure can help other people protect themselves; for once an infected person is known, prospective partners will insist on protected sex. Disclosure encourages openness that helps women in negotiating safer sex.
- As more people disclose their HIV status, self-denial, stigma and discrimination are reduced.
- Disclosure promotes respectability.

However, these benefits are not realized overnight. Rather than being an event, disclosure is a process that requires patience if it is not to be traumatic. The benefits of disclosure also come gradually.

It is important that a client is counselled and supported to think through what they want to do about their HIV positive status. Planning for disclosure enables one to anticipate possible outcomes and to manage the potential negative impacts of disclosure. Planning should include, but not be limited to:

- Identifying sources of support after disclosure, such as PLWHA groups, which can reassure the HIV patient.
- Discussion of options regarding future sexual activity, including the need to protect partners from infection.
- Preparing the client for a shocked and even hostile reaction from family, place of work and the society. The reaction may include stigma and discrimination, but the client should be assured that people close to them will eventually accept their HIV status.
- The need to sequence disclosure: it might be easier to initially disclose status to those closest to them, which can be incorporated into planning.
- Help and support for the client to be strong enough to cope with others’ reaction to the disclosure.
- Provision of information on how the client can live positively with HIV and AIDS.

**Remember this about disclosure**

The decision to disclose one’s HIV status is very personal and should never be used as a yardstick by which to judge other HIV positive individuals who may not (yet) be ready to divulge their status. Care should be taken in disclosing HIV status through the media because the latter might have a very different objective of getting information on your status. For example, a media decision to use the disclosure as a headline could generate an interest that you might not be prepared to deal with.

**Possible Consequences of Non-disclosure**

Often, it seems that there is too much to lose in disclosing one’s HIV status. However, non-disclosure also has major consequences the client should also consider. The latter include:

- Ignorance of one’s status among others elicits no support from them, meaning the client has to deal with everything on their own.
- Placing others—especially spouses and partners— at risk of stigma and discrimination.
Session: Role of Support Groups in Positive Living

Definition of support groups

These are groups of people whose common interests – such as the HIV affliction – causes them to face similar challenges and to recognise the potential synergy that might exist among them. They develop rules and regulations which provide a framework that allows people of different characteristics to work harmoniously. The appreciation of individual differences transforms into the unity underlying a group’s success. Membership can be at various levels, viz. the village, zonal, district, provincial and national. The groups meet regularly, share experiences and help each other socially, spiritually, economically and emotionally.

Support Group Activities

Each member of the group must initially focus on what they can do for the group rather than what it can do for them. This ensures that each member gives something to the group and maximises the possibility of their also getting something from the group.

Spiritual support is an important activity in such groups. Members pray for one another, help each other adapt to their circumstances and offer each other love. This is especially important in dealing with stigma and discrimination from the self and others.

Group members help one another materially: for example, they give their monthly contributions to a single member. They also give money to members during emergencies, such as an illness or death. Other activities engaged in include sports and games. New members benefit from the support of experienced older group members.

Benefits of HIV/AIDS support groups

Support groups assist victims to exploit the potential of their members, with individuals being given responsibilities related to their abilities and interests. Other benefits are:

- Support groups can be a gateway to resources for economic improvement since potential benefactors recognise their organisation.
- Appreciation of what some group members have that other members might not have.
- Providing an opportunity to teach and to learn from one another since everyone is given freedom of speech.
- Forming lasting relationships, such as through the memory book writing project.

Identifying and defining specific limited priorities that can be achieved with scarce finances.

Group Solidarity

Each Support Group experiences dynamics that are either positive or negative. Among the positive ones are links within groups that lead to friendships. Conversely, favouritism could undermine solidarity, especially if the leadership are seen to practise it. Conflicts arise from causes such as gossip, leadership wrangles, differences in interest, broken confidences, selfishness and laziness.
**Overcoming Challenges to Solidarity**

Educating Support Group members on the dynamics of potential conflict diminishes their occurrence. Other means of diminishing conflict include team building exercises, continuous counselling of members, the conduct of esteem communication skills and regular exercise.

**Session: Spiritual Care and Support**

When people learn of their HIV positive status, they get confused and go through a long period of anger, fear, self-blame, denial etc. When they come to terms with their circumstances, they often re-examine their relationship with God, becoming closer to their religion and its leaders. People in trouble often seek spiritual care irrespective of their faiths, whether Christian, Buddhist, Muslims, etc.

While pastoral care has previously been limited to counselling by clergy in the church, this role has changed with time and needs. Today, Faith Based Organizations (FBOs) provide care in the areas of health and social interaction, alongside spiritual care and counselling. Most FBOs now focus their interventions in five areas:

- Physical
- Psychological
- Social Welfare
- Spiritual
- Health

They also provide guidance in the areas of marriage, material help and counselling and conduct home visits, making the church an umbrella that shelters its people all the time.

Traditionally, FBOs have not been sufficiently prepared to handle HIV/AIDS issues in a neutral manner. For example, the fact that HIV is contracted primarily through sex leads to stigmatisation of positive people and FBOs perceives them as victims, sinners and unclean. This attitude has created a barrier between the church and positive people, undermining FBOs’ effectiveness in meeting the needs of HIV/AIDS victims, including teachers.

Care and support involves a dialogue, where the care-giver provides an opportunity for the infected to express their feelings, raise issues and ask questions. Such dialogue is undermined by the biased approach taken by FBOs, whereby religious leaders make general statements filled with negative riddles and innuendo. This has been perceived by some infected and affected as an astigmatic breach of confidentiality. One area where the FBO’s have excelled is in providing health care through mission hospitals. However, much needs to be improved in their spiritual support and counselling roles. FBO capacity needs to be strengthened to fully understand HIV/AIDS and the associated issues and challenges in order to empower them to better address the spiritual support and counselling components of HIV and AIDS.

For example, while Jesus welcomed all, the church has been quite discriminative. Jesus had invited all to come to him unconditionally; for it is for their sins that he died. Yet, the pastors argue as follows:

“I urge the infected and affected persons to be proactive and state your needs to the religious leaders, and tell them what
you expect them to do for you to uplift your spirit. For example, if you want to marry, you should marry a positive person. In this case, you may want the religious leader to counsel both of you, marry you and bless you. Be responsible. But if you are positive and you want to marry a negative person, the Church will have a problem with this. Lack of common understanding between the FBOs and infected and affected about care is crucial but we have to address it.”

This reflects a church in denial; which is also the case with condom use. These matters need further discussion. What should a discordant couple do? What about re-infection among married couples? All these are areas where if the church does not approve condom use, at least it should not oppose it, but rather, live and let live.

The work of giving care and spiritual support involves much patient listening to the client. The role of the counsellor is to offer guidance and options and let the client make a decision on what to do. The counsellor should not impose religious values on an already low-spirited person.

People look to their religious leaders for guidance in spiritual living for the life hereafter. Consequently, the terminal reality of HIV pushes its victims close to their priests. FBOs must therefore prepare themselves adequately to address HIV/AIDS issues effectively.

For counselling within the church is different from professional counselling. How is the gap to be bridged?

FBOs also provide care and services in other areas, which require specialist capacity building, including:

- Counselling support groups for PLWHi
- Educating local communities about HIV/AIDS
- Peer education programs aimed at HIV prevention
- Income generating activities (IGA)
- Care and support programs for AIDS orphans
- VCT

Since FBOs have a countrywide presence, KENEPOTE should liaise with their networks – including pastors, teachers prayer groups and fellowship groups— to reach remotely located teachers and schools.

Session: Behaviour Change Communication

Behaviour Change

Behavior change is a term used in health communication to emphasise that people need to go beyond information or knowledge to changing their habits, such as by adopting practices like safe sex or no smoking, drinking or use of drugs. For the KENEPOTE workshop, behaviour change communication addressed the challenge of HIV and AIDS bearing in mind that while AIDS has no cure, HIV infection and its progression to AIDS can be prevented through behaviour change.

Model of the Stages of Behaviour Change

- Knowledge: - first step; involves understanding the issues and facts about HIV/AIDS.
- Acceptance: - second step; involves getting the client to discuss and understand the modes of transmission, prevention, care and support.
- Intention: - third stage; calls for resolutions on intended actions, such as intending to be faithful, to abstain or practice safe sex or to go for STD check ups.
- Practice: - fourth stage; being able to put the above intentions into practice.

The Pillars of Good Behaviour Change

- Message Source: - this has to be authentic.
- Message Design: - message has to appeal to personal risk and be emotional, realistic and dramatic. For example, marital separation
may not be realistic and alternative solutions must be sought from real life situations.

- **Message Delivery:** message has to be consistent and widely distributed (multiplicity of sources, through parents, schools, video vans, TV, printed material etc.)
- **Message Receivers:** message must be focused on and relevant for a particular audience. For example, the message for clients in the denial stage will be different from that for those who have gone public with their status. Whether a client is fatalistic about HIV infection, or is determined to prevent it, also matters. The client’s culture, knowledge level, attitude, beliefs and spiritual disposition are also significant.

**Principles of Behaviour Change Communication (BCC)**

These principles are sometimes called the 4Ks. They include:

- **Know** the subject;
- **Know** your audience: - are you addressing youth, children, church congregation or teachers?
- **Know** your limitations: challenges and opportunities; and
- **Know** the determinants of the behaviour of your audience.

**Skills and approach to BCC**

Start with the known and move to the unknown. Let your audience speak and verbalize their views and feelings until they reach reasonable conclusions.

**Behaviour Formulation**

The choice of words should be deliberate and specific. Let people know the benefits and costs of a particular behaviour. Thus, if you want encourage teachers to go for VCT, you might say:

“Go for VCT to enable you know your status and plan accordingly. If you test negative, take great care to maintain that status. But, testing positive is not the end of life and the world. Seek counselling on the steps towards Positive Living with the virus. Counselling will lead you to check ups and medical attention and to other PLWHA with whom you can share experiences. In all you do, remember to protect your loved ones.”

**Catch Phrases**

“True love waits!”

“Smart girls says’ NO!’”

**Do not stigmatise**

Do not stigmatize clients if you want to be effective in BCC work. Instead, be pro-active against the mind-set: for example, speak against the myth that ‘people who are infected are sinners’. Point out that fifty per cent of infected wives only have one sexual partner. Advocate love and support for infected people, for in reality, we are all either infected or affected. Overcome personal inhibitions, such as denial, stigma, ignorance and cultural inhibitions, and be a good role model instead.

**OBJECTIVE 5: Explore stigma and discrimination and determine how to reduce them in order to promote Positive Living**

**Session: Group Work**

The objective of this session was to draw on the participants’ personal knowledge of and experiences with HIV/AIDS: The session engaged them to:

- Define and discuss stigma and discrimination;
- Discuss stigma as it relates to teachers suffering from HIV and AIDS;
- Identify ways and means of breaking the vicious cycle of stigma;
- Draw plan of action for reducing stigma and discrimination using the power of PLWHA networks.

**The participants defined stigma as**

- A negative attitude towards the self or rejection by others;
- Looking down upon, demeaning, devaluing, segregating, isolating or negativity in reference to, an HIV positive status;
• A situation of lack of acceptance by self, family or society.

The Facilitators’ Definition of Stigma

“The process of devaluation of people living or associated with HIV/AIDS and the discrimination follows. Stigma and discrimination breach fundamental human rights. Denial is one of the outcomes of stigma. Stigma blocks access to treatment and reduces the quality of life and self-esteem, causes despair and depression, reduces planning for families and therefore leaves widows and orphans destitute. Society is more fearful of stigma than HIV/AIDS and opportunistic diseases associated with it. People can only admit they have HIV/AIDS when stigma is removed. Therefore we must kill the secrecy that fuels stigma by breaking the silence.”

Because of stigma, some women are chased away from the family/clan land and denied the right to own, inherit or enjoy family property. One of the factors fuelling stigma is the fact that HIV is contracted through sex. Discrimination follows stigma.

Definition of discrimination

The facilitators defined discrimination as “(the) unfair and unjust treatment of an individual on the basis of his or her perceived status.” Stigma and discrimination breach fundamental human rights. Like stigma, discrimination also threatens jobs and livelihoods, careers, confidentiality, self-esteem and leads to loss of benefits; rejection by society (other teachers and students) and sickness due to stress.

Facilitators described the power of networks as a strong
weapon for reducing stigma because of the following characteristics:

• Possess the power of a united voice that compels people to listen, e.g. TAC in South Africa;
• Face the common challenge of hosting HIV and living with stigma and discrimination daily; hence the urgent need to address the issues;
• Composed of prospective beneficiaries of stigma reduction who consequently have a passionate interest in such action. This facilitates consensus on key advocacy issues;
• Disclosure of HIV/AIDS status by members and their narration of personal experiences becoming a weapon against the stigma fuelled by secrecy.

**Conclusion on Stigma**

Teachers have always been well respected in society, being responsible for moulding the characters of children, educating them and graduating them into the world of work. For these reasons, teachers have been perceived as role models and counsellors. One of the groups wrote: “A teacher is a role model, leader, opinion leader, wise and knowledgeable”

HIV/AIDS in Kenya is spread largely through heterosexual sex. This underscores a widely held association between the disease and promiscuous sex, making its patients immoral, irresponsible, foolish and dishonest.

Such perceptions affect HIV-infected teachers negatively, causing them to feel depressed, stressed, lonely, rejected and unstable, unable to perform their duties effectively and efficiently. HIV positive teachers face stigma in their families and immediate social environs, such as their churches or mosques. “Stigma is killing teachers faster than HIV/AIDS,” one of teachers lamented. “When you sit and mourn alone, you feel lonely and lack direction.”

The participants decided that their project priorities would be the reduction of stigma and the strengthening of advocacy for rights of HIV-positive teachers. They also undertook to develop a one-year plan of action during the Workshop.

Group work generated varied suggestions on how to reduce stigma, the list below summarising ideas that were mentioned by all groups:

1. Accepting one’s HIV status and fighting personal stigma and self-condemnation.
2. Strengthening ties within families and establishing and patronising support groups, such as peer counselling groups and post-test clubs.
4. Educating the teachers and students on HIV/AIDS issues and providing relevant IEC materials to students, teachers, parents, school administrations and PTAs.
5. GIPA (getting HIV positive teachers represented in organs like TSC, KNUT and SACCOs).
6. Strengthening KENEPOTE at the grassroots level.
7. Strengthening the training of teachers in peer counselling and guidance.
8. Providing spiritual support; for , as one participant said: “God’s love is great!”
9. Capacity building for teachers to address HIV/AIDS issues and kill the stigma against it.
10. Promoting good nutrition and positive living.
11. Promoting behaviour change with HIV positive teachers displaying honesty, credibility and diligence.
12. Developing HIV networking and strengthening membership of organs like KENEPOTE.
13. Fighting stigma effectively beyond the education sector.
(It is important to note that POLICY project is starting with KENEPOTE members, but will eventually involve other network of HIV positive people)

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<tr>
<th>Topic</th>
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<th>Group III</th>
<th>Group IV</th>
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<tbody>
<tr>
<td>Stigma and Discrimination</td>
<td>An act of rejection or negative attitude towards self</td>
<td>Looking down upon, demeaning, devaluing, segregating, isolation, negativity in reference to HIV positive status</td>
<td>A situation of lack of acceptance by self, society, family, etc yet a teacher is a role model, leader, opinion leader, wise and knowledgeable</td>
<td>A social process that marginalizes and labels teachers due to their HIV/AIDS status</td>
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<tr>
<td>Stigma issues as relates to HIV/AIDS</td>
<td>Stigma leads to: • Loss of employment  • Loss of livelihood  • Rejection by parents, students, pupils  • Denial of promotion/transfer</td>
<td>• Head Teachers fail to respect and honour requests of positive teachers e.g. go to the clinic on clinic days, getting rest when feeling tired, reducing workload and breach the confidentiality by telling other teachers and students about positive teachers  • Gossip and talk openly about positive teachers, look down upon ideas given by positive teachers, isolate them, not willing to cooperate and share the workload  • Teachers discuss the teacher’s status with learners/students</td>
<td>• HIV positive teacher is perceived to be a failure, immoral, untrustworthy, irresponsible, infectious, foolish, dishonest and incompetent  • These perceptions affect the image of the teacher and makes the teacher emotionally unstable, depressed, stressed, moody, and lonely, have self pity and low self esteem, rejected, loss of friends and feels rejection.</td>
<td>Self stigma  Denial, condemnation, anger, shame, low bargaining, dismissal and defiance  Societal Stigma  Condemnation, big sinner, threat, a burden, shame, disgrace and gossip  Discrimination  By church, health services, institutions changing regulations by Head Teachers and leaders, social systems</td>
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<tr>
<td>Learners/students</td>
<td>• Pass negative messages through songs, writings on walls and classroom boards, make insinuations, refuse assignments to be marked by positive teachers (by not turning in their assignments), learners do not take instructions</td>
<td>• Parents Teachers Association  • Some insist on transfer of HIV positive teachers  • Personalise discipline issues on HIV status  • Parents discuss HIV positive teachers with students</td>
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| Parents Teachers Association | • Some insist on transfer of HIV positive teachers  • Personalise discipline issues on HIV status  • Parents discuss HIV positive teachers with students |  |  |  |
## Outcome of the Group Work

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<tr>
<td><strong>How to reduce stigma</strong></td>
<td>• Teacher to fight self stigma.</td>
<td>• Disclose status to Head Teachers</td>
<td>• Teachers to fight self stigma in order to gain confidence</td>
<td>• Accept HIV status</td>
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<td></td>
<td>• Acceptance of the situation as it is</td>
<td>• Create awareness among Head Teachers, other teachers, learners and the community</td>
<td>• Accept HIV status</td>
<td>• Empower teachers to kill stigma</td>
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<td></td>
<td>• Establish post test clubs</td>
<td>• Sensitise HIV positive teachers not to self stigmatise</td>
<td>• Stop self condemnation</td>
<td>• GIPA</td>
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<td></td>
<td>• Implement MOEST policy on AIDS</td>
<td>• Create fora in schools to discuss HIV and AIDS i.e. HIV clubs</td>
<td>• Develop family relationships</td>
<td>• Exposure to fora</td>
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<td></td>
<td>• Establish peer counselling groups</td>
<td>• School curriculum to be more comprehensive in order to adequately address HIV issues</td>
<td>• Positive teachers to disclose their status</td>
<td>• Join and establish strong support groups starting at the grassroots level</td>
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<td></td>
<td>• Greater involvement of HIV positive teachers in all fora representing them e.g. KNUT, SACCOS</td>
<td>• Make HIV/AIDS a subject of its own</td>
<td>• In-depth learning and education on HIV/AIDS by teachers</td>
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<td>• Spiritual support</td>
<td>• Train teachers to address HIV/AIDS issues and fight stigma</td>
<td>• Disclosure of positive status and face the consequences self preparation to deal with the bad news and live positively with HIV</td>
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<td>• Administration to discuss HIV/AIDS related issues with teachers privately and not make it a school issue during school open day</td>
<td>• Include stigma reduction in school guidance and counselling programs</td>
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<td></td>
<td></td>
<td>• GIPA</td>
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<td></td>
<td>• Recognise teachers fighting AIDS</td>
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<td>• Positive teachers to manage OVC programs in schools</td>
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<td><strong>How to promote positive living</strong></td>
<td>• Self status acceptance</td>
<td>• Build the capacity of teachers in peer counselling</td>
<td>• Disclosure of status</td>
<td>• Good nutrition (kitchen gardens)</td>
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<td></td>
<td>• Disclosure of status</td>
<td>• Empower teachers to believe in themselves and access a quality life</td>
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<td></td>
<td>• Empower teachers to believe in themselves and access a quality life</td>
<td>• Maintain self dignity and self acceptance</td>
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<td></td>
<td>• Be role models in the community</td>
<td>• Formation of task forces for teachers</td>
<td>• Encourage companionship and partnership</td>
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<td></td>
<td>• Eat quality diet</td>
<td>• Form support for positive teachers</td>
<td>• Access to care (ARVs, treatment of OI)</td>
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<td></td>
<td>• Good grooming and body hygiene</td>
<td>• Network with stakeholders</td>
<td>• Join support groups</td>
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<td></td>
<td>• Exercise and get leisure time and rest</td>
<td>• Stress free living</td>
<td>• Income generating activities for PLWHA</td>
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<td></td>
<td>• Learn about basic health tests and go for the tests</td>
<td>• Live each day at a time</td>
<td>• Networking within and outside</td>
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OBJECTIVE 6: Discuss existing MOEST HIV/AIDS policy and legal rights of positive teachers.

This objective was covered in three sessions, viz. legal issues on HIV/AIDS, MOEST education policies and TSC sub-sector policies.

Session: Legal Issues on HIV AIDS

Legal and ethical issues relating to HIV/AIDS are brought about by man's reaction to the epidemic termed the third epidemic.

Examples to of man's reaction to the epidemic include:
- Fear of association with infected persons leading to their isolation and stigmatization, and discrimination against them
- Breaches of confidentiality in medical employment and medical practice
- Unethical and unauthorized research on human subjects
- Illegal and mandatory testing for HIV
- Abuse of human rights such as confinement of infected persons

The legal and ethical issues are centered around the following question:
- Should HIV testing be mandatory or voluntary?
- Should the entire population be tested?
- Should people be tested for entry into educational institutions?

The Legal Position on Testing

Kenyan law prohibits all forms of non-consensual testing except for the military and sentinel surveillance purposes. Testing should only be done with prior informed consent of the individual.

Confidentiality

Confidentiality as a general rule should be maintained by health care providers. It may be waived by the consent of the infected person or by court proceedings.

The HIV and AIDS Prevention and Control Bill 2003—currently awaiting parliamentary debate—seeks to introduce exemption from breach of confidentiality where, after counseling and the lapse of reasonable time, an infected person fails to disclose his or her HIV status to persons at risk of infection.

Human Rights Aspects

Human rights principles relevant to HIV/AIDS include, amongst others:
- The right to non-discrimination, equal protection and equality before the law.
- The right to life.
- The right to the highest attainable standard of physical and mental health.
- The right to liberty and security of the person.
- The right to freedom of movement.
- The right to privacy.
- Freedom of opinion and expression, and the right to freely receive and impart information.
- The right to freedom of association.
- The right to work.
- The right to marry and have a family.
- The right to an adequate standard of living.
- The right to share in scientific advancement and its benefits.
- The right to participate in public and cultural life.
- The right to be free from torture and cruel, inhuman or degrading treatment or punishment.

These rights are derived from the Universal Declaration of Human Rights and in the Kenyan constitution where rights are spelled out, but their enjoyment is made subject to others, to the public interest, morality, public order and the general welfare of a democratic society. Like all rights, there are no rights without responsibility.

Family Issues

However, these rights have gray areas which lead to infringement on rights of others. For example: The issues of polygamy; early marriage where protection of
the girl child is lacking. In some cultures in Kenya, a young girl is sent to her brother-in-law’s to take care of her deceased sisters’ children. If the sister died of HIV/AIDS the young sister may be infected with HIV. Other gray areas include widow inheritance, marriage, divorce and separation, marital rape, legal protection of women and children.

These gray areas may be addressed within the relevant statuses yet the law may not provide answers for all.

**HIV/AIDS and Criminal Justice**

The Kenyan penal code does not provide for any criminal sanctions with respect to HIV. For example, one cannot be criminalized for deliberately infecting another. Kenya cannot deport foreign nationals because they are positive. Further, no sick HIV patient can be subjected to euthanasia.

The HIV and AIDS Prevention and control bill, 2003 seeks to criminalise knowingly or carelessly placing another person at risk of infection by failing to disclose one’s HIV status to his sexual or other contacts. Abortion, euthanasia and commercial sex work remain unlawful in Kenya.

Kenya has amended the Public Health Act (Cap 242) to make AIDS a nonviable disease.

Kenya has development guidelines on the following areas:

- HIV/AIDS testing
- Blood Donor Service
- Nursing
- Counseling
- Community/Home Based Care
- Parliament has adopted The policy paper on HIV/ AIDS- Sessional Paper No 4. of 1997 and report of The Task Force on Laws relating to HIV and AIDS. These are in addition to the HIV and AIDS Prevention and Control Bill, 2003 currently awaiting Parliamentary debate.

**Conclusion**

Criminal sanctions and breaches of confidentiality drive infected persons underground.

**Session: MOEST Education Policy**

The Education Sector Policy on HIV and AIDS formalizes the rights and responsibilities of every person involved directly or indirectly in the sector about HIV/AIDS. Annex A of Education Sector Policy identifies the elements to be included in the fight against AIDS as:

- Early childhood care and education
- Primary education
- Special needs education
- Secondary education
- Teacher’s vocational education and training
- Adult and continuing education

Focus will also reach semi-autonomous government agencies and all other stakeholders in the provision of education, such as TSC. The education sector policy which is under implementation, was distributed to KENEPOTE workshop participants to take back to their schools and communities and for their personal use. Teacher-training colleges have mainstreamed HIV/AIDS education in schools in their curricula. They address behaviour change, culture and prevention. Universities have courses on guidance and counselling while the Kenya Institute of Education has prepared HIV/AIDS curricula for schools and colleges.

To interpret and implement the HIV/AIDS policy, MOEST needs partners to develop action plans and to reach into schools and work with intended beneficiaries. MOEST is already working with TSC as a sub-contractor, but needs further partnerships for the programme.

**Session: TSC Sub-Sector Draft Policy**

TSC/ACU was established in 2000 and upgraded by National AIDS Control Council (NACC) to a fully-fledged AIDS control unit in April 2004. The unit was formed to address the prevention and impact of HIV/AIDS pandemic in the education sector. HIV and AIDS have
continued to negatively affect the health and performance of teachers, raising concern for TSC as the employing agency. The focus of ACU is to protect the uninfected teachers and support the infected, its draft sub-policy being based on the MOEST’s policy. The policy is therefore a workplace policy.

The policy sets out the rights and responsibilities of employers and employees. It provides a framework for collective action and deals with: -

- Stigma and discrimination
- Human rights
- Job security
- Prevention
- Confidentiality
- Employee benefits
- Recruitment Procedure
- Performance management
- Discipline and dismissal etc.

The draft policy stipulates that there will be no HIV/AIDS testing as a requirement for employment or continual service. It also assures teachers that they will be protected against discrimination as well as stigmatisation, assuring infected teachers of the same rights and obligations as their uninfected colleagues. Teachers’ development, promotion and career progression will be based on merit, irrespective of HIV/AIDS status. Infected teachers are entitled to the same benefits enjoyed by non-infected employees. TSC will reimburse the cost of in-patient medical treatment for all teachers irrespective of the nature of illness.

However, greater challenges surround the issues that are not yet fully resolved socially (such as persisting discrimination and stigmatisation despite extensive HIV/AIDS knowledge) or understood scientifically (such as the existence of discordant couples). Before existing policies can take root, attitudes that perpetuate stigma and discrimination have to be eradicated.

The effectiveness of (draft) policies will be measured by their applicability in addressing the needs of HIV positive teachers and other members of the population.

Session: Testimonies of Teachers

The KENEPOTE workshop listened to many powerful testimonies from HIV-positive teachers, which will forever change strategies for addressing HIV and AIDS in the profession. We publish three here with prior consent. The testimonies highlight the very wide gap between the frameworks (policies and draft sub policies) and the real life situations of teachers, their communities and families. The great challenge will be to take the policies to intended beneficiaries, harmonising them with deeply rooted traditional beliefs and customs, such as the
dictates of witchcraft, or inequality between the sexes.

1. Testimony by J. Muthuri Raiji

My experience as a person living with HIV in a discordant partnership

I have been married for seven years and my wife and I are blessed with two lovely children, a girl aged six and a son who is only four months old. Early 2004, when my wife was expecting our son, we decided that it was good to take a VCT test.

Though it was my wife who suggested that we go for the test, she declined at the very last moment due to fear. As a household head, I had the test alone to encourage her to take her test. I was sure that my test was going to be negative because I have been a faithful husband. “Faithful husbands like me do not get the virus,” I said to myself. My wife had refused to stay as I was undergoing the test despite the fact that she impressed upon me the importance of the test in view of her pregnancy. Unexpectedly I got a rude shock when I was told I tested HIV positive.

Eventually I confessed to her that I was HIV positive. We cried together because we concluded that we were both positive since I was positive. With our little knowledge on HIV and AIDS, we believed that our unborn baby would also be positive.

My wife is a woman of untold courage; I also say thanks to God for giving me a woman with unselfish and unconditional love for me. When I told her I was HIV positive, she decided to go for VCT. She tested negative. Our child was also born negative. After two more tests in different places, we are now convinced that we are a discordant couple.

Friends we are lucky and God has been gracious to us and we thank the Almighty for that, but we can never be truly comfortable. Things have changed between us. It is a pity that very little is known about this discordant status. For a couple that truly love each other, exposing the other to the risk of contracting HIV is psychologically unacceptable. Considering the fact that lovemaking in a young marriage such as ours is probably a must, the truth must be faced “with a condom”. Yet, we know that a condom, however skilfully used, cannot be 100% safe. Does the couple really enjoy sex? When both partners are HIV positive they may enjoy it more than the discordant couple. Sexual interaction is all a matter of the mind. The mind must be free from all inhibitions for it to be enjoyed to its fullness. Many times, the condom is put on in a hurry because of excitement. You snigger and call that carelessness? You think the couple is playing with “death” because of the strains of the virus? Maybe you are right: but how many times has a sexually active person taken dangerous and risky adventure all because of love?

Many questions remain unanswered; how is this challenge of discordance being looked into? Isn’t there somebody out there who is trying to do something more than the much hyped about counselling? Maybe a kind of “drug or medication” to kill the virus during lovemaking?

The issue of condom use is not enough. How many times has it burst out on me? How many times have I had to fish the condom from in there? It slips off especially if you get distracted. The mind keeps playing tricks on you. Suppose the condom bursts? Suppose it slips off? In 1992, in a seminar that had nothing to do with HIV/AIDS, a Dr. Riara told us that the size of the virus is so small that some can wriggle through the holes of the condom. By that time, I was
negative and I paid little attention to what was being said by the gynaecologist. Now what he said many years ago ring in my ears all the time and I believe him. And now I am being told to use the same condom on somebody I love. How comfortable can that get? How satisfying can the lovemaking be? How long would such a marriage last? How? How? How?

At night, I find my wife crying because of me, praying for my life to be prolonged? How many times has my child asked me, “Dad is it true that you are going to die?” Why? Because my wife is always praying loudly so that God may keep me longer. My son asks me, “Will you be able to take me and Junior to school?” “Will you continue buying us things you buy for us now?” It is painful.

More counselling? Yes; and again, Yes! But please pay more attention to this status of discordant couples if you can, so that my wife and children can sleep at night.

2: Testimony by Annette Musumba

I am Anne Musumba, a teacher by profession, positively living with HIV. My late husband tested positive to HIV in 1994. Presumably, we got the virus even earlier.

I gave birth in 1995 to a bouncing baby girl who turned out to be HIV positive in 1997. This implied to me that I had passed the virus to an angel. What a trauma! My husband and daughter kept falling sick and getting treatment. Eventually, both of them died.

My late husband resigned from his pace of work due to stigma. He had herpes zoster on his neck and face, so he could not hide the symptoms which were very obvious. He absolutely used all his funds on drugs and treatment, which made him and me poor. He died in 2002. I overheard that my colleagues had been rumouring that I was positive and so was my daughter. I had not opened up to say it out. It was in fear, self-denial and lonely though, I pretended to move on. In 2003, my beautiful daughter left me. I was so stressed, touched and have never got over it. I needed a shoulder to lean on; it was too much for me.

This made me open up to my brothers, sisters-in-law and parents. They accepted me and began giving support, especially my father and brothers Pat and Richard. I went for HIV testing and was found to be HIV positive. I was not surprised. I went ahead and informed my Head Teacher and his Deputy about my HIV status. Somehow, all teachers were already aware. One of the teachers told his daughter about my status. The daughter is a pupil in the school where I teach. She in turn told the other pupils that I had AIDS. Kids came asking me, “Teacher so and so is saying that you have AIDS: is it true?” Some even wrote down on the boards and wall that they did not want me as their teacher because I was sick.

At this point, I had no option but to declare my status to other teachers to reduce gossip, questions and pressure. The stress made me weaker and weaker. For some teachers, I was a teaching aid on HIV/AIDS classes. I was so thin that none of my clothes could fit me. But I still had hope and I was determined to live.

I joined the comprehensive care AIDS unit in Mombasa where I met a wonderful counsellor, James Mito. He told me, “Look at me, Mimi ni mkongwe wa Ukimwi, (I have grown old with HIV/AIDS) so why worry. Live positively and worry less about what your pupils and colleagues think and say about you.” I tested my CD4 count and was put on ARVs in July 2004. I am now doing so well and I thank my Lord for being so faithful. I joined a support group known as COPE, which is community based and established under the department of social services. It comprises of all coast people living with HIV and AIDS, regardless of their status. We visit each other and make weekly contributions in order to save and acquire soft loans to boost our health. I love it. It has made me so encouraged to talk about my status. I do not mind what others say. I get support from my school and family.

I stay with my younger sister Angeline who so loving and my
late sister’s daughter Julie. HIV is just a condition, which is manageable. I lost many friends, but now I have got many others, especially in KENEPOTE. I am now ready for full disclosure.

3. The Price of Ignorance, by anonymous participant

I was born and brought up in a Catholic family. Being the first born, I lived up to my parent’s expectation. After college, I taught for three years before I got married. In my community, marriage is not so much celebrated. However, the births of children are celebrated! In 1993 when I was 26 years old a suitor came my way and he being a born again Christian, married me in May.

In April 1994, I was heavy with baby. A week to my EDD, I noticed a painful pimple on the left side of my bosom. I applied Vicks to the site and to my dismay the pimples multiplied! The pain affected my left hip, thigh and leg. I could not walk. I was limping as I went to consult my gynaecologists. On showing him the blisters, he dismissed it as a simple viral infection. He gave me some drugs which did not ease the pain.

The following day I decided to go to the nearest mission hospital. The pain was so severe and being a primigravida, thought I was in labour. The nurse on duty asked me why I was limping. I told her that I thought baby’s weight had affected my balancing. When she examined me, she was so shocked because of the blisters that she called the doctor. He was an American. On examining me, he told me that back in his country that condition is called “herpes zoster”. To me that sounded Greek and meaningless!

There was no treatment for the “herpes zoster”. They put for me G.V and I stayed in hospital four days before I delivered a bouncing baby boy of 3.7kg. I was discharged from hospital. The blisters burst and dried up leaving a painful skin on touching. The joy of baby stole my attention from finding out more knowledge about “herpes zoster”.

After four months, the baby developed diarrhoea and a cough. I took him to best paediatrician, but every time his condition kept deteriorating. He finally died in 1995 when he was 9 months old. My parents and parents-in-law blamed me for having caused baby’s death by not heeding their advice to take baby to witchdoctor. To them, the baby died because of witchcraft.

In 1995, I conceived and I was constantly sick. I was always hospitalized at the district hospital and treated for malaria.

In 1996, I got a baby boy of 3.6kg who was born yellow. I was discharged from hospital and the doctor advised me to go and give baby glucose solution and also expose him to sunlight. I did that and after one week his skin colour was light. My mother and mother-in-law are light skinned, so I assumed baby had taken after them. Baby’s father developed herpes zoster around his mouth. One day baby developed fever and in the evening he collapsed and died when he was one month old. In the morning, I noticed that his skin colour had gone back to yellow! It then dawned on me that colour was actually jaundice.

My parents wanted me to leave this man as his community is not normally in good terms with my community. I was in a fix, because I am a born again Christian.

My parent’s in-law on the other hand told their son to leave me because seemingly, there was a curse in my life that was causing the children’s death.

As these accusations were levelled against me, I had conceived the third child. In 1997, I got a baby 3.6kg. I had been attending clinics at Aga Khan hospital. I continued taking baby there to insure that he lives. I took a loan from our Sacco society to make sure baby lives. All the same at four months he started coughing and diarrhoea. I strongly believed in miracle healing; so I took baby to every crusade where the advert read- “the sick shall receive healing” etc. I was also advised to give to baby nutritional products from “Swissgarde” to help in his growth. It was quite expensive, but I wanted baby to live at
all costs. However, all these were in vain! Baby's health kept deteriorating until he was diagnosed with T.B.

In September 1998, I was so much stressed by my relatives beyond explanation. I decided to ask my husband if we could address this mystery in our marriage scientifically. I was for the opinion we go test for HIV. He was so mad and declared the end of our relationship.

Everybody, including my own mother was against me. The last person I expected to turn hostile to me was my husband! We therefore parted ways.

In 1999 March, baby died. In my community children belong to their fathers. Therefore I summoned his father and we took baby for burial in his home. His brothers, sisters and neighbours heckled abuses at me. They called me a killer who caused them losses! On the burial day, my father-in-law made a speech where he said; “this girl is cursed”. I felt like hell would have been more comfortable than where I was seated! I needed someone to console me, but nobody stood by me.

I could not continue teaching in my station. 1999 September, I went to TSC and talked to Mrs. Rotich (staffing officer then) about what had happened. To my surprise and joy, she accepted to transfer me.

I went to the new station and started life afresh. Thereafter I would fall sick so often. I had constant cough and diarrhoea. During exam time, I would fall sick because of stress. Somehow, I managed to perform my duties.

In 2002, mid August, after marking the district mock exams I fell sick. I was treated for malaria and fever. After a week, I developed sores in the mouth. For about a week I could not eat or swallow anything. I became so weak and the fever intensified.

During the first week of September, on Friday I started vomiting and had pain on the right side of my chest. I went to the hospital and they diagnosed pneumonia. The hospital staff refused to admit me claiming I was as good as dead! They were tired of my many visits to the hospital.

My school was in a complex where there was a convent, the church, the priest’s house, hospital, girls’ high school, three primary schools and a technical institute. I was staying within this area. On this particular Friday, one nun who had known me saw me being wheeled to the hospital. So in the evening she decided to visit me in the house. The hospital staff told her that they had purposely refused to admit me. Instead, they had just given me drugs and send me back to the house.

On Saturday, my nun-friend told her friend, the Principal of the Girls’ high school about my case. The two then decide to visit me in the house. My nun-friend on seeing me became emotional! The Principal Sister/H/M took up the role of inquiring about how long I had been sick etc. She then asked me if I could take herbs to stop the vomiting. Her suggestion was welcome. The herbs were delivered on Sunday. On taking the first dose, the vomiting stopped instantly! I became fine.

I even managed to go for KCSE supervision. At the end of the exams, I came back to school but I had become anaemic so I collapsed in school.

My Principal Sister/H/M and best friend ever came to my aide. She gave all that she could in the form of iron supplements. She was so dear to me.

In my school, my H/M was extremely supportive. All my staff mates were so supportive. But my Principal Sister/H/M friend made all members of the staff to be my friends including the subordinate staff! You would not tell which staff I belonged to since the schools are neighbours.

Somehow, I improved. Then one evening in November 2003, my Principal Sister H/M friend came to my house. She talked to me about testing for HIV. I was so scared but since She was my BEST, I did not want to disappoint her, I accepted.

She talked to me concerning the doctor I was to visit. Sister
told me that the doctor is an American Professor. She advised me that when I reach him I should not mince words and beat about the bush but I was to let him know that I had been sick, treated but failed to respond to treatment and therefore needed the test.

The following day a Tuesday, my Principal Sister H/M friend sent her school driver with the school van and their matron and a mattress so that I could be taken to be tested.

I did not go through VCT. I was so courageous and just waited for my turn at the health centre. When it came I explained my case and requested for the test. The doctor was perplexed and said: “Well, since she has requested we have no objection”. My results for the test were undetectable. Since I looked sick, the doctor started me on septrin, vitamin tablets and ionized tablets to prevent TB. I was also advised on good nutrition. From then, I was given routine clinic of two weeks. I attended without failure.

In 2003 May, I was tested again and my CD4 cell count was 67. The doctor then started me on Anti-Retroviral drugs at a fee of KShs. 2800. The treatment was quite expensive. I managed to go through that session with so many side effects.

From the time I went for testing, I discarded all those archaic beliefs of witchcraft and curses!

I had neighbour who could not even greet me. Her children used to sing to songs to the fact that AIDS Kills. She is a primary school teacher; a widow whose husband died of yellow fever, she really stigmatized me.

I could not cope with such an environment. I applied for transfer but TSC was adamant. During the matatu strike I got stranded and went to Margaret Wambete’s house. We shared and I joined the Yes plus Support group where she is the chairperson. Then she advised me to go to the TSC Aids Control Unit and talk to Sarah Irungu about my case.

Sarah Irungu showed great concern and ensured that I was transferred. I thank the TCS for that A.C.U. because we can now tell them what infected teachers go through.

Much later Margaret Wambete asked me if we could start a society for positive teachers. I was happy about her suggestion but feared active participation in-case people came to know of my status.

I came to seminar half-heartedly but when I was asked to share, I accepted. At the end, many participants told me that my testimony had healed them. Am now free even to tell others who are going through mysterious sickness to go test for HIV/Aids so that they are set free. I have managed to take three friends for testing and they got ARVs. They are living positively. They are two ladies and one gentleman. One is a secretary, the other is high school teacher and the man is a farmer.

In the seminar we were told to go to the VCT, I am planning to go so that I am complete with counsel. My best book is the Bible. I like the Psalms. I read 108: 17, 91 and 142 daily.

She concluded her testimony by saying “KNOWLEDGE IS POWER”!

Lessons learned from the testimonies

- Knowledge is power
- It is important to promptly adjust to the adversity of HIV/AIDS and push on.
- Early disclosure of HIV-positive status pre-empts unnecessary gossip.
- More sensitisation on facts about HIV/AIDS are needed to allow it to be treated like any other clinical disease.
- Living as a discordant couple is stressful for both parties. Besides other obstacles, lovemaking is often inhibited by the fear of the possibility of infecting the other since condoms do not provide 100% protection.
- More research is needed to improve information on discordant couples, a situation perpetually underlain by the threat of separation arising from, amongst other things, the failure to enjoy uninhibited sex.
Good counselling provides hope and enhances the scope for positive living. Support groups are also helpful fora through which to share experiences and companionship and to promote group therapy and income generating activities (IGA), with stress reducing possibilities.

**OBJECTIVE 7: Develop a one-year action plan for the Network**

**Session:**

**Development of One-Year Plan of Action**

**Plenary Discussions and Group Work**

**Step 1**
The course co-ordinators from POLICY Project and KENEPOTE led participants in officially identifying thematic areas and cross cutting issues for action as follows: -

**Thematic Areas**
1. Capacity building
2. Prevention
3. Stigma and discrimination
4. Psychological and social support
5. Care and treatment
6. Strengthening and expanding KENEPOTE
7. OVC
8. IGA and nutrition.

**Cross Cutting Issues**
1. Discordant couples
2. Gender
3. BCC and IEC
4. Education

**Step 2**
The course co-ordinator defined
- Vision
- Mission
- Objectives
- Activities and indicators

**Step 3**
Participants were divided into 4 groups, which were assigned the task of reviewing KENEPOTE’s Vision, Mission and Strategic Objectives and reporting to the plenary.

**Step 4**
Each group’s presentation was critiqued by the plenary.

**Step 5**
Consensus was build on the Vision, Mission and Strategic Objectives, after which they were adopted.

**Step 6**
The participants were divided into groups, each of which was asked to evaluate the KENEPOTE objectives in light of its revised Vision, Mission and Strategic Objectives and to report to the plenary.

**Step 7**
During plenary, the participants reviewed inputs into KENEPOTE’s Objectives.

**Step 8**
The plenary repeated the consensus building exercise after which it adopted the Objectives.

**Step 9**
The participants were requested to prioritise the Objectives and pick one to three objectives they would like to address in Year One. The following objectives were identified:

1. Reduce stigma and discrimination among HIV-positive teachers.
3. Strengthen the capacity of KENEPOTE to manage and implement the program and all its resources, including financial affairs.

**Step 10**
The participants adopted the three (3) objectives to be addressed in Year One.

**Step 11**
The participants were divided into eight (8) groups, with each group consisting of participants from the same province. Each group was assigned the task of developing a log frame of activities, specifying resources required, persons responsible for implementing, implementation timeframes, budget estimates and monitorable indicators of performance. The Vision, Mission Strategic Objectives and the provincial one-year action plans are attached as the workshop deliverable.

**Conclusion and Recommendations**
- Donors should support KENEPOTE to implement the Action Plan developed in Nakuru and the rest of its objectives.
- Policy Project and other organisations should provide technical support to KENEPOTE in capacity building, refining its Strategic Plan, fundraising, management and monitoring and evaluation. KENEPOTE should also be assisted in developing strategic alliances and partnerships with MOEST, TSC and KNUT especially for disseminating policy and monitoring its application. It should also be assisted in developing a data based of prospective and actual membership.
- USAID should include KENEPOTE in the list of its 2005 partners, considering that six (6) of its Objectives coincide with USAID’s own strategic objectives.
Annex 1

Summary of KENEPOTE Action Plan for 2005

This section outlines KENEPOTE’s plan of action for Year 1, which is based on its Vision, Mission and Strategic Objectives developed during its Nakuru workshop of December 2005. The plan relates to the thematic areas that emerged during the Workshop.

KENEPOTE Vision

An environment where teachers with HIV/AIDS are free from fear, shame, denial, stigma and discrimination and avoid further spread of HIV/AIDS, benefitting from access to information, education, care, treatment and support for its members and OVCs. The dignity and professionalism of teachers would not be compromised regardless of their status, allowing them continue to serve as productive agents of change in their communities and beyond.

KENEPOTE Mission

KENEPOTE is a network that builds the capacity of its members in advocacy for the reduction of stigma and discrimination, protection of rights of HIV positive teachers and OVCs, increased access to psychosocial support services and skills to teachers to prevent further spread of HIV/AIDS. KENEPOTE collaborates with stakeholders and FBOs, CBOs, and public, and private and civil society organizations to bring positive change in the attitudes and behaviour of the community towards HIV/AIDS.

Purpose of the Program

The overall aim of the action plan is to strengthen the capacity of KENEPOTE officials and HIV-positive teachers, especially within KENEPOTE, to advocate for the reduction of stigma and discrimination and protection of the rights of HIV-positive teachers, as well as for care and treatment. As part of capacity building, the program will offer training-of-trainers opportunities for teachers in all the eight provinces who will train staff and volunteers from FBOs, CBOs and NGOs to develop programs that can effectively reduce stigma and advocate for protection of rights of positive teachers. KENEPOTE members have committed themselves to protecting their loved ones and to serving as role models in preventing the spread of HIV/AIDS. KENEPOTE will recruit as many HIV-positive teachers as possible to work towards its objectives, serving as a capacity building organ within communities. It will advise its members and other teachers requiring services in VCT, counselling, care and treatment for HIV and OIs. KENEPOTE will also train its members to provide home-based care, and social and spiritual support to HIV-positive teachers.

Objectives

The objectives identified during the Workshop are listed later in this annex and in Annex 3. However, KENEPOTE is prioritising three objectives for 2005 because the network is still relatively young and needs to build its capacity before taking on a larger program. The prioritised objectives are:

1. Reduce stigma and discrimination against teachers living with HIV/AIDS (TLWHA) and orphans in and out of schools.
2. Intensify advocacy and lobbying for protection of rights of TLWHAs and their access to treatment, care and support
3. Strengthen the capacity of KENEPOTE officials and members to ensure implementation of program activities and efficient and effective management of the program.

**Strategic Results**

Reduced vulnerability of TLWHAs in an environment that pays special attention to:
- Their ability to claim and exercise their rights.
- Support to KENEPOTE to meet the needs of HIV-positive teachers including building the capacity of teachers to be agents of change in the context of the AIDS pandemic.
- Protection of HIV-positive teachers from abuse, isolation, shame and discrimination
- Prevention of the spread of HIV/AIDS or re-infection in all learning institutions.
- Encouraging HIV-infected teachers and students to overcome self stigma and disclose their HIV-status to their families and the public, leading to improved support and access to treatment and care.

**Outcome Results and Activities**

*Outcome 1:* Ministry of Education Science and Technology (MOEST), Teachers Service Commission (TSC), Kenya National Union of Teachers (NUT) and Head Teachers provide greater protection to HIV-positive teachers, students and orphans against abuse, stigma and discrimination by establishing and/or strengthening institutional frameworks that facilitate such endeavours.

**Activities of Outcome 1**
- Implement MOEST HIV policy.
- Establish HIV/AIDS disciplinary committees in schools, colleges and universities to monitor abusive and discriminatory behaviour towards HIV-positive teachers and students.
- Develop and document disciplinary measures to be taken against teachers and students who violate the rights of HIV-positive teachers and students.
- Convene regular meetings in schools, colleges and universities that bring stakeholders together, including disciplinary committee members to monitor rights abuses and discriminatory practices.
- Regular KENEPOTE visits to TSC, KNUT, MOEST, and learning institutions to sensitize teachers and students about rights issues.
- Organize advocacy meetings and seminars on stigma and discrimination.

*Outcome 2:* Teachers and students are aware, empowered and have capacity to respond positively to HIV/AIDS in schools and institutions

**Activities of Outcome 2**
- Train KENEPOTE members and other teachers as HIV/AIDS peer educators, peer counsellors and trainers of trainers.
- Establish support groups for TLWHAs.
- Use the media to create awareness on HIV/AIDS issues, such as through radio programmes.
- Ensure that HIV-positive teachers are incorporated in all HIV/AIDS committees of MOEST, KNUT, SACCOs, TSC, and Head Teachers associations, so that their voices can be heard.
Outcome 3: Teachers and students have access to and use appropriate information and services for HIV/AIDS prevention

Activities of Outcome 3
• Establish HIV/AIDS information centres in schools.
• Use radio to disseminate information and messages.
• Translate existing HIV/AIDS materials into local languages and distribute them in schools.
• Visits to learning institutions to talk to staff about HIV prevention and prevention of re-infection and the consequences and impacts of infection.
• Initiate HIV/AIDS education and counselling in all learning institutions.
• Form educational groups in learning institutions and train them on HIV/AIDS issues using drama, poetry, music and puppetry.

Output Results and Activities

Output Result 1: Capacity of KENEPOTE is increased to manage and implement the program

Activities
• Develop strategic plan for KENEPOTE
• Establish strong representation of KENEPOTE in every province, ensuring it has adequate equipment. There should be at least a programme coordinator and a finance and administration officer to manage programme activities, including donor funds.
• Recruit new members to KENEPOTE.
• Train KENEPOTE staff and members on management of HIV/AIDS programs, and on basic facts and figures on modes of transmission, prevention and treatment. Provide them with communication, advocacy and monitoring and evaluation skills.
• Train KENEPOTE members on TOT for all the program contents, such as HIV/AIDS, Advocacy, Social Mobilization.
• Develop a data base on teachers with HIV/AIDS.
• Expose KENEPOTE members through workshops, seminars and conferences
• Sponsor KENEPOTE members for exchange programs, study tours and international conferences to get exposure.

Output Result 2: Capacity increased of HIV-positive teachers to conduct community and social mobilization, provide spiritual support and advocate for protection of their rights

Activities
• Convene workshops through provincial head teachers associations to inform them about KENEPOTE, sensitize them on HIV/AIDS issues and give them orientation on social mobilization.
• Identify Head Teachers who are cooperative and work with them to draw a plan for social mobilization of HIV-positive teachers in their schools.
• Train at least 30 HIV-positive teachers per province on social and community mobilization skills, basic facts on HIV/AIDS, and issues of rights, stigma and discrimination. Provide them with skills to develop advocacy plans for the issues on hand and how to communicate them.
• Provide the trained teachers with social mobilization and advocacy materials such as videos, books, posters and banners.
• Coach teachers on public speaking and preparation of motivational talks.
• Sponsor KENEPOTE members for spiritual care and counselling training.
**Output Result 3: Change in attitudes and practices of Head Teachers, Parents Teachers Associations (PTAs) and students that lead to stigma, discrimination and abuse of rights**

**Activities**
Sensitise teachers on HIV issues and solicit their participation through social mobilization activities such as football, cycling, and tug of war with HIV-positive teachers matche against the rest to re-emphasise their equality.
- Football matches to kick out stigma and discrimination from institutions of learning;
- Cycling to chase away the virus;
- Tug of war to demonstrate the power of HIV-positive teachers and to emphasise that HIV is not AIDS.
- Radio messages to announce results of the matches alongside spot announcements with key HIV messages on prevention, stigma and discrimination.

**Output Result 4: KENEPOTE Officials and members empowered**

**Activities**
- KENEPOTE represented in all major HIV/AIDS committees and boards under MOEST, KNUT, TSC and SACCOs AIDS Constituency Committees to represent the views of all HIV-positive teachers in Kenya.
- Mobilize members of parliament to participate in advocacy programmes for PLWHA.
- Develop mutual support groups for HIV-positive teachers, and challenge them to have income generating activities.

**Output Result 5: Teachers have increased access to spiritual care, psychological care, home based care and anti-retrovirals to prolong life and continue to pursue KENEPOTE objectives**

**Activities**
- Provide KENEPOTE members with a list of facilities nearest to them where they can obtain ARVs.
- Train KENEPOTE members as counsellors and home based care providers and give them home-based care kits.
- KENEPOTE members conduct home visits to give human face to the pandemic and share experiences to lift the spirit and encourage disclosure of status.
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<th>Objectives</th>
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<th>Indicators</th>
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<tr>
<td>1. Reduce stigma &amp; discrimination against teachers living with HIV/AIDS (TLWHA).</td>
<td>• Mobilize teachers to go for VCT; • Counsel those who test HIV-positive to accept their new status; • Encourage them to join existing support groups; • Where there are no support groups, encourage them to form support groups; • Refer HIV-positive teachers to KENEPOTE members for supportive counselling, spiritual support &amp; encouragement for disclosure; • Organise football matches to kick out stigma; • Organise cycling competitions to chase away the virus from learning institutions; • Organise tug of war contests to show how strong HIV-positive teachers are and prove that HIV is not AIDS; • Use radio sports announcements during the matches to spread KENEPOTE objectives; • Use motivational speeches during sports and games to spread KENEPOTE objectives.</td>
<td>• 50% of teachers present themselves for VCT; • 25% of teachers who test positive declare their status publicly and join support groups; • Absenteeism from work by HIV-positive teachers reduced by 50%.</td>
<td>• One mobile VCT &amp; VCT kits to provide access to schools and targeted institutions far from existing VCT centres; • Funds to train KENEPOTE members on counselling &amp; spiritual support; • Technical assistance in monitoring and evaluation; • Training teachers in social mobilization.</td>
<td>Jan- March 2005</td>
<td>• KENEPOTE members and other teachers to mobilize trained counsellors; • VCT centres in project catchments areas; • TLWHA, KNUT, PDE, MOEST, TSC, school committees and PTA to sensitize and mobilize teachers.</td>
<td>• Teachers will join KENEPOTE.</td>
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<td>Objectives</td>
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<td>2. Intensify advocacy and lobbying for protection of rights of TLWHA</td>
<td>Organize seminars and workshops for teachers, tutors and lecturers to disseminate and intertemperate MOEST HIV policy; Implement MOEST policy; Establish HIV/AIDS disciplinary committees in schools and participating institutions; Develop guidelines on disciplinary actions against those who violate the rights of HIV-positive teachers and students; Convene quarterly/regular meetings of stakeholders in teaching institutions to monitor rights abuse &amp; discrimination; Mobilize members of parliament to participate in advocacy programs; Advocacy visits to learning institutions; Develop messages for media; Develop advocacy materials such as posters, banners, leaflets and fact sheets;</td>
<td>100% teachers with AIDS given time off by Head-Teachers to attend clinics on their appointment days; 80% of positive teachers have their work load reduced; 100% of transfers requested by HIV-positive teachers granted. No HIV-positive teachers lose employment or miss promotion because of their status; Non-positive teachers or those who do not know their status provide home-based care for visiting TLWHA; KENEPOTE represented in all HIV/AIDS committees in MOEST, TSC, KNUT, NACC and NASCOP.</td>
<td>Resources and funds to train media personnel on rights of PLWHA, and to develop or procure advocacy materials, organize advocacy workshops and seminars, radio programs and newspaper coverage; Funds to train support group and KENEPOTE members on advocacy; Technical assistance from POLICY Project and NASCOP;</td>
<td>Mar-May 2005</td>
<td>KENEPOTE members Teachers living with HIV/AIDS KNUT PDE MOEST Legal bodies Community POLICY Project Media Houses HIV/AIDS Support Groups Members of parliament Stakeholders will cooperate Donors will provide funds</td>
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<td>Incorporate KENEPOTE members in MOEST, KNUT, and TSC in HIV/AIDS committees to participate in decision-making processes and advocacy for rights and protection of teachers; Establish strong support groups for TLWHA and create a voice for HIV-positive teachers that can yell when rights are abused;</td>
<td>Develop a strategic plan for KENEPOTE; Establish KENEPOTE offices in all provinces with a coordinator and finance manager/administrator; Train KENEPOTE officials and staff on management of HIV/AIDS programs, M&amp;E, advocacy, communication skills, leadership, management, social mobilization, facilitation skills, membership drive and fund raising;</td>
<td>Strategic plan is in place and being used to guide programming and implementation; 10 KENEPOTE offices established, equipped and functioning in Kenya; Database on HIV-positive teachers developed; 10 members of KENEPOTE attend local and/or international conferences;</td>
<td>Consultant to finalize strategic plan; Funds acquired for training; Equipment i.e. for the office, radio, training etc; HIV/AIDS educational materials, computers, etc; One vehicle per province, total 8.</td>
<td>June-August 2005</td>
<td>KENEPOTE, POLICY Project, MOEST, KNUT, TSC</td>
<td>Stakeholders and donors will cooperate</td>
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<td>Representation of KENEPOTE in Coast Province</td>
<td>Management training for KENEPOTE staff and members; Expose KENEPOTE members through conferences and seminars.</td>
<td>M&amp;E systems developed and utilized; 144 TOTs trained in home based care and counselling (2 per district); 300 teachers trained in prevention, education, social mobilization, rights issues, basic facts on HIV/AIDS advocacy and networking; 144 TOTs of peer educators trained; 2500 HIV-positive teachers recruited to join KENEPOTE in Year One in eight provinces; 30 HIV-positive teachers trained in radio message development and public speaking.</td>
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Annex 2

Thematic Areas and Objectives as Identified by KENEPOTE Workshop Participants

1. Capacity building
2. Prevention
3. Stigma and discrimination
4. Psychological & social support
5. Care and treatment
6. Strengthening and expanding KENEPOTE
7. OVCs
8. IGA

Cross Cutting Issues

- Discordant couples
- Gender
- BCC & IEC
- Education

Day Three

- Recap and evaluation
- Stigma – Group work
- Definition
- Causes
- Manifestation
Tackling stigma

- BCC& spiritual care and support
- Positive Living (both group work and presentation)
- Role of VCT
- Acceptance
- Disclosure
- Coping mechanism
- Role of support groups
- OVC issues

Group 1 & 4 Objectives

1. Promote knowledge and better understanding of HIV and AIDS and share experiences at national, provincial and district levels.
2. Strengthen partnerships between KENEPOTE, MOEST and build strong relationship with donors to leverage resources and gain support.
3. Increase community knowledge about VCT and facts about HIV/AIDS.
4. Create an enabling environment for teachers to live positively with their HIV-positive status and serve as role models and change agents.
5. Strengthen the capacity of HIV positive teachers to adhere to the nutrition required by their condition, and to the ART regimen.
6. Encourage the teachers living with HIV/AIDS (TLWA) to break the silence and disclose their status so that they may optimally receive care and treatment.

**Group 2 Objectives**

1. Increase access to medical, emotional, physical, social and spiritual care and support for HIV positive teachers.
2. Advocate and promote integration of HIV-positive teachers into their communities to reduce isolation and loneliness.
3. Increase the knowledge and skills of TLWA to reduce their personal stigma, advocate against discrimination and live openly with their status as role models.

**Group 3 Objectives**

1. Reduce stigma and discrimination against TLWA and OVC inside and out of schools.
2. Reduce the impact of HIV and AIDS on teachers and orphans in all schools.
3. Promote networking and collaboration between KENEPOTE teachers and healthcare providers to increase access to information and treatment.
**Kenya Network of Positive Teachers Association (KENEPOTE)**  
**Provincial Action Plans: January-December 2005**

### Eastern Province

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</table>
| 1. Reduce stigma and discrimination against TLWHA | • Organize football matches for teachers and use the opportunity to recruit for KENEPOTE;  
• Use SACCO meetings to encourage teachers to know their HIV status and declare it;  
• Coaches  
• 10 balls  
• 120 T-shirts | • X teachers reached during the football matches;  
• X teachers recruited as KENEPOTE members;  
• X teachers go for VCT and know their status. | January-March 2005 | KENEPOTE teachers, KNUT officials, SACCO officials | • Teachers will realize the importance of getting tested, knowing their status and joining KENEPOTE;  
• SACCO officials will cooperate. |
| 2. Intensify advocacy and lobbying for protection of rights of PLWHA | • Going to schools to talk to teachers about rights of TLWHA;  
• Talking to organized groups of PLWHA on how to manage personal stigma and enlighten them about their own rights as PLWHA;  
• Organize and implement 30 advocacy seminars (3 per district). | • X teachers advocating for rights of PLWHA;  
• PLWHA giving testimonies on radios and talking to friends on how they are stigmatised and advocating for stigmatisation to stop. | May-July 2005 | • Head Teachers in Eastern province schools;  
• Provincial and district MOH officials;  
• Palliative care takers;  
• Medical practitioners from private hospitals  
• KENEPOTE |
| 3. Strengthen the capacity of KENEPOTE to implement its program activities and manage the project effectively and efficiently | • Establishment of district and provincial KENEPOTE offices and liaising with provincial and local authorities | • Well functioning KENEPOTE offices in districts and at the provincial headquarters | Jan-Dec 2005 | • Members of KENEPOTE, DCs, DOs, and PCs offices |  |
## CENTRAL PROVINCE INCLUDING NAIROBI

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<tr>
<td>1. Reduce stigma and discrimination against TLWHA</td>
<td>• 80% of KNUT officials, Head Teachers’ associations and SACCOS are aware of KENEPOTE and speak openly against stigma and discrimination against people with AIDS, especially teachers; • 50–100 teachers recruited as members of KENEPOTE; • 50 teachers trained on HIV/AIDS prevention and on advocacy against stigma and discrimination; • 60% of requests from teachers regarding rest, workloads and transfers given their HIV status, are honoured; • HIV-positive teachers allocated roles and responsibilities in school without discrimination.</td>
<td>• Advocacy materials (KENEPOTE brochure, badges, car stickers, banners, microphones, fliers); • Communication facilities (postage, telephones, email, faxes, radios air time, TV, newspaper space, etc.).</td>
<td>January-April 2005</td>
<td>• KENEPOTE members from Central Province:- George (Nyeri)- Josephine (Maragwa)- Nancy (Kiambu)- Gladwel (Muranga)- Rose (Nairobi)- Jennifer (Nairobi).</td>
<td>• HIV-positive teachers will realize the value of breaking the silence and declaring their status; • KENEPOTE members will be active in their regions; • Funding for these activities will be made available by donors.</td>
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<td>2. Intensify advocacy and lobbying for protection of rights of PLWHA.</td>
<td>• Organize a five-day training for the recruited teachers on the rights of HIV-positive teachers and skills in advocacy.</td>
<td>• 50 trained teachers speaking on the radio, meetings and other fora on the rights of PLWHA;</td>
<td>• Training facilitators (2);</td>
<td>May-August 2005</td>
<td>• KENEPOTE members from Central Province:</td>
<td>• KENEPOTE members from Central Province: George (Nyeri) Josephine (Maragwa) Nancy (Kiambu) Gladwel (Muranga) Rose (Nairobi) Jennifer (Nairobi) In partnership with officials from TSC, KNUT and MOEST.</td>
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<td>• HIV-positive teachers interacting freely with non-positive teachers in 60% of the schools;</td>
<td>• Training materials;</td>
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<td>• At least 100 teachers declaring their HIV status;</td>
<td>• Reference materials on advocacy and rights;</td>
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<td>• HIV-positive teachers represented in all HIV/AIDS committees at MOEST, KNUT, SACCO, TSC and Head Teachers' associations;</td>
<td>• Travel &amp; per diems;</td>
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<td>• Support groups for TLWHA established and operational in each district with at least 20 members.</td>
<td>• Financial resources to be raised from USAID, MOEST, POLICY Project, KNUT, TSC and other partners and donors.</td>
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<td>3. Strengthen the capacity of KENEPOTE to implement its program activities and manage the project effectively and efficiently</td>
<td>• Establish and equip KENEPOTE offices in Nyeri and Nairobi and decentralise to divisional levels;</td>
<td>• Establish and equip KENEPOTE offices in Nyeri and Nairobi and decentralise to divisional levels;</td>
<td>• Funds to rent office space;</td>
<td>May to August 2005</td>
<td>• KENEPOTE members from Central Province:</td>
<td>• KENEPOTE members from Central Province: George (Nyeri) Josephine (Maragwa) Nancy (Kiambu) Gladwel (Muranga) Rose (Nairobi) Jennifer (Nairobi) In partnership with officials from TSC, KNUT and MOEST.</td>
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<td>• Develop induction material for new staff and volunteers;</td>
<td>• Develop induction material for new staff and volunteers;</td>
<td>• Basic office furniture, including 4 computers;</td>
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<td>• Conduct orientation of new staff and volunteers;</td>
<td>• Conduct orientation of new staff and volunteers;</td>
<td>• 2 programme coordinators, 2 finance and administration persons (in Nairobi and Nyeri) (full time staff);</td>
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<td>• 4 KENEPOTE offices fully functioning in central province;</td>
<td>• 4 KENEPOTE offices fully functioning in central province;</td>
<td>• Funds to rent office space;</td>
<td>May to August 2005</td>
<td>• KENEPOTE members from Central Province:</td>
<td>• KENEPOTE members from Central Province: George (Nyeri) Josephine (Maragwa) Nancy (Kiambu) Gladwel (Muranga) Rose (Nairobi) Jennifer (Nairobi) In partnership with officials from TSC, KNUT and MOEST.</td>
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<td>• 90% of KENEPOTE staff and volunteers inducted into their new roles using induction manual and volunteer policy</td>
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<td>• Basic office furniture, including 4 computers;</td>
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<td>• Funds to rent office space;</td>
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<td>• 2 programme coordinators, 2 finance and administration persons (in Nairobi and Nyeri) (full time staff);</td>
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Budget requested: 2 million shillings per year
### CENTRAL PROVINCE INCLUDING NAIROBI cont

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<td>3. cont.</td>
<td>• Develop volunteer management policy; • Train new members and volunteers in leadership and management skills, HIV/AIDS, communication, counselling, peer education, financial and resource management; • Develop a monitoring and evaluation system and database.</td>
<td>• Well functioning Management Information Systems (MIS) and financial management systems in all KENEPOTE offices.</td>
<td>• 2 vehicles (kombis, in Nairobi and Nyeri) for mobilisation and training • Training materials; • Stationery and office supplies.</td>
<td>May-August 2005</td>
<td>• Jennifer (Nairobi) In partnership with officials from TSC, KNUT, MOEST and POLICY Project.</td>
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### NYANZA PROVINCE

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<tr>
<td>1. Reduce stigma &amp; discrimination against TLWHA 2. Intensify advocacy and lobbying for protection of rights of PLWHA</td>
<td>• Mobilize PDE, MOEST and DEO, KNUT, SACCO officials and brief them on KENEPOTE and its one year work plan in Nyanza and seek their support; • Convene a workshop for Nyanza Provincial Head Teachers Association to inform them about KENEPOTE, introduce the project, train them on basic facts about HIV/AIDS, advocacy skills and strategies of reducing stigma;</td>
<td>• 80% of provincial education staff, MOEST officials KNUT officials, Head Teachers’ Associations and SACCO are aware of KENEPOTE and speak openly against stigma and discrimination directed at PLWHA; • 400-500 teachers recruited into KENEPOTE;</td>
<td>• Advocacy materials (KENEPOTE brochure, badges, car stickers, banners, microphones, fliers, etc.; • Communications (postage, telephones, email, faxes, radios air time, TV, newspaper space); • At least 50 HIV-positive and other teachers working with KENEPOTE officials in Kisumu and national officials, CACC, PACC,</td>
<td>January to March 2005</td>
<td>• Provincial and national KENEPOTE officials PDE, MEO, DEO, zonal office, Head Teachers and HIV-positive teachers; • City Council of KSM, Agakhan Health Services, Lions Club.</td>
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### Nyanza Province Cont

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<td>2. cont.</td>
<td>• At the workshop, identify cooperative Head Teachers to be involved in an action plan to recruit HIV-positive teachers into KENEPOTE and to play active role in stigma reduction; • Recruit HIV-positive teachers through membership drives; • Train and orientate new KENEPOTE members on HIV/AIDS issues, its impact and stigma and discrimination reduction strategies; • Identify all OVC’s in schools and monitor their treatment by students and teachers and act against any abuses; • Form support groups for HIV-positive teachers.</td>
<td>• 100 teachers trained on HIV/AIDS prevention and advocacy on stigma and discrimination reduction; • 60% of requests from teachers regarding rest, workload and transfers to cope with their HIV status are honoured; • HIV-positive teachers allocated roles and responsibilities in the school without discrimination; • An up-to-date list of all orphans in school maintained;</td>
<td>KNUT, MOH, POLICY Project, provincial officials • Training facilitators (2); • Training materials; • Reference materials on advocacy and rights; • Travel &amp; per diems; • Financial resources to be raised from USAID, MOEST, POLICY Project, KNUT, TSC, other partners and donors.</td>
<td>January to March 2005</td>
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| 3. Strengthen KENEPOTE capacity to implement the project activities and manage its programs effectively and efficiently | • Train HIV/AIDS teachers in:  
  - Management skills  
  - Rights issues  
  - Stigma and discrimination  
  - Provide technical support to KENEPOTE to define roles and responsibilities and to develop monitoring and evaluation plan and management information systems.  
  - Also provide TA for the development of a database for teachers with HIV and OVC. | • 2 KENEPOTE offices fully functioning in the province;  
  • 90% of KENEPOTE staff and volunteers inducted into their new roles using induction manual and;  
  • Well functioning MIS and financial management systems in all KENEPOTE offices;  
  • M&E plans in place in KENEPOTE offices in Nyanza and are being utilized;  
  • At least 50% of all KENEPOTE members in Nyanza Province and HQ are trained in management, rights and stigma issues. | • Funds to rent office space;  
  • Basic office furniture;  
  • 2 computers;  
  • 1 programme coordinator, 1 finance and administration persons in Kisumu (full time staff)  
  • 1 vehicle (kombi in Kisumu) for mobilisation and training;  
  • Training materials, stationery and office supplies. | January to April 2005 | |
## RIFT VALLEY (NORTH & SOUTH) AND WESTERN PROVINCES

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</table>
| 1. Reduce stigma and discrimination against TLWHA | - Sensitize teachers on HIV issues and solicit their participation through social mobilization activities such as: 
  - Football matches to kick out stigma from schools 
  - Cycling to chase away virus from school 
  - AIDS run 
  - Tag of war 
  - Messages to reduce stigma announced during and between sports and games. | - 60% of TLWHA participate in football, tug of war, running, cycling, etc.; 
  - 1,500 positive teachers join KENEPOTE 
  - (500 per province) | - Radio air time for spot announcements of anti-stigma and HIV/AIDS messages; 
  - Football and cycling coaches; 
  - IEC material, such as posters and car stickers; 
  - Trophies, KSSA, KFA, The right to Play organization, Ministry of Sports and Culture, MOEST, TSC, KNUT, SACCO. | January to December 2005 | | |
| 2. Intensify advocacy and lobbying for protection of rights of PLWHA | - KENEPOTE members to attend meetings organized by Head Teachers, SACCO, KNUT, TSC to educate them on the rights of PLWHA and to raise instances of rights violations requiring rectification. | - 50% of the HIV-positive teachers get requested transfers; 
  - 90% of HIV-positive teachers get time off for treatment when sick or for ARV refills; 
  - NO HIV-positive teachers lose their jobs because of their status during 2005; 
  - 100% of teachers feeling sick are transferred to duties they can handle, or have reduced hours. | - Advocacy materials e.g., pamphlets, containing rights of TLWHA; 
  - MOEST policy document on HIV/AIDS; 
  - Funds for a workshop to interpret policy to KENEPOTE members; 
  - T-Shirts, posters, banners. | April to Dec 2005 | KENEPOTE, Head Teachers, KNUT, MOEST, SACCO, B/S, DEO, MEO | Identified partners will cooperate and discuss the issue of HIV-positive teachers openly; 
  - Teachers will go for VCT and those who are HIV-positive will declare their status to provide a basis for fighting for their rights; 
  - ARVs will be made available for all teachers who declare their positive status to make it worthwhile for more teachers to declare their status; 
  - Positive teachers will behave responsibly to compel others to treat them with dignity and to observe their rights |
## RIFT VALLEY (NORTH & SOUTH) AND WESTERN PROVINCES cont.

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<th>Responsible Persons</th>
<th>Assumptions</th>
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<tr>
<td>3. Strengthen the capacity of KENEPOTE to implement the program activities and manage the project effectively and efficiently.</td>
<td>• Establish one KENEPOTE offices per province; Recruit one coordinator and one finance and administration manager for each office, in the three provinces; • Train staff on management of donor funds and HIV/AIDS programs; • Train 90 KENEPOTE members drawn evenly across the districts in social mobilization, facts on HIV/AIDS, stigma and discrimination strategies, rights issues, peer education, counseling and public speaking and facilitation/TOT skills so that they can train others; • Organize district-level seminars and workshops for KENEPOTE members for orientation on social mobilization, advocacy, stigma reduction skills, monitoring and evaluation, management and HIV/AIDS; • Sponsor teachers for training in spiritual guidance, counseling and psychosocial support.</td>
<td>• At least one KENEPOTE office functioning efficiently and effectively in each province.</td>
<td>• Funds to establish and operate the three offices; • Funds for training, M&amp;E and program money. Also requires technical support from POLICY, MOEST, KNUT and TSC,</td>
<td>January to June 2005</td>
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## NORTH EASTERN PROVINCE

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<th>Time Frame</th>
<th>Responsible Persons</th>
<th>Assumptions</th>
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</table>
| 1. Strengthen the capacity of KENEPOTE members to increase knowledge and better understanding of HIV/AIDS issues and to respond to the needs of positive teachers. | - Establish a regional KENEPOTE office in NE Province with a resource centre;  
- Recruit a competent secretariat to respond to needs of TLWHA;  
- KENEPOTE members to share their experiences with teachers and others at regional level to promote better understanding on HIV/AIDS issues;  
- Engage partners and stakeholders to meet the identified needs;  
- Establish HIV research centre. | - 20 HIV-positive teachers recruited into KENEPOTE, willing to be trained as peer counsellors and educators;  
- 40 people visiting the resource centre seeking information on HIV/AIDS;  
- 50% of teachers have access to and use information for HIV/AIDS and STI prevention;  
- Primary and secondary HIV/AIDS research being undertaken in the province, with findings shared with stakeholders including teachers. | - Space for an office resource and research centre;  
- Funds for 3 workshops;  
- Technical support on policy and management and facilitation skills;  
- Stationery and vehicle for transporting trainees and facilitators and researchers. | January to June 2005 | | |
| 2. Strengthen partnership between KENEPOTE and other stakeholders | - Convene stakeholders and partnership fora at regional level. | - Number of partners working with KENEPOTE in research or support of its programs | - Funds to convene the workshop;  
- Transport;  
- Personnel. | June to July 2005 | TSC, MOEST, KNUt, SUPKEM, CBOs, private and civil society organizations. | The partners will complement rather than compete with KENEPOTE |
### NORTH EASTERN PROVINCE cont.

<table>
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<th>Time Frame</th>
<th>Responsible Persons</th>
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<tr>
<td>3. Increase community knowledge about HIV/AIDS</td>
<td>• Teachers in North Eastern to translate HIV/AIDS policy of MOEST and other IEC material into local languages and work with POLICY Project and NASCOP to develop a communications strategy; • Conduct peer education in and out of schools.</td>
<td>• Materials available in vernacular; • Radio spot messages are aired in major languages of North Eastern; • 80% of teachers in North Eastern province and their spouses are aware of basic HIV/AIDS facts on prevention, transmission and treatment; • 80% of teachers have access to HIV/AIDS IEC materials and are aware of self stigmatisation and general stigmatisation by the public or at work place, and can name ways of controlling these; • Positive relationships between teachers and their communities, employers, and pupils.</td>
<td>• IEC materials; • Radio airtime; • Trained peer educators in schools; • Media concept paper, transport; • Technical support; • MOEST policy documents and TSC policy documents (if available by then); • Technical support in translating and interpreting the policy documents; • Technical support in developing HIV/AIDS communication strategy.</td>
<td>January to December 2005</td>
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# COAST PROVINCE

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<th>Assumptions</th>
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</table>
| 1. Reduce stigma and discrimination against TLWHA | • Mobilize teachers to go for VCT and counsel the HIV-positive to accept their new status;  
• Encourage HIV-positive teachers through psychosocial therapies to declare their status;  
• Establish support groups and post-test clubs that HIV-positive teachers can fall back on before and after declaring status;  
• Involve PLWHA in developing educational materials. | • 50% of teachers present themselves for VCT;  
• 25% of teachers testing positive declare their status publicly;  
• TLWHA participate in AIDS programs in their places of work and residential communities;  
• Decreased unnecessary teacher absenteeism. | • Funds;  
• Technical assistance in program and financial management;  
• KENEPOTE, POLICY Project, NUT, MOEST | January to March 2005 | | |
| 2. Intensify advocacy and lobbying for protection of rights of PLWHA | • In collaboration with legal bodies sensitize MOEST, PDE, and DEO on rights of TLWHA;  
• Extend sensitization to local communities;  
• Mobilize members of parliament to participate in the advocacy programs;  
• Empower TLWHA by incorporating them in communities of MOEST, KNUT, and TSC in committees dealing with HIV/AIDS and use staff seminars to participate in decision-making processes affecting teachers;  
• TLWHA given time off by Head-Teachers to go for treatment;  
• Legal rights of TLWHA observed, such as confidentiality and consent before testing;  
• Less stigma;  
• Increased interaction between TLWHA and their communities and teachers who are not positive or do not know their status, providing home-based care or visits. | • Legal advisors;  
• Funds from stakeholders;  
• Technical assistance from POLICY Project and NASCOP. | March to May 2005 | TLWA;  
KNUT;  
PDE  
MOEST  
Legal bodies  
Community  
NASCOP  
POLICY Project | Stakeholders will cooperate  
Donors will provide funds |
## COAST PROVINCE cont.

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<tr>
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<tr>
<td>2. cont</td>
<td>• Provide TLWHA with feedback from such fora; • Use media and other IEC links to promote issues regarding HIV/AIDS; • Establish strong support groups for TLWHA.</td>
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<td></td>
<td>June to August 2005</td>
<td>KENEPOTE, POLICY Project, MOEST, KNUT, TSC</td>
<td>Stakeholders will cooperate</td>
</tr>
<tr>
<td>3. Strengthen the capacity of KENEPOTE to implement its program activities and manage its project effectively and efficiently</td>
<td>• Develop strategic plan for KENEPOTE; • Establish strong representation of KENEPOTE in Coast Province; • Train KENEPOTE staff and members on management; • Expose members of KENEPOTE through workshops, conferences and seminars.</td>
<td>• Develop five strong support groups; • 200 HIV-positive teachers recruited into KENEPOTE; • One strong regional office in Coast Province with trained staff; • Staff and members of KENEPOTE attend international and local conferences.</td>
<td>Funds; • Office eEquipment; • Halls for meetings; • Strategic plan; • HIV/AIDS information and educational materials</td>
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### Annex 4

## Participants List

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Organization</th>
<th>Tel/Address</th>
<th>E-mail</th>
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<tbody>
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<td>Elizabeth Ayugi</td>
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<td>10.</td>
<td>Annette Musumba</td>
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<td>16.</td>
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<tr>
<td>18.</td>
<td>Alice A. Waweru</td>
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<td>19.</td>
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<td>20.</td>
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<tr>
<td>21.</td>
<td>Dr. Boaz Nyunya</td>
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<td>22.</td>
<td>Lucy Chesire</td>
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<td>Dickson V. Zuma</td>
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<td>Voli M. Alois</td>
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<td>Nancy Ombega</td>
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<td>John K. Kimtai</td>
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<td>Mary Goretti Boroswa</td>
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<td>51</td>
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<td>54</td>
<td>Regina Owino</td>
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<td>56</td>
<td>Elizabeth Aroka</td>
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Annex 5

Kenya Network of Positive Teachers Association (KENEPOTE)

HIV/AIDS PLANNING WORKSHOP AT WATERBUCK HOTEL, NAKURU: 13–18 December 2004

Workshop objectives

1. Sensitize potential partners about the goal, mission and activities of the Kenya Network of Positive Teachers (KENEPOTE).
2. To share experiences/concerns of infected teachers living with HIV/AIDS from the provinces.
3. Increase the knowledge of members on HIV/AIDS facts, care and support of PLWHA and OVC
4. Identify key issues/problems/needs of TLWHA and draw plans on how to address them.
5. Explore stigma and how to reduce it-promoting Positive Living.
6. Discuss existing MOEST HIV/AIDS policy and legal rights of TLWHA.
7. Develop a one year action plan for the Network.

Programme

DAY ONE 13th December 2004
3.00 pm Arrival and registration–KENEPOTE

DAY TWO 14th December 2004
8.30 – 9.30 am Climate setting: Session Chair–Millicent Obaso, POLICY Project
- Welcome remarks–Margaret Wambete, Chairperson – KENEPOTE
- Introduction
- Participant’s expectations
- Key experience/concern about HIV/AIDS by a participant
- Fears about the workshop
- Group norms and responsibilities – Millicent Obaso
Workshop objectives – Millicent Obaso

9.30- 10.30 am Updates on HIV/AIDS facts: Prof. Boaz Otieno-Nyunya – Moi University
- Current situation
- National response
- Basic facts (The Virus, AIDS, Mode of transmission/factors fueling spread and prevention)

10.30- 10.45 am Q & A

10.45- 11.00 am TEA BREAK

11.00- 12.15 pm HIV/AIDS management: Kiboi Samson–Moi Referral Hospital
Adherence to ARV treatment and care: Regina Owino – Moi Referral Hosp.
Principles of care– Dr Killingo B. M, Meru Hospice
Home Based Care – Dr Killingo B. M, Meru Hospice

12.15-12.45pm Nutrition Support: - Lucy Chesire / Mrs. Anyumba

12.45- 1.00 pm Q & A
1.00- 2.00 pm  
**LUNCH BREAK**

2.00- 3.00pm  
**Official opening:** 10 min each person.

Welcome Remarks – *Margaret Wambete*, Chairperson, KENEPOTE

Brief about KENEPOTE – *Elsa Ouko*, Coordinator, KENEPOTE

Remarks – *Mr. J. A. Awiti*, National Sec., Kenya Secondary School Heads Association

Remarks – *Mr. Victor Jaoko*, Customer Advisor, Barclays Bank, Nakuru

Testimony – By a participant

Remarks – *Mr. Dimarco*, Provincial Director of Education, Rift Valley Province

Remarks – *Ms. Angeline Siparo*, Country Director, POLICY Project(USAID)

Key note address – *Mr. Luka Spira*, AIDS Control Unit, TSC

**NB:** *Evening session: Video show*

### DAY THREE

15 December 2004

8.30- 9.00 am  
Recap/evaluation of previous day

9.00-10.00 am  
Group Work on Stigma & Discrimination Issue – *Millicent Obaso*

10.00- 11.00am  
Group Presentations & Talk on Stigma & Discrimination – *Jeremiah Okuto*

- Definition
- Causes
- Manifestation
- Tackling stigma-strategies

11.00  11.30  
**TEA BREAK**

11.30- 1.00pm  
Psychosocial & Spiritual Support:

- Behavior change: *Mary Amolo*
- Spiritual care & support: *Rev. Joshua Orawo*

1.00- 2.00pm  
**LUNCH BREAK**

2.00- 4.00pm  
Positive living with HIV/AIDS: *Margaret Wambete & Rose Njeri*

- Role of VCT: *Jecinta Mulatya*
- Acceptance:-
- Status disclosure: *Elsa Ouko*
- Coping mechanisms: *Jemima Atieno*, Kisumu Boys...
- Role of PLWHA support groups: *Jemima Atieno*
- Issues of OVC( at school, at home and community): *Jeremiah Okuto*

4.00-4.30pm  
**TEA BREAK**

4.30- 5.00pm  
Q & A

**NB:** Eventing session- Experience sharing from provinces.
DAY FOUR

16 December 2004

8.30 – 9.00 Recap/Evaluation previous day – Millicent Obaso, POLICY

9.00 - 10.30 Group reports on emerging issues/problems
Psychological needs of PLWHAs: Lillian Adhiambo – WOFAK
Social needs of PLWHAs: Lillian Adhiambo – WOFAK
Principles of psychotherapy: Lillian Adhiambo – WOFAK
Behavior change: Lillian Adhiambo – WOFAK

10.30- 11.00 TEA BREAK

11.00- 12.00pm The Legal Rights and inheritance rights of PLWHA Teachers – Elizabeth Aroka – Kenya Ethical and Legal Issues Network (KELIN)
Education sector Policy on HIV and AIDS
Mr. Laban Airo, Ag. Snr. Dep. Director of Education.
TSC Policy: Alice Waweru
• Implications of the bill on terms and conditions of service for teachers

12.00pm- 1.00pm The challenges of HIV/AIDS positive teachers – Margaret Wambete
Experience by three participants (5 minutes each)
Group discussion on emerging issues

1.00 – 2.00 Pm LUNCH BREAK

2.00- 4.30 pm Action Planning: Millicent Obaso, POLICY & Elsa Ouko
Review the KENEPOTE Goal, Mission < Vision and objectives (group work)
Group reports
Stakeholders identification and analysis
(Their importance and roles) (Plenary discussions).
Wrap up the day

4.30- 5.00 pm TEA BREAK

NB: Even evening session: Experience sharing/videos.

Day FIVE

17th Dec.

8.30- 9.00 Recap/Evaluation previous day– Millicent Obaso, POLICY Project

9.00 -10.30 Drawing a One year Action plan– Millicent Obaso, Margaret Wambete & Elsa Ouko
Consensus on Thematic areas for action
Visioning for the one year

10.30 11.00 TEA BREAK

11.00 – 1.00 Setting goals, objectives and strategies as per each thematic area

1.00 – 2.00Pm LUNCH BREAK

2.00 – 3.00 Action planning using a provided tool – Jeremiah Okuto, KENEPOTE Lawyer
Action
Timeline
Responsibility
Indicator of performance
Source of information/data for action taken
Resources needed
Assumptions
Activities- Use a provided tool.

3.00 - 3.30 Group reports
3.30 - 4.00 pm Evaluation of the workshop
4.00 - 5.00 pm Closing the workshop – .... Nganga, KNUT