INTRODUCTION

1.0 In Kenya HIV/AIDS pandemic is 21 years old. The first Case of HIV/AIDS infection was occurred in 1978, in communities living around the shores of lake Victoria. In 1984, six years later the first Aids case was officially reported by the Kenyan Ministry of Health. Since then;

- More than 1.5 million people have died of HIV/AIDS.
- Infected cases living with HIV/AIDS is over 2 million of whom 600,000 are children and women.
- There is an increasing number of HIV/AIDS orphans as parents die of the disease.
- The country is losing about 300 people daily from HIV/AIDS. Last year the number was 700. The drastic reduction is a result of use of anti-retroviral drugs.
- The HIV/AIDS has been declared a National disaster. It was declared at Mombasa in November 1999 by the then President, Daniel Arap Moi. Then the National Aids Control Council (NACC) was established to coordinate all Aids programmes in the country.
- Most infected cases live in the rural areas and the majority is young people aged 15 – 39 years. This is the most active reproductive age. It is also the most economically productive age population.
- Cases of HIV/AIDS has been reported in every district through mobile voluntary and counseling testing units – Voluntary Counseling and Testing Units. (VCTS).
- Between 40-70 percent of patients occupying hospital beds in major public hospitals suffer from HIV/AIDS related illness. This is a big constraint on public health facilities.

1.2 The major factor contributing to the high incidence of HIV/AIDS in Kenya is the rising level of poverty among Kenyans where over 50 percent of the population lives below the poverty line (economic survey 2000), with an average annual basic income of less $300 that’s less than $1 per day. The impoverished families spend less on such basic needs as food, shelter routine preventive health care, general medical care and education. There is a direct link between levels of poverty of the family and enrolments, participation and completion of learning in educational institutions. Women are generally at a greater risk and are more disadvantaged due to their physical, social and economic vulnerability.
Other factors which have contributed to the increase of HIV/AIDS in the country include:

- Peer pressure among adolescents on sexual behaviour
- Conservative cultural practices and values
- Socialization rituals
- Attitude borne of ignorance
- Alcohol abuse
- Wife inheritance
- Casual attitude towards sex including habitual contact and commercial sex.

1.3 The majority of the infected people aged between 15-39 years. This is a correct reflection of a population, which has over 50% people less than 16 years of age. This means that the majority of the basic education clients and the productive groups are within Aids vulnerable category ad therefore very susceptible to infection: if the labour force (15-49) are infected by HIV/AIDS, the production in country will decline and a vicious circle of poverty will persist.

### 2.0 GOVERNMENT EFFORTS TOWARDS HIV/AIDS

- In 1984 first AIDS case diagnosed
- Between 1985-89
  - Development and launch of a 5 year Medium Term Plan – focus on prevention through blood screening promotion of safer sexual practices and early diagnosis of STDs
  - National AIDS Committee
  - AIDS programme secretariat formed

- 1992 – formation of National HIV/AIDS Control Programme. This was merged with National STD Control Programme to form the National HIV/AIDS and STD Control Programme – NASCOP.
- The Government established the National AIDS Control Council as a body corporate under state corporation Act by President’s order.
2.1 **NACC MISSION STATEMENT**

i. To provide policy and a strategic framework for mobilizing and coordinating resources for prevention of HIV transmission and provisions of care and support to the infected and affected people in Kenya.

2.2 **NACC FUNCTIONS**

i. Coordinate and supervise HIV/AIDS activities.
   
   ii. Mobilize resources for prevention and control of HIV/AIDS.
      
   iii. Develop policy, strategy and guidelines relevant to prevention and control of HIV/AIDS.
      
      
   v. Develop national MIS for HIV/AIDS control.
      
   vi. Collaborate with local and international agencies working in AIDS control.
      

2.3 **THE STRATEGIC PLAN**

i. NACC developed the Strategic Plan as a Policy Guide for the fight against HIV/AIDS for the period covering 2000-2005.
   
   ii. The Strategic Plan is supposed to guide all the stakeholders implementing any HIV/AIDS activities in various sectors.
      
   iii. The Strategic plan has three main objectives:
   
   ▪ Reduce prevalence by 20-30% for 15-24 years by 2005. that’s targeting youth and young adults.
      
   ▪ Increase support and care to infected and affected.
      
   ▪ Strengthen capacity and coordination for response at all levels.

2.4 **KEY MESSAGE DRIVING THE STRATEGY**

2.4.1 **PRIORITY AREAS**

i. Prevention and advocacy
   
   ii. Treatment, continuum of care and support
      
   iii. Mitigation of the socio-economic impact
      
   iv. Monitoring, evaluation and research
      
   v. Management and coordination
2.4.2 PREVENTION AND ADVOCACY

i. Promotion of behaviour change through community mobilization for social change to reduce the spread of HIV by targeting priority groups.
ii. Prevention and control of STD infections.
iii. Prevention of mother to child transmission.
iv. Prevention of blood borne infections.

2.5 TREATMENT AND SUPPORT OF A CONTINUATION OF CARE FOR THE INFECTED AND AFFECTED

2.5.1 The components of Comprehensive care and support include the following:-

i. Clinical care
ii. Nursing care
iii. Counselling and emotional support
iv. Home based care
v. Social support
vi. Spiritual care
vii. Occupational therapy.

2.6 EFFECTS OF HIV/ AIDS

2.6.1 Industrial sector

i. Increased absenteeism
ii. Lower productivity
iii. Higher overtime
iv. Increased funeral costs
v. Increased health care costs

2.6.2 Education

i. Drop in quality of education
ii. Children forced into marriage or workforce.
iii. Decreased participation in adult learning due to poor health and additional family responsibilities e.g. taking care of orphans and the sick.
iv. Shortage of teachers e.g. Nyanza District.
2.6.3 Household
i. Decrease in incomes
ii. Increase in dependants
iii. Increase in school drop outs
iv. Increase in cost of health care.

2.6.4 health
i. Increase in the number of people seeking health services
ii. Increased cost of healthcare in the country.

2.7 ROLES OF KEY PLAYERS

2.7.1 Government of Kenya (GOK)

i. Policy direction
ii. Institutional development
iii. Resource Mobilization and
iv. advocacy

2.7.2 National Aids Control Council (NACC) Secretariat

i. Mobilize resources for control and prevention
ii. Develop MIS for HIV/AIDS control
iii. Provide mechanism and guidelines for implementation
iv. Monitor and evaluate HIV/AIDS programmes
v. Lead in advocacy and PR for HIV/AIDS programmes.
vii. Coordinate and supervise HIV/AIDS interventions
vii. Develop and coordinate policies and programmes for the infected and affected.
viii. Strengthen other NACC units.

2.7.3 AIDS Control Units

i. Mainstream HIV/AIDS activities.
ii. Coordinate intersectoral advocacy in the ministries/department.
iii. Develop operational objectives and prepare action plans.
iv. Develop MIS to monitor HIV/AIDS programmes in the ministries and departments.
2.7.4 Provincial Aids Control Council (PACCs)

i. Develop guidelines for prevention and control of HIV/AIDS in the province.

ii. Mobilize resources

2.7.5 District Aids Control Committee (DACCs)

i. Mobilize resources

ii. Coordinate and supervise implementation of AIDS activities in the district

iii. Facilitate set up of sectoral AIDS programmes in the district collaborate with others.

iv. Mobilize other stakeholders towards the fight against AIDS.

v. Develop strategies to deal with HIV/AIDS in the district.

vi. Develop and implement MIS for AIDS activities.

3.0 DEPARTMENT OF ADULT EDUCATION

3.1 Brief History of the Department of Adult Education
The Department of Adult Education was established in 1979 to spearhead the presidential directive on eradication of illiteracy. The programme on eradication of illiteracy is part of a package on development strategies aimed at alleviating poverty through the provision of basic needs. The provision of education to adults is important as a vehicle for creating an enlightened human resource and generating self-employment. Adult Education enables adults to acquire knowledge, skills, values and attitudes, which are a prerequisite for meaningful and active participation of the individual in national development. The Department is guided in its work by the Board of Adult Education Act

3.2 The Vision
The vision of DAE is to create a literate, learning and empowered society.

3.3 Mission
The mission of DAE is to eradicate illiteracy and provide Adult and continuing Education for self-reliance and to enhance the contribution towards the social-economic development of the country.

3.4 Mandate
The mandate of DAE is to provide literacy and Adult Education to out-of-school youth and adults, in order to create a well-informed human resource capable of impacting on the country’s sustainable development.
3.5 **Core Functions of DAE**
- To provide Adult, Education and Literacy to both adults and out-of-school youth.
- To coordinate adult and continuing education programmes by performing the functions of the secretariat of the Board of Adult Education.
- To train local manpower for rural development through participatory integrated Development approach.
- To provide community education to address emerging and cross cutting issues including HIV/AIDS education.

3.6 **The main objectives of the Department are to:**
- Eradicate illiteracy among out of school youth and adults by providing them with basic communication and numeracy skills.
- Sustain and promote literacy through post-literacy and continuing education programmes.
- Provide alternative mode of education to out-of-school youth through non-formal education.
- Promote acquisition of relevant knowledge, attitude and skills among adults in order to facilitate their adaptation to new technologies and production skills.
- Promote self-confidence, values and positive behaviour towards society through general adult education programmes.

3.7 **DEPARTMENT RESPONSE TOWARDS HIV/ AIDS**
The department of adult Education mission is to eradicate illiteracy and promote adult education and lifelong learning to out of school youth and adults hence to enable them make informed decisions, become self-reliant and improve their livelihood. Since HIV/AIDS scourge has affected the departments staff establishment and service delivery tremendously it has therefore established Aids Control units up to grass root level which coordinates Aids activities as follows:-

- Mainstream the HIV/AIDS in the programmes
  - i] Incorporated HIV/AIDS trainings on behavior change.
- Co-ordinate several, Advocacy seminars in the department
  - i] Public campaigns through videos shows, counseling to adult teachers & learners.
- Prepare action plans.
  - i] Plan to train 60 headquarters departmental officers.
  - ii] To train 100 field officers on behavior change.
  - iii] To translate HIV/AIDS materials into local languages.
- Mobilization and distribution of information education communication [IEC] staff.
i] Distribution of HIV/AIDS materials to learners.
ii] Distribution of HIV/AIDS materials to teachers.
iii] Distribution of HIV/AIDS materials to officers.

• Co-ordination of trainings for staff on HIV/AIDS and capacity buildings.
• Distigmatisation of HIV/AIDS.

Encourage people to go for VCTs to know their status.
Come up with slogans that educate people to open up.

• Promoting cultural and behavioral change among the departmental staff and community.

  i] wife inheritance
  ii] Circumcision

• Mobilizing departmental staff to play an active role in the fight against HIV/AIDS
  i. participating in Worlds’ AIDS day/Candle Light memorial.
  ii. visiting orphans homes.

• Playing a leadership role in participating in the fight against HIV/AIDS through the World Aids Day/Candle light Memorial.

• Collaboration and networking with other key players in HIV/AIDS control programs Ngos, other Ministeries, Central Bureau Organizations.

• Disseminating accurate information and creating awareness about HIV/AIDS effects to learners, teachers & staff.

  i] Say the truth about the effects of HIV/AIDS.
  ii] Tell them the correct measures they should take; education of safe sex, distribution and use of condoms.

3.7.1 How Department of Adult Education as a key literacy provider empowers communities in the fight against HIV/AIDS.

Response to Short Term issues on HIV/AIDS

While as yet there is no infection, adult education has potentials to:

  i. Provide knowledge that will inform self projection
  ii. Foster development of a personally held, constructive value system.
iii. Install skills that will facilitate self projection
iv. Promote behaviour that will lower infection risks
v. Enhance capacity to help others to protect themselves against risk.

**When infection has occurred, adult education has the potential to:**

i. Strengthen the ability to cope with personnel infection
ii. Strengthen capacity to cope with family infection
iii. Promote caring for those who are infected
iv. Help young people to stand up for the human rights that are threatened by their personal of family HIV/AIDS condition.

v. Reduce stigma, silence, shame and discrimination

**When Aids has brought death.**

i. Assist in coping with grieved loss
ii. Help in the reorganization of life after death of family members
iii. Support the ascertain of personal rights
iv. Right take of medicines

**Response to Long Term issues on HIV/ AIDS**

Adult Education has the potential to:

i. Strengthen and expand preventive and promote health services education institution

ii. Expand and strengthen HIV/AIDS Education throughout the Education system Link HIV/Aids with poverty eradication interventions in preventive management.

iii. Strengthen guidance and counciling to the community.

iv. Produce reader friendly materials.

v. Collaborate and network with other stakeholders involved in HIV/AIDS Eradication.

vi. Disseminate HIV/AIDS materials to community.

vii. Mobilise and sensitize the local communities in linkage with school based interventions.

viii. Promote and strengthen like skills aspects in the curriculum.

x. Create a sound information network on all learning centers and health services.

4.0 ACHIEVEMENTS

1. Mainstream HIV/AIDS activities in our core functions.
   - Incorporated in programmes of training of all officers in the department so as to train to gain skills on HIV/AIDS and train their learners.


3. Establishment of community learning resource centers at the grassroots. (CLRCs) equipped with,
   - HIV/AIDS books are kept there.
   - Condoms male and female.
   - IEC materials on HIV/AIDS.
   - CLRCs is managed by a trained manager.

4. Capacity building
   - Field officers have been trained on HIV/AIDS upto grassroot level.
   - District officers have been trained as TOTs on behavior change.
   - Teachers also have been trained on behavior change.

5. Our officers at the grassroot level are members of Community Aids Control Council (CACC).
   - They act as secretaries of panels.
   - Teachers are members of the panels.

5.0 CHALLENGES

1. Community participation.

   It has been noticed that its not easy to implement HIV/AIDS activities without support of politicians and community leaders.

   Solution; The political and community leaders support can be strengthened by ensuring continuous involvement of politician and community leaders in all aspects of project planning implementation.
2. Workplan and disbursement of funds

There is delay by National Aids Control council to approve the workplan in such cases by the time the work plan has been approved, the training needs may have changed.

5.1 Education materials

1. Lack of guidelines on education materials.
2. Most of the materials are in Kiswahili and English and people at the grassroot level are not conversant with these languages.

Solution: Translation of HIV/AIDS materials into Kiswahili for urban areas and mother tongue for rural communities.

5.2 Community awareness

1. Lack of strategy for developing communication approaches to motivate different need to change their behaviour.

5.3 Resource Centres

2. Resource centers are few and are not in all the districts.

Solution: DAE policy is to expand CLRCs by establishing them in all communities.

5.4 Cultural practice and traditions

Cultural practice hinder the change of attitude towards the epidemic. For example, inheriting of wives, circumcision etc.

Solution: Intensified campaign to educate people on the need/importance of knowing your status.

5.5 Voluntary Counseling and Testing

Many people have not been convinced to go for Voluntary Counseling & Testing (VCT). The VCTs are limited and not accessible at the grassroot level.

5.6 Training programmes/ Activities

DAE in collaboration with MOEST and other stakeholders conduct training programs on