

*Full Length Research Paper*

# **An Assessment of the Policies And Programmes of Zimbabwe in addressing the HIV/Aids Epidemic in the Education Sector**

**Symphorosa Rembe\***

**University of Fort Hare, South Africa**

Accepted 20 September 2006

**This study assessed the policies, strategic plans and structures that have been put in place in Zimbabwe to address the HIV/AIDS epidemic in the education sector. It also examined the comprehensiveness of projects and programmes currently being implemented by the government in collaboration with partner organisations and NGOs. The findings show that the epidemic has had a very adverse impact on the education sector. They also reveal that policies and strategies put in place in this sector have sound and clear aims and objectives particularly in preventing and mitigating the impact of the HIV/AIDS epidemic. Zimbabwe has reduced the prevalence of HIV/AIDS from over 30 per cent to less than 25 per cent. However, there are a number of challenges in the implementation of HIV/AIDS projects and programmes which include, among others: lack of capacity in terms of skills, human and financial resources, lack of proper monitoring and follow up partly due to inadequate staff and transport. Moreover, the prevailing political climate in Zimbabwe has led to some donors withholding funding which is essential for the implementation of current and future programmes to combat the HIV/AIDS epidemic in the education sector.**

**Key Words:** policies and strategic plans, programmes and projects, assessment, prevalence, prevention, mitigating impact, implementation, funding, Education Sector, Zimbabwe.

## **INTRODUCTION**

The HIV/AIDS epidemic is wiping out all the hard won development gains and is affecting adversely the future prospects of many countries in the Sub-Saharan Africa. The latter has the highest HIV prevalence rates in the world (Whiteside and Sunter 2000). The most affected are those in the eastern, central and southern regions (UNAIDS 2002). Studies have estimated the number of infected people in the Southern African region, which is also home to the majority of the Southern African Development Community (SADC) Member States, as 14 million adults and children which is close to 51% of the infections in Africa (Barnett and Whiteside 2002; SADC Human Resources Development Sector 2003). The HIV/AIDS epidemic has had a devastating impact on individuals, families and households; and on the social and economic sectors of the countries in the southern African region (Barnett and Whiteside 2002; SADC Human Resources Development Sector 2003). Education which is the most crucial sector in the production of human capital is among the sectors that have been most

affected by the epidemic in all the countries of the SADC region (Kelly 2000a; UNAIDS 2000; Barnett and Whiteside 2002). Studies have shown that the epidemic is affecting adversely school enrolments, teachers, education costs, quality of education, system management etc. (Kelly 2000a; UNAIDS 2000).

Countries in the southern African region have put in place policies, programmes and other measures to tackle the HIV/AIDS epidemic in the education sector. Zimbabwe is among the countries that have used different strategies to address the epidemic in the education sector. This study assessed the current status of Zimbabwe education sector policies in addressing the HIV/AIDS epidemic. It also examined the comprehensiveness and feasibility of programmes that have been introduced to implement such policies. The main research questions were:

- What are the major aims and objectives of policies and strategic plans that have been put in

- place in the education sector to address the HIV/AIDS epidemic?
- What are the structures that have been in place to enhance the implementation of policies and programmes and how are they functioning?
- Which interventions are being implemented?
- How are the interventions being implemented?
- What challenges are being encountered?
- What makes things happen despite resource constraint?

### Basic facts about Zimbabwe

Zimbabwe is a landlocked country situated in the Southern African subcontinent with an estimated population of 13 875 574, of which 48% are male and 52% female (Central Statistical Office 2000). The 1992 Census revealed that the population growth rate was 3.14%, one among the highest in the world. However, the 1997 Census showed that it had dropped significantly to 2.25% (Central Statistics 2000). Although infant and child mortality rates had dropped by 1988, both rose significantly in 1995 (HIV/AIDS in Education Assessment Team (HEAT) 2002). Life expectancy rose from 55 years to 62 years in 1990 but dropped to 43 years in 1999 (HEAT 2002). The rise in infant and child mortality rates and the decline in life expectancy have been attributed to the HIV/AIDS epidemic (National AIDS Council 2003). Following independence in 1980, there was high expenditure on social services and continuous investment in economic development. However, this changed due to a number of factors. Domestic factors and persistent drought over two years; and also changes in the regional and international economic environment (including the effects of globalisation), have adversely affected the economic development of Zimbabwe (SAfAIDS News 2002).

The political climate in the country remains volatile. The contestation by the main opposition party on the legitimacy of the election and ensuing problems over the government's land reform and redistribution policy have added to the polarisation of Zimbabwean society and affected investor confidence. As a result, the country is facing a political and economic crisis which impacts on growth rates, inflation and levels of government debt. There has been an increase in the level of poverty, with the unemployment rate at over 50% (SAfAIDS News 2002). These factors have impacted negatively on efforts to combat the HIV/AIDS epidemic in the country.

### Education System

Following independence, the Zimbabwe government emphasized education as a tool for social and economic development. It invested heavily in formal and non-formal

education (HEAT 2002). The initial focus was to improve access and participation in education since many of the children had been denied the right to basic education (EFA Assessment Team 2000). Up to 2000, there were massive increases in enrolment with the number of primary schools doubling and that of secondary schools increasing eight fold (Ministry of Education, Sport and Culture (MOESC) 2001). Literacy programmes increased rapidly after independence mainly due to literacy campaigns and support from political leadership (Chisholm et. al.1998; EFA Assessment Team (2000); HEAT 2002). Literacy level in the country rose to 86 per cent making Zimbabwe one of the countries with the highest literacy levels in Africa (EFA Assessment Team (2000); MOESC 2001; HEAT 2002).

A number of measures were taken to make education more relevant to the country's situation which also emphasised quality and equity (HEAT 2002). The school curriculum was overhauled, teaching materials were revised and there was reorientation of teachers. Training programmes were put in place with the aim of producing more qualified teachers (MOESC 2001). Due to economic constraints obtaining in the country in the 1990s, there has been a decline in real education budgets. This led to more emphasis being put on increasing system efficiency and management with decentralisation of many managerial and planning functions to regional, district, cluster and school levels. Community participation and involvement in school management and other activities have been encouraged (EFA 2000 Assessment Team (2000); MOESC 2001; HEAT 2002). However, with the prevailing economic constraints, there has been a decrease in the capacity of communities to provide financial support for school development. The government has also sought assistance from other stakeholders, particularly NGOs, in providing education and training in schools (Chisholm et. al. 1998; MOESC 2001).

There are two ministries that deal with education, namely: the Ministry of Education, Sport and Culture (MOESC) which is responsible for Early Childhood Education and Care, Primary education, Secondary education, Sport and Culture; and the Ministry of Higher and Tertiary Education (MOHTE) which oversees tertiary education (teacher training, technical and vocational education, and university education). The MOHTE is also responsible for developing the non-formal sector (Chisholm et. al. 1998; HEAT 2002).

### Methodology

The study adopted an interpretive qualitative methodology where qualitative multi- methods were used to interpret, understand, explain and bring meaning to attitudes, perceptions and behaviour as discussed by respondents. The methodology was adopted given the fact that the study is assessing the status of HIV/AIDS policies in the education sector and also the comprehensiveness and feasibility of programmes that have been put in place to implement

such policies. It enabled the researcher to obtain people's perceptions, opinions and views on how the HIV/AIDS epidemic is being addressed. Hence, it was possible to get a holistic picture on initiatives and interventions on the epidemic. Qualitative data from primary and secondary sources were collected by using open structured interviews and focus group discussions. Data were also obtained from secondary sources mainly from official and non-official documents. Consequently, the study used a questionnaire to collect quantitative data. The questionnaire required statistics of different groups in the education sector over a number of years in order to measure the impact of the epidemic. Telephonic interviews were held with different respondents to authenticate some of the information collected through other methods.

Data was collected from head offices of different ministries, namely Ministry of Education, Sport and Culture (MOESC); Ministry of Higher and Tertiary Education (MOHTE); Ministry of Health and Child Welfare; and Ministry of Labour and Social Welfare. It was also collected from provincial education offices, National AIDS Council (NAC), teacher organisations, tertiary education institutions, non-governmental organisations (NGOs) which are involved in the implementation of HIV/AIDS programmes in the education sector, community based organisations (CBOs), donor and partner organisations.

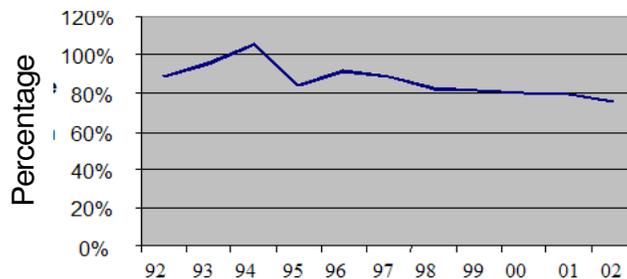
## The Main findings of the Study

### HIV/AIDS Prevalence

The first HIV/AIDS case was identified in Zimbabwe in 1985. Reporting started in 1987 when 119 cases were documented. Since then, the epidemic has spread rapidly, as evidenced by prevalence figures provided by the UNAIDS (2002) and the Zimbabwe Government (2003). The figures have been alarmingly high with a prevalence of over 30 per cent (National AIDS Council 2003). However, the situation changed gradually. According to estimates provided by the National AIDS Council (2003), HIV infection rate among women aged 15 to 24 and men aged 17 and 29 decreased dramatically. These developments have been attributed to a change in behaviour which resulted in reduction of casual sex among adult men and women; delay of first sexual experiences; and increase in condom use. The estimates showed:

- Prevalence of 24.6 per cent in the 15 – 49 age groups.
- An estimated 1.8 million Zimbabweans (out of a population of 11.6 million) living with HIV, and 90 per cent of those infected not aware of their status.
- More than 50 per cent of those infected are women and children;
- The rate of mother to child transmission was 30 – 40 per cent. The number of infected children aged 0–15 years was estimated at 240 000 (12%).
- Of those infected, 600 000 had developed symptoms of AIDS and required varying degrees of care and support;
- About 60 – 70 per cent of deaths of children below the age of five resulted from HIV/AIDS.

More than 70% of AIDS cases are found among adults between the ages of 20 and 49 years (National AIDS Council 2003). This poses a serious problem because this age group represents the highest proportion of economically active individuals, which spells a loss to Zimbabwe of productive years and investment in education and training. It also imposes a burden on families as individuals in the 20–49 year age group raise young children who are likely to become orphaned. The peak ages for HIV/AIDS infection are 20–29 years for females and 30–39 years for males (National AIDS Council 2003). It has been observed that in Zimbabwe, HIV is mainly transmitted through heterosexual contact and mother-to-



**Figure 1.** Percentage of Learner Enrolments by year. **Source:** EMIS, Ministry of Education, Sport and Culture

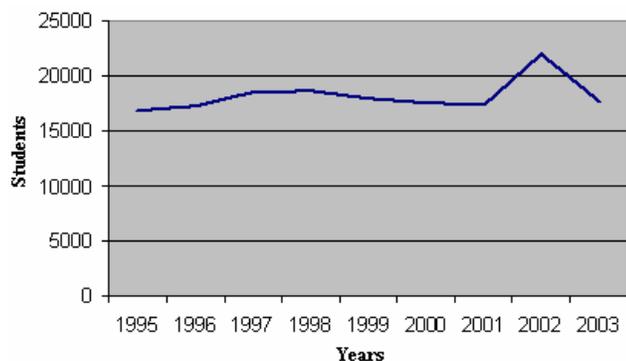
child transmission during and after birth through breastfeeding (Ministry of Health and Child Welfare 2000; Republic of Zimbabwe 1999). Factors that have led to the spread of the epidemic include (National AIDS Council 2003; Ministry of Health and Child Welfare 2000): multiple sexual relationships; a high incidence of sexually transmitted diseases (STDs), which increase the risk of HIV transmission several fold; the high vulnerability of women due to their low socio-economic status and tradition; migrant labour patterns, where a husband lives away from his wife for long periods; and the socio-economic situation and unemployment which force some individuals to practise commercial sex, thereby putting themselves and their partners at risk.

## The Impact of HIV/AIDS on the Education Sector

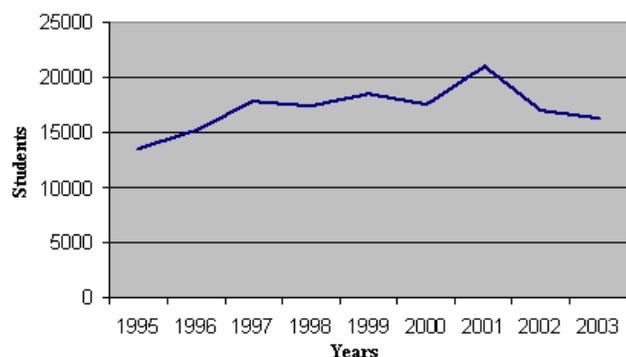
### Impact on Learners

The HIV/AIDS epidemic has had a devastating impact on the economic and social life of Zimbabwe. The epidemic on the education sector was observed by all the respondents in the study. They acknowledged that it has compromised the quality and quantity of education in the country. The epidemic has adversely affected school enrolments, teachers, education managers, college lecturers, education costs, system management etc. Similar situations have also been observed by studies conducted in other countries in sub-Saharan Africa and SADC (Kelly 2000a; UNAIDS 2000). The HIV/AIDS epidemic is likely to lead to a decrease in learner enrolments due to an increase in the number of deaths of infected children and women of child bearing age; some of those infected might opt not to bear children (Kelly 2000a; UNAIDS 2000; Economic Commission for Africa 2000; Barnett and Whiteside 2002). Enrolments are also likely to be affected by the number of orphans who will drop out of school or not attend regularly (Kelly 2000a; Barnett and Whiteside 2002). In Zimbabwe there is evidence of a decline in learner enrolments. According to ECA (2000:7), within a decade, the number of learners of school going age is likely to be 24% lower. Data on primary school enrolment indicates that enrolment reached a peak in 1994, went down and peaked again in 1996, and remained static until 1998 when it started to decline (see Figure 1).

Officials from MOESC confirmed that a similar trend



**Figure 2.** Enrolments in Teachers' Colleges 1995 – 2003.  
**Source:** Ministry of Higher and Tertiary Education



**Figure 3.** Enrolments in Technical and Vocational Colleges 1995 – 2003.

**Source:** Ministry of Higher and Tertiary Education

can be discerned in secondary schools where enrolments have also slowed down since 1998. While these developments might not be attributed entirely to HIV/AIDS, it shows the devastating effects of the epidemic on school enrolments. HEAT report (2002:25) identify other factors which might also have effect on learner enrolment such as the near achievement of universal primary education, low expansion in school provision, poverty and household pressures due to drought and other economic factors. MOESC officials attested that the epidemic has affected school attendance as children are taken out of school to care for sick parents and other relatives. Terminal illness or death of household income earners means that there is less income available in the families to meet their financial obligations. Children might have to stay at home due to lack of school fees or due to the trauma of seeing a family member die. Such children are likely to stay at home because at school, they face a lot of stigma and discrimination (HEAT 2002; MOESC 2002).

Enrolment in teachers' technical and vocational colleges seem to have declined from 2001 (see figure II and figure III).

Figure II indicates that enrolments in teachers colleges reached a peak in 2002 and then showed a decline in 2003. In Figure III, technical and vocational colleges' enrolments reached a peak in 2001 and began to decline in 2002 and 2003. The period of decline in enrolment in both types of colleges is short and it is difficult to draw any conclusions. However, one could not discount the possibility of students pulling out because of either being infected or affected by HIV/AIDS.

One of the effects of the HIV/AIDS epidemic on learners is the experience of being orphaned through the loss of one or both parents. The number of orphans in Zimbabwe has risen rapidly from a small number in 1990 to 150 000 in 1995 and 543 000 in the year 2000. This number is bound to rise dramatically to 910 000 and 1.2 million in the next 5 – 10 years (HEAT 2002; MOESC 2002). The consequence of orphanhood is delayed school enrolment, an increase in the drop-out rate, erratic attendance, lack of concentration and poor performance in school and behaviour disturbances. HEAT report (2002) observed that on the commercial farms, 48 per cent of primary school orphans had dropped out of school due to parents' illness or after death, while 20 per cent of those in secondary schools had dropped out for the same reasons. The same report showed that 13 per cent of children were not able to attend school after the death of adult female member of the household while 76 per cent were absent for close to six months due to lack of financial resources (HEAT 2002). The following problems are encountered by orphans in Zimbabwe which prevent them from continuing with their education (HEAT 2002:33):

- Material needs, including hunger and temporary or longer-term inability to pay for various needs including inability to pay for uniforms, levies, fees and basic materials.
- Psychosocial problems due to stress, grief, stigmatization, neglect and abuse.
- Loss of parental guidance and socialization to reinforce learning and school going and appropriate value systems.
- Greater household responsibilities.
- Loss of longer term vision in favour of short term needs and desires.
- Lack of responsiveness of school to orphans and other vulnerable children needs.
- Perceptions of infection and sometimes stigmatisation and discrimination.

Studies have shown that there is a small percentage of primary and secondary school learners infected with HIV (UNAIDS 2000; MOESC 2002). It is estimated that the infection rate among learners range from 0.05% to 11%; girls from 0 to 18.5%; and boys from 0 to 8% (HEAT 2002:11). MOESC officials indicated that learners become infected with HIV/AIDS through sexual abuse,

**Table 1:** Teacher and school heads deaths and ill-health retirements.

	1999	2000	2001
Teachers – deaths	303	726	807
Teachers – medical retirements	57	306	933
Heads – deaths	7	44	75
Heads – medical retirements	2	14	42
Teachers and heads – total deaths	310	770	882
Teachers and heads – total deaths & medical retirements	369	1090	1857
Total deaths (% of total trained teachers)	0.38	0.91	0.98
Total deaths & medical retirements (% of trained teachers)	0.45	1.29	2.05

Source: HEAT Report (2002:65)

rape, maternal transmission or intergenerational sex. Infection rates among students in tertiary institutions could not be ascertained but it was acknowledged by officials and college management that there is a high infection rate among students, who become more vulnerable particularly during teaching practice. The Policy on HIV/AIDS for Teachers' Colleges acknowledges:

There is need to deal with the problems faced by student teachers during their teaching practice deployment. Financial constraints and exposure to unfavourable environment lead to high risk behaviour.....There is need to address the issue of deployment patterns for students, especially married students, and avoid separation of spouses during teaching practice (MOHTE 2004:5)

Although HIV/AIDS related deaths occur among staff and students but people are not open about it due to stigmatisation and discrimination. There is frequent absenteeism by both staff and students who have to visit or care for terminally ill relatives, and attend funerals. Often sick staff and students withdraw from colleges take long or extended sick leave due to AIDS related illnesses.

### Impact on Teachers and other Education Staff

The HIV/AIDS epidemic has had a devastating effect on the teaching corp, those in education management in different levels and support staff (ECA 2000; Kelly 2000; Hunter 2000). Projections by HEAT (2002:64-65) showed that close to one third of all teachers in Zimbabwe were infected with HIV/AIDS in 2001 and this figure was likely to rise to 40% if there was no behaviour change among teachers and student teachers. Projections by the same report also showed that around 3700 primary and 1800 secondary school teachers had AIDS related illnesses in 2002. Consequently, information on mortality due to HIV/AIDS related illnesses among teachers and school

heads has been provided by HEAT (2002:64) (see Table 1).

While it is difficult to discern a trend due to limited data and short period involved, HEAT (2002) acknowledges that the above information shows that the rate of deaths among teachers and head teachers seems to be high particularly between 2000 and 2001. Consequently, medical retirements for both groups seem to have picked up within the same period. The Report noted, "Death and ill health retirements combined which is probably a more reliable indicator of terminal illness had reached over 2 per cent of teachers in 2001" (HEAT 2002:67). While it might not be possible to draw definite conclusions from the data, such increased trend in the number of deaths and medical retirements among teachers and head teachers could likely be attributed to AIDS. HEAT projected cumulative death toll among teachers as a result of the HIV/AIDS epidemic. The projections estimated that MOESC could lose around 30 000 teachers to AIDS or AIDS- related deaths between 2001 and 2010, and 50 000 between 2002 and 2015. This is an equivalent of 30% and 50% of the current teaching workforce respectively (HEAT 2002:66). While the projections seem to be alarmingly high, it is evident that the education system needs to put high priority in identifying and implementing strategies that will enable it to sustain itself as a functioning entity.

There have been negative effects on the education system in Zimbabwe as a result of HIV/AIDS infected and affected teachers and other Ministry staff. There has been a high level of absenteeism among infected teachers and other Ministry staff due to frequent illness. Absenteeism was also attributed to attendance to funerals and other family issues including taking care of terminally sick relatives and spouses. Women were more affected as most times they are the ones who take care of the sick at home. Absenteeism by teachers disrupts learning and undermines the provision of quality education. In case of absenteeism in schools, colleagues stand in for the absent teacher's class. This means extra workload which puts a lot of pressure, anxiety and stress on schools, and on teachers who are required to produce good results.

In cases of prolonged absence, the Ministry employs temporary teachers. This is a measure that has been put in place by the Ministry. Temporary teachers are paid by the government and they stay in place until absent teachers resume work or until vacant positions are filled. Many of them are inexperienced and unqualified particularly those in rural schools. They also require mentoring and supervision which places additional burden and responsibilities on experienced teachers. Proper mentoring and supervision is essential in order to maintain quality teaching. Due to delays in the recruitment process, there is a high turnover of temporary teachers due to low pay and lack of other types of incentives and mechanisms to retain them. This aspect was also raised in the HEAT report (2002:87) which suggested “a more structured career development path towards permanent positions for temporary teachers; creation of greater opportunities to participate in in-service training; and changes in remuneration”.

Prolonged absenteeism by other Ministry staff makes the work of managing the education system difficult. Both Ministries of Education do not have a proper system in place for the replacement of national, provincial and other senior officials. As in most other countries in the Sub-Saharan Africa, the majority of senior officials hold their posts by virtue of their seniority or the experience gained through serving different ranks. According to HEAT (2002), disruptions are likely to occur if key managers and specialists are absent or die, as key decisions may be delayed. It was observed that many of the teachers and other Ministry staff who are very sick continue working for fear of stigma and discrimination and also for low terminal benefits which might not be adequate to sustain them. Having sick teachers and other Ministry staff in schools and working places put a lot of stress on colleagues and learners who are unable to assist them. Moreover, there is an imbalance in the distribution of teachers in different areas in the country. This is attributed to some teachers and other staff having to move to urban areas to look for better treatment and medical services while others who are very sick opt to go back to their homes in the rural areas to be cared for by relatives. As a consequence, some areas in the country have experienced severe shortage of teachers. Therefore, the above discussions show that in Zimbabwe like in many other Sub-Sahara African countries, the HIV/AIDS epidemic has adversely affected the education system and the provision of education.

### **Response to the HIV/AIDS epidemic: National and Education Sector Levels**

The government of Zimbabwe has addressed the epidemic by putting in place short and long term measures. Among the measures are policies, strategic plans, programmes, structures and the deployment of different types of resources at the national and education

sector levels. Other stakeholders such as NGOs, organs of civil society, donors and development partners have also participated in the fight against HIV/AIDS and significantly complemented government's efforts in this regard. Informed and committed leadership are among the crucial factors in addressing the HIV/AIDS epidemic. In the initial stages of the epidemic in Zimbabwe, political commitment to publicly acknowledge the problem and take steps to respond positively was patchy and sporadic. There was a denial by the political leadership and, like in many other African countries, the HIV/AIDS epidemic was treated as a health problem and it became the responsibility of the Ministry of Health (MOESC 2002; HEAT 2002; Republic of Zimbabwe 1999). This was evident in the first seven years when the government introduced the Short Term Emergency Plan (1987 to 1988) and the first Medium Term Plan (1988 to 1993). The two put more emphasis on limiting the transmission of HIV and other sexually transmitted diseases and mitigating the medical and psychological effects of the epidemic. The National AIDS Coordination Programme (NACP) which was established during that period to lead national efforts for HIV/AIDS prevention, control, care, and impact mitigation had showed deficiencies in the coordination of responses (Republic of Zimbabwe 1999).

The initial response to the HIV/AIDS epidemic was haphazard, un-coordinated and lacked a central focus, with each agency doing its own thing. There was bias towards urban areas while rural areas were ignored. This was acknowledged in the second Medium Term Plan (1994 to 1998) where a review in 1998 showed how the HIV/AIDS epidemic was decimating a high percentage of the population and wiping out the country's gains of many years. The outcome led to establishment of concrete measures by political leaders and government officials to address the epidemic. Some of the measures included the establishment of the National AIDS Council (NAC) and the National AIDS Trust Fund; the development of national HIV/AIDS policy and HIV/AIDS strategic framework; the establishment of decentralised management structures in all levels; and the adoption of a multi-sectoral approach where partners, organisations and stakeholders inside and outside the government worked together to plan and implement HIV/AIDS programmes in a collaborative and coordinated manner (Republic of Zimbabwe 1999). A Cabinet Committee on social services with an AIDS sub-committee was established. The Chairman and Director of the NAC Secretariat are ex-officio members of the Cabinet Committee.

### **The National HIV/AIDS Policy and the National HIV/AIDS Strategic Framework**

The National HIV/AIDS Policy and the National HIV/AIDS Strategic Framework were developed in 1999 in a highly consultative way. Consultations were made at national,

provincial, district and sectoral levels where different groups, individuals and organisations were able to make their own submissions (Republic of Zimbabwe 1999). The Policy is intended to promote and guide current and future responses to AIDS in Zimbabwe. The policy document states that as the “epidemic develops and more experience is gained some policies may need to be revised in accordance with prevailing circumstances” (Republic of Zimbabwe 1999:2). The National HIV/AIDS Policy deals comprehensively with different aspects of prevention, care, support and research. It also defines the human rights of people living with HIV/AIDS. The Policy is guided by the following underlying principles (Republic of Zimbabwe 1999:2):

- HIV/AIDS is a serious public health, social and economic problem affecting the whole country, and therefore, it has to be addressed as a major priority through appropriate individual and collective action;
  - Information and behaviour change are the cornerstones for the prevention and control of HIV/AIDS;
  - Human rights and dignity of all people irrespective of their HIV status should be respected; avoidance of discrimination against people with HIV/AIDS should be promoted;
  - Provision of care and counselling is essential in order to minimize the personal and social impact of HIV/AIDS;
  - Sensitivity to gender and commitment to promoting gender equality should be integrated into the different policies;
  - Research should be an integral part of the effort to combat HIV/AIDS;
  - A supportive environment at every level of society will enhance the response to HIV/AIDS by individuals, families and communities;
  - An appropriate National AIDS Coordination and Advocacy Framework is essential to oversee further policy development, implementation and coordination.
- Prevention of HIV/AIDS for those not yet affected through IEC and reduction of vulnerability and susceptibility. This includes promotion of awareness and greater empowerments of their social economic conditions to enable them enhance their human condition and overcome vulnerability.
  - Mitigating the impact of HIV/AIDS through provision of cost effective care and support for the affected and their families.
  - Promoting research as the basis for policy and programme design and development;
  - Ensuring that long-term sustainability is an integral part of the HIV/AIDS projects and programmes.
  - Making advocacy and lobbying the main tool for influencing policy change in all sectors. This entails information dissemination, promotion of dialogue and debate through different fora, showcasing best practices and achievements, documentation of processes and information etc.
  - Ensuring that all strategies are in compliance with the guiding principles of the National Policy on HIV/AIDS.

However, NGOs and CBOs claimed that the process of policy formulation was dominated by experts and academics who only consulted on the final stages when decisions had already been made.

The National HIV/AIDS Strategic Framework set out frameworks for action in terms of prevention, mitigation through care and support, reduction of negative economic impacts from household to societal level, improvement of management of the national response, resource mobilization and other ways of strengthening implementation. Among the key strategies for the Framework are (Republic of Zimbabwe 1999:29):

The Strategic Framework also outlines strategies to promote prevention; strategies to promote mitigation by caring and supporting the affected; strategies to reduce negative economic impact; strategies to improve the management of the national response; and strategies for resource mobilisation. Labour Relations (HIV/AIDS) Regulations developed under the Statutory Instrument 202 of 1998 stipulate the rights and responsibilities of both employers and employees with regards to the prevention and management of HIV/AIDS and its consequences at the work place.

Implementation of the policy and strategic plan is ongoing and there is multi-sectoral involvement of sector ministries, private sector, churches, academic institutions, NGOs, CBOs, development partners and other stakeholders. There is also a very strong community involvement through existing socio-political structures and traditional leaders. Both the HIV/AIDS Policy and the Strategic Plan have clearly outlined goals and objectives. They also outline clearly how different components are going to be implemented in order to achieve the stated goals and objectives. While they recognise the importance of addressing gender needs and those vulnerable groups, incorporation and mainstreaming of these aspects in all programmes have proved difficult partly due to lack of necessary skills and capacity. In cases where these aspects have been integrated or mainstreamed in policies, there is lack of effective implementation. The government has put structures in all levels to enable effective implementation of the policy and strategic plan. Among the structures are the National AIDS Council (NAC) and the National AIDS Trust Fund.

### **The National AIDS Council (NAC)**

The national response to HIV/AIDS is spearheaded by the multi-sectoral National AIDS Council (NAC) made up of government ministries and departments, the private sector, NGOs, churches, communities, community-based organizations, support groups for people living with HIV/AIDS, media and international collaborating partners (Republic of Zimbabwe 1999). The responsibility of the NAC is to “provide overall leadership, policy direction, guidance and co-ordination to the material response to HIV/AIDS; and ensure effective social and resource mobilization to combat the epidemic” (Republic of Zimbabwe, 1999:19). The coordination process is done through decentralised structures that include Provincial AIDS Action Committee (PAAC), District AIDS Action Committees (DAACs), Ward AIDS Action Committees (WAACs) and Village AIDS Action Committees. The country is divided into ten provinces with a NAC office in every province to provide technical support to HIV/AIDS responses by districts, wards and villages. In total, there are 84 districts in both rural and urban areas of the country.

However, NGOs and other organs of civil society have expressed concern that the efforts of the NAC, although commendable, have neither been comprehensive enough nor engaged and included all civil society actors. Hatendi observes:

Policy awareness and availability is generally limited, patchy and varied among NGOs. There exist weak policy advocacy, dissemination and distribution strategies. NGOs continue to implement HIV/AIDS prevention, care, and control and mitigation activities without following national guidelines due to limited awareness of their existence and poor document advocacy. Though the policy was generally perceived as an important document and milestone in the Zimbabwe government’s commitment to HIV/AIDS, little has been done to popularise and enhance its use. There exists poor capacities among civil society to engage in HIV/AIDS programming, thus only the traditional players (health-related NGOs) are implementing the policy, albeit in a fragmented and uncoordinated manner.

NGOs expressed the need for increased mainstreaming and incorporation of HIV/AIDS in existing programmes. It is viewed that the planning and implementation of most of the measures to address the epidemic has been “top down”, undertaken with limited consultation, participation and involvement of key civil society stakeholders. This view is also confirmed by Hatendi; 2001 who states:

Civil society ownership of the policy is low, with unclear NGO-specified and responsibilities in the

implementation process. Findings also reflected the low participation by NGOs in District AIDS Action Committees, due to limited NGO knowledge and therefore their poor participation in the District policy implementation planning processes.

However, Zimbabwe AIDS Network (ZAN) a non-profit national network of NGOs that deal with implementation of different HIV/AIDS interventions and programmes asserted that the situation is gradually improving although it is likely to worsen given the current prevailing economic and political climate. More NGOs and other organs of civil society have been included in the provincial and district structures. ZAN has provincial chapters in all the ten provinces with representations on some of the structures of NAC, namely, provincial and district AIDS Action Committees. The measure enhances participation of NGOs, CBOs and other organs of civil society in making decisions on planning and implementation of HIV/AIDS programmes and projects.

### **The National AIDS Trust Fund**

Since 1999 the government established a National AIDS Trust Fund to provide funds for different components of HIV/AIDS programmes. The Fund provides national financial support primarily from an AIDS levy introduced in 1999 through an Act of Parliament (NAC 2003; HEAT 2002). Individuals and companies in Zimbabwe pay 3 per cent of their incomes to National AIDS Trust Fund (NAC 2003). The Fund is administered and disbursed by the NAC Board. District AIDS Coordinator coordinates district interventions. The different committees at all levels are of a multi-sectoral composition reflective of the national board. Districts and wards are assisted through the committees to develop action plans that are informed by the district specific situation analysis and identified key challenges to address HIV/AIDS. The districts implement HIV/AIDS interventions with the support of the National AIDS Trust Fund.

By 2003, NAC had collected an amount of 8 billion Zimbabwe dollars since the National AIDS Trust Fund was set in January 2000. It had disbursed over 4 billion Zimbabwe dollars from the Fund to various communities, sector ministries and NGOs to support HIV/AIDS programmes. It had also disbursed over 100 million Zimbabwe dollars to NGOs working in HIV/AIDS programmes (NAC 2003). However, there are challenges in these efforts. First, given the high inflation rate and the existing economic situation, it may not be possible to raise the required amount of funding through the National AIDS Trust Fund. It was observed that the amount raised since the inception of the Fund was not adequate to address the HIV/AIDS epidemic (NAC 2003). Second, the criteria adopted to determine allocations disadvantaged other groups in terms of their geographic coverage and

levels of need. Financial assistance was approved on the basis of the ability to write project proposals and access information. It was discovered that most grass root communities who should also have benefited were left out because they could not meet the stipulated criteria. Hence, in order to address the problem the NAC opted to disburse the funds through the 84 rural and urban districts in the country. From 2001, the focus shifted to community based district action programme which focused on HIV/AIDS prevention, care and support, impact mitigation and research. District AIDS Action Committees developed plans which became the basis for allocation of funds from the National AIDS Trust Fund and resources secured by districts from other sources. Funds allocated were used for prevention programmes and mitigation focused activities conducted by Ministries, NGOs, CBOs, faith based organisations (FBOs), communities and other stakeholders.

The NAC has been able to function because of the assistance from the UNAIDS and other UN agencies. This has enhanced and strengthened the Council and has also facilitated the harmonisation and effective coordination of the national response. However, the functioning of the Council still faces a number of limitations. The demand for funds is too high and many times, people who are in most need are not covered. It is also evident that the amount of funds raised through the National AIDS Trust Fund is very little, given the fact that the value of Zimbabwe dollar has depreciated significantly coupled with high inflation rate. However, some NGOs and CBOs complement the efforts of the NAC by soliciting funding from donors within and outside the country. Outside funding has facilitated the implementation of programmes that would have otherwise not been possible due to lack of financial assistance from the NAC. However, the deteriorating political situation in Zimbabwe is likely to undermine efforts aimed at controlling HIV/AIDS as donors and funding agencies of some of the programmes withdraw their financial support.

Inefficiencies and other inhibiting factors have resulted in delays in the disbursement of funds by the NAC. One is lack of communication and proper information regarding fund operations. Some NGOs and CBOs have failed to submit proposals for funding to the NAC because of not being conversant with application procedures and deadlines for submissions. Lack of proper follow up and monitoring of the use of disbursed funds has also been identified as a weakness. Due to lack of capacity and skilled human resources, the monitoring process has been *ad hoc* and haphazard without proper coordination. Response to the HIV/AIDS epidemic at the national level has set precedents and guidelines which have been adopted at the sectoral levels. The following findings identify the response to the epidemic by the Education Sector.

### **Response to the HIV/AIDS epidemic: Education Sector**

In the initial stages of the epidemic, the response within the education sector was fragmented as different actors, namely, the two Ministries (MOESC and MOHTE), local authorities, NGOs and CBOs, local communities, donor community, universities and research institutions acted without a clear formalized framework (Republic of Zimbabwe 1999). Senior management officials in both Ministries were not informed properly and they underestimated the magnitude of the epidemic and how it was destroying the education system in the country. Lack of political will and commitment to take urgent measures to address the epidemic was also evident (MOESC 2001; HEAT 2002). However, the devastating effects of the epidemic became manifest when an impact assessment of HIV/AIDS on the education sector that was funded by DFID was conducted in 2002. The outcome of the study alarmed politicians, senior education officials, NGOs and international agency staff who became informed of the magnitude of the epidemic and its impact on the education sector (NAC 2003). As a result, they also initiated different measures to address the epidemic (HEAT 2002; MOESC 2002; MOHTE 2004).

Among the measures taken are: the development of sectoral policies and strategic plans to reduce the prevalence of HIV/AIDS and mitigate the impact of the epidemic; the establishment of management structures responsible for planning, managing, coordinating and providing support and a range of other HIV/AIDS related responsibilities; working in liaison with Zimbabwe development partners, international organisations, bilateral organisations, government Ministries, NGOs, CBOs and other organs of civil society to implement activities and programmes and provide support in HIV/AIDS interventions in the education sector; provide financial resources to fight the epidemic. The major sources of funding for HIV/AIDS programmes and interventions have been the AIDS Trust Fund through the NAC and donors from within and outside the country.

### **Development of Sectoral Policies and Strategic Plans**

The response of both ministries to the HIV/AIDS epidemic forms part of the overall national response which is "to reduce the incidence of HIV, AIDS and STD in the general population and mitigate the impact of the epidemic" (Republic of Zimbabwe 1999:2). Both MOESC and MOHTE have developed policies and strategic plans that have incorporated the main aspects outlined in the National HIV/AIDS Policy and the National HIV/AIDS Strategic Framework. Strategic plans which outline priority areas, interventions and the programmes that are to be implemented. MOHTE has a sectoral HIV/AIDS policy while MOESC was developing its policy in 2005

when data for this study was being collected. However, both ministries inform schools, regional and district offices about policy issues on HIV/AIDS by issuing circulars and directives. Like the National HIV/AIDS Policy and National HIV/AIDS Strategic Plan, the development of MOESC and MOHTE strategic plans, and MOHTE HIV/AIDS policy for tertiary institutions, entailed extensive discussions and consultations with different stakeholders. The following section looks at MOESC strategic plan and MOHTE HIV/AIDS sectoral policy.

### **MOESC HIV/AIDS and Life Skills Education Strategic Plan (2002 – 2006)**

MOESC outlined the strategic goals and objectives of the HIV/AIDS and Life Skills Education Strategic Plan as to (MOESC 2002:6):

- effectively coordinate the response of the education sector to the HIV/AIDS epidemic;
- provide up to date and relevant information on prevention, impact mitigation, care and support to children (including orphans, street children and those with disabilities), youth and adults that instil values and attitudes leading to positive behaviour change and a reduction in the incidence of HIV/AIDS and STIs;
- contribute to the reduction of the incidence and prevalence of HIV among MOESC personnel, students, pupils and the youth;
- strengthen the management and mitigation of the impact of the epidemic on individuals particularly children (orphans and vulnerable children), youth and MOESC personnel;
- establish school-community partnership in HIV/AIDS education, prevention and care; wwwstrengthen capacity building and support initiatives with a view to strengthen HIV/AIDS prevention and impact mitigation in the MOESC;
- effectively monitor and evaluate the MOESC's response to the HIV/AIDS epidemic.

The strategic plan outlines priority target groups for the response as children of primary school age, orphans, out of school youth, teenage girls, secondary school students, teachers and other service providers of education and professional, management and support staff. It also includes communities where learners live or stay. MOHTE strategic plan identifies priority groups as all tertiary students - these include student teachers or teacher trainees, technical and vocational college students, university students etc., college lecturers,

management and support staff and other providers and families and communities where students live. MOESC identifies the following priority strategies and interventions that will be pursued in order to achieve the stated goals, namely (MOESC 2002: 9-10):

- Education awareness and sustainable behaviour change;
- Impact mitigation;
- Resource mobilisation;
- Co-ordination;
- Institutional strengthening and management support;
- Monitoring and evaluation.

The above priority strategies and interventions are currently being implemented. However, concerns were raised over the lack of integration and mainstreaming of gender and poverty issues in most HIV/AIDS programmes and activities outlined in the strategic plans and policies. The need for understanding and addressing the issue of gender in HIV/AIDS policies and programmes was raised in a report by the National AIDS Council, the National AIDS Trust Fund and the Zimbabwe Women's Resource Centre and Network (2003). Discussions with officials from the Ministry revealed that circulars giving directives on HIV/AIDS policies are sent from the head office to provinces and then to districts and schools. However, at times the information does not flow smoothly mainly due to inadequate financial resources. This also affects proper implementation of the HIV/AIDS policies.

### **MOHTE HIV/AIDS Policy**

The objectives of MOHTE policy as outlined in policy document are (MOHTE 2004:7):

- To provide a standard framework and guidelines which colleges and institutions of higher learning can use in the implementation of HIV/AIDS programs;
- To prevent new infection and the spread of HIV/AIDS by encouraging responsible behaviour;
- To care and support the infected and affected and empower them with skills to cope with their lives.
- To ensure that structures and a conducive and supportive environment exists in all colleges to assist and empower those infected and affected;
- To train and equip students and staff with accurate and up to date information on HIV/AIDS and offer in-service training for those who have not received HIV/AIDS training at college;
- To produce peer educators, trainers and volunteers who are adequately equipped with

- relevant and up to date knowledge and skills to carry out duties in outreach programs in the communities;
- To ensure that gender issues are mainstreamed in the implementation of the college HIV/AIDS programs;
- To empower colleges to establish strategic partnerships and linkages to enhance HIV/AIDS program implementation.

The policy includes the following components: incorporation of the HIV/AIDS programme into professional training and other activities within all the departments at the college (professional training, sport and recreation as part of HIV/AIDS awareness programme); formulation of programmes for prevention, care, and support in colleges; the rights and responsibilities of members of the college community affected by or living with HIV/AIDS, gender and HIV/AIDS and linking and collaborating with other stakeholders (MOHTE 2004:7). The aim of MOHTE policy is to enable colleges produce graduates who are adequately trained and skilled to provide support to learners and members of the community who are infected and affected with HIV/AIDS; and in addition, to manage responses to the new challenges that HIV/AIDS puts on the education sector. It identifies programs that have to be implemented in the colleges for prevention and care including treatment and provision of anti-retroviral drugs, and support for management, academic and non-academic staff and students.

Like the national HIV/AIDS Policy and the Strategic Plan, both the HIV/AIDS strategic plans of MOESC and MOHTE and the HIV/AIDS policy of MOHTE have clearly outlined goals and objectives, and beneficiary target groups. The development of HIV/AIDS strategic plans by both Ministries and the need for their implementation led to the establishment of HIV/AIDS management structures. These include a secretariat and coordinators to steer the implementation of the plans. The following section discusses the findings on the HIV/AIDS organisational and management structures in the education sector in Zimbabwe.

## **HIV/AIDS Coordinating and Management Structures**

### **The MOESC HIV/AIDS Management Structures**

The MOESC established HIV/AIDS Secretariat in 1999 to plan, coordinate, manage and provide technical support in the educational sector response to the epidemic. The HIV/AIDS Secretariat exists as a separate unit under the Research, Planning and Development Division of the MOESC. It has a National Coordinator and two assistant National Coordinators; one responsible for technical matters, namely, planning and facilitation of programmes

and activities, and the other for administration and finance. The Secretariat reaches out to provincial, district and school levels through provincial and district coordinators. There are HIV/AIDS provincial coordinators at provincial level; HIV/AIDS district coordinators at the district level; HIV/AIDS cluster trainers where a number of neighbouring schools are grouped together in a district; and head teachers as coordinators at school level.

Provinces supervise and coordinate the implementation of HIV/AIDS programmes and activities which take place at the district levels, in the clusters and also at school level. Provincial teams together with the HIV/AIDS Secretariat plan their annual activities at the beginning of each year. Provincial teams go back to their work places to implement the programmes. Due to lack of capacity in terms of adequate numbers of people and expertise, provincial teams are assisted in the implementation of programmes by NGOs and CBOs. The functioning of the Secretariat depends heavily on technical assistance provided by UNICEF and UNESCO. Both organisations have provided a lot of assistance in drawing out the HIV/AIDS and Life Skills Education Strategic Plan (2002 – 2006) and a five year work plan (2002 – 2006); writing proposals and raising funds from outside donors; securing computers and vehicles for head office, the provinces and some of the districts.

The Secretariat monitors the implementation of activities through reports which are submitted by provincial coordinators each month and once a term. Respondents viewed that relying on reports only is not adequate; there is a need for field visits to authenticate some of the reports. However, this has not been feasible due to inadequate staff and transport and also shortage of fuel.

### **MOHTE HIV/AIDS Structures**

MOHTE does not have HIV/AIDS committee nor a full-fledged Secretariat but two members of staff who are charged with the responsibility of coordinating HIV/AIDS programmes and activities in tertiary institutions. One staff member is responsible for coordinating HIV/AIDS in teachers' colleges and another is in charge of technical and vocational institutions. Both coordinators are under the Manpower Planning and Development Division of MOHTE. Their main responsibility is planning, coordinating, managing and monitoring of HIV/AIDS programmes and activities at tertiary education level (teachers' colleges and technical and vocational institutions). Implementation of programmes and activities entails collaboration with other Ministries, NGOs, other stakeholders and donors. The two coordinators at the head office communicate directly with teachers' colleges and technical institutions. Individual institutions have departments which are responsible for teaching the HIV/AIDS programme. They are also charged with the responsibility of coordinating HIV/AIDS programmes in

the institutions. UNESCO provided technical assistance in developing the Strategic Plan and the HIV/AIDS Policy. It also assists with drawing proposals and raising funds from donors outside the country.

### **Challenges experienced by the Management Structures**

The major challenge by both Ministries has been inadequate capacity of the structures in terms of the number of staff and expertise. MOESC and MOHTE have attempted to build the capacity of the Secretariat and coordinators at the national, provincial and district levels by taking them through training in the use of computers and HIV/AIDS and Life Skills, but the training has been inadequate. This was attributed largely to lack of financial resources as well as increased staff turnover as those trained and skilled left for better paid jobs in organisations within and outside the country. The situation has also been aggravated by the deteriorating political climate in the country. This has affected continuity and effective implementation of activities.

Lack of financial resources was identified as a very serious problem. Management structures in both ministries depend entirely on donor funds and very limited finances from the NAC for the operational costs as well as implementation of programmes and activities. Inadequate transport and fuel shortage has been another challenge as it has hampered implementation of HIV/AIDS programmes and effective monitoring and evaluation, particularly in the remote rural areas. It has also been difficult to run and maintain vehicles donated by organizations such as UNICEF largely due to the economic problems facing the country. Besides the HIV/AIDS units in both Ministries, there are no HIV/AIDS committees and no focal persons in different directorates of the Ministries. Since the management structures in both ministries are functioning as separate entities, there has not been serious commitment by other directorates or departments of ministries to take responsibilities in driving the process. Addressing the HIV/AIDS epidemic has been seen by other departments or directorates of both ministries as the responsibility of the small management structures of both ministries and not as a collaborative effort.

Coordinating structures in the two Ministries have received a lot of assistance from UNICEF and UNESCO. There are personnel assigned from both organisations to work with the management structures in both Ministries to write proposals, develop programmes and to solicit funding. However, there is heavy dependence on NGOs in implementation of the HIV/AIDS programmes and activities in the education sector. Both Ministries enlist the support of NGOs in the implementation of the HIV/AIDS programmes because many of the NGOs have the necessary financial resources and expertise on

HIV/AIDS. It is this collaboration that has enabled the Secretariat in MOESC and coordinators in MOHTE to function despite financial and capacity constraints.

### **HIV/AIDS Interventions and Programmes**

Planning and implementation of the HIV/AIDS activities and programmes is done by MOESC and MOHTE in collaboration with other ministries, NGOs, teacher organisations, donor agencies and development partners. Some of the donors and development partners include UNESCO, UNICEF, UNAIDS, WHO, UNDP, UNFPA, World Food Programme, the Royal Netherlands Embassy, SIDA, World Bank and ILO. There are close to 100 NGOs and other organisations of civil society that are running some of MOESC and MOHTE planned and coordinated HIV/AIDS programmes. Many NGOs have the capacity, finances and the flexibility to respond quickly to various local requests for assistance in dealing with HIV/AIDS. Implementation of most HIV/AIDS programmes in MOESC takes place at the district level with training being done by provincial coordinators, district coordinators and district trainers working with NGOs and other ministries. Since most provincial teams do not have adequate capacity and financial resources to cover all areas, they rely heavily on NGOs on areas that are not readily reached by MOESC which are mostly in the rural areas. Implementation of MOHTE programmes take place at college level. It is also done in collaboration with NGOs and other ministries.

Most programmes in both ministries are intended to raise awareness on HIV/AIDS and to bring about sustainable behaviour change. The programmes cover teaching HIV/AIDS and Life Skills Education in all colleges, secondary and primary schools; training teachers and lecturers in HIV/AIDS to enable them to impart knowledge on learners and students and also understand how the epidemic affect them as individuals; provision of awareness sessions and training programmes for MOESC and MOHTE staff; provision of awareness sessions to communities, parents and out of school youth; and training peer educators. There are also programmes geared towards mitigating the impact of the epidemic on both MOESC and MOHTE personnel as well as learners and students. Other activities include: sensitisation of senior Ministry officials on HIV/AIDS; training teachers and lecturers on counselling; establishment of peer counsellors; provision of assistance to orphans to enable them acquire education; and development of service conditions and human resources sensitive to HIV/AIDS. UNICEF and UNESCO as development partners play a very dominant role in response to the HIV/AIDS epidemic in the education sector in Zimbabwe. Both Ministries rely heavily on both organisations to provide assistance in different areas to enable them address the epidemic. Among the areas

they have played a major role include: planning and development of HIV/AIDS policies; strategic plans and work plans at ministerial and institutional levels; setting up HIV/AIDS Secretariat; raising funds for different activities and programmes; production of HIV/AIDS materials for schools, colleges, ministerial head offices and communities; putting in place mechanisms for monitoring and tracking the impact of the epidemic.

There was a feeling among NGOs that both Ministries do not have a clear understanding of the epidemic and what their exact roles should be. The respondents observed that the Ministries hardly come up with their own programmes and solutions. Most of the activities and programmes come from NGOs and development partners. This was also the feeling held by some respondents from partner organisations. Heavy reliance on development partners, NGOs and other organs of the civil society could be one of the factors which enhance implementation of some of the HIV/AIDS activities and programmes despite the prevailing financial constraints in the country.

### **Implementation of HIV/AIDS Programmes that address Prevention**

Data collected in this study showed that the major interventions that are being implemented by MOESC and MOHTE are on programme prevention aimed at reduction of the incidence of HIV and mitigation of the impact of the HIV/AIDS epidemic. The specific programmes being implemented by these two Ministries are described below:

#### **Prevention Programmes for Learners Implemented by MOESC**

MOESC introduced HIV/AIDS and Life Skills Education in schools as part of the curriculum in 1992. Life Skills teaching on HIV/AIDS became compulsory for Grade 4 to Form 6 in 1993 and had to be formally timetabled. For Grades 1-3, HIV/AIDS is offered as part of Social Studies. Schools are required to allocate at least one period per week for teaching and learning of HIV/AIDS and Life Skills Education. Schools are also encouraged to integrate HIV/AIDS education in other subjects whenever opportunities arise. Materials have been developed by the Ministry in collaboration with NGOs to provide support for teachers. The HIV/AIDS Secretariat is overseeing the implementation of the programme. In 1998, the HIV/AIDS and Life Skills Education was reviewed and it was found to have the following weaknesses:

- There was little participation of children and youth in the assessment, analysis and implementation of the programme.

- Cascade approaches were adopted for training where few teachers were chosen and received training and they in turn, trained others in schools. The strategy was disappointing because the required information was not transmitted properly and it failed to equip teachers with the requisite skills.
- Basic information on HIV/AIDS for teachers was not emphasized and this resulted in apathy among teachers.
- Teachers needed counselling skills to assist children and other teachers where necessary.
- Adequate coordination and networking with all organisations working with in-school youth needed strengthening.
- There was lack of a link between formal and non-formal education.

Consequently HEAT (2002:24-25) identified the following additional weaknesses in the implementation of the programme:

- Schools did not take teaching HIV/AIDS seriously as the teachers selected to teach Life Skills and HIV/AIDS were surplus or inexperienced teachers who did not have subjects to teach in the schools. Many of them were newly qualified teachers who lacked sufficient experience.
- HIV/AIDS and Life Skills Education was not being taken seriously because it is not an examinable subject. In some cases it is not being taught despite the fact that it is included on the timetable. In other schools it was not even included on the timetable.
- Many teachers could not handle the sensitive issues of HIV/AIDS and they avoided engaging pupils on the subject.
- Teachers were supposed to act as role models and yet some had sexual relationships with pupils.

MOESC has since produced a syllabus on HIV/AIDS and Life Skills Education, textbooks, and made the subject of HIV/AIDS examinable. It will also receive time allocation on the timetable as any other subjects. Implementation of the new syllabus was expected to take place in 2005/2006.

#### **Capacity Development for HIV/AIDS and Life Skills Education Implementers**

Capacity development of educators is seen by MOESC as one of the most essential aspects for the successful implementation of the HIV/AIDS and Life Skills Education programme. Hence, in-service training workshops have been conducted for provincial and district education

officers, heads and deputy heads of schools, teachers and SDC/SDA representatives. As stated above, when the programme started teachers involved received two days' training. The training was reviewed in 1998, after which strategies for training workshops were changed. The cascade approaches of training were abandoned and the numbers of days of training were increased. Provincial teams and NGOs conducted all the training. Training workshops for heads and deputy heads of schools, teachers and SDC/SDA representatives currently take place at district and cluster levels as follows:

**Training of district cluster teachers:** These teachers trained by provincial teams and NGOs are trainers for different clusters of schools. They are supposed to train teachers in their clusters on how to handle or integrate HIV/AIDS within the curriculum and also on participatory methods of teaching HIV/AIDS. District cluster teachers receive five days training where three days are devoted to acquiring thorough knowledge on HIV/AIDS awareness; how HIV/AIDS affect teachers as individuals; and the impact of HIV/AIDS on communities and them as individuals. Two days are used to train teachers on using participatory methodology as a teaching strategy. MOESC defines participatory methodology as "the process in which various groups are involved in identifying their own problems, discussing solutions, planning and carrying out effective action programmes" (MOESC 2003:2).

**Training of heads and deputy heads of schools:** The training is intended to enable school heads to impart knowledge and understanding of issues related to HIV/AIDS in their schools. It is also intended to enable them to coordinate HIV/AIDS training in their schools.

**Training teachers in counselling skills:** Training of teachers in counselling skills is expected to enable schools to provide support to learners and teachers infected and affected by HIV/AIDS. MOESC is trying to have a trained counsellor in every school.

**Community sensitisation programmes:** MOESC realizes that there are attitudes, social and economic factors that undermine prevention and behaviour change. Poverty is also a factor that leads to intergenerational and unprotected sex. Lack of adequate adult supervision, lack of recreation and easy access to drugs also leads to risky sexual behaviour (HEAT 2002). To address these issues, the Ministry is taking measures to involve and educate parents and communities by conducting sensitization programmes on HIV/AIDS. This includes bringing together community members, teachers and learners to discuss HIV/AIDS issues, and holding workshops where parents and other community members discuss HIV/AIDS and reproductive health issues with their

children. The Ministry has used the media, particularly television and radio, to disseminate and educate communities on HIV/AIDS. Other issues discussed include: poverty, gender issues and the empowerment of marginalised and vulnerable groups in the community. There are also monthly workshops conducted by Zimbabwe Family Planning Council which are geared towards educating communities on reproductive health issues. This is a major breakthrough and good practice given the cultural inhibition on discussing sex between parents and children in many African countries.

**Training of Student Peer Educators:** According to UNAIDS (1999:5) peer education involves the use of members of a given group to effect change among other members of the same group. MOESC officials confirmed that in 2003/2004 the Ministry had planned to hold 80 district student peer educators' training workshops where 5000 student peer educators would have been trained. However, due to lack of funding, the target could not be achieved as fewer training workshops were held. The provincial coordinator of Manicaland which has 7 districts also confirmed that they had planned to conduct 70 peer educators' training workshops in 2004 but by July 2004, they had not held any activity due to lack of funding.

Student peer educators are provided with information, communication and education (IEC) materials which they are supposed to use in schools. Peer education programmes are also complemented with other activities such as competitions on arts, debates, poetry, drama, dances, singing, and distribution of campaign materials, posters, pamphlets or going on road shows on HIV/AIDS. Most of the road shows are hosted by the Ministry of Health and Child Welfare. Schools have also established AIDS Clubs where peer education activities are held as part of their extra-curricular activities.

The major challenge in capacity training, particularly of teachers, has been training all teachers within a short period of time. This has not materialised because of inadequate financial resources and also due to the fact that training can only be done during school holidays.

## Material Development and Distribution

The Ministry in collaboration with NGOs is producing materials on HIV/AIDS (posters, textbooks, charts, pamphlets etc.) for schools and those that are used for training of teachers. UNICEF, UNESCO and other donors are providing funding and technical assistance. Materials produced are sent to districts and then distributed to schools. Due to inadequate funding, inadequate materials are produced.. Schools are also encouraged to produce their own materials. While this is a very useful strategy, there is lack of expertise to accomplish this task.

### **Out-of-School Youth HIV/AIDS Programmes**

MOESC in collaboration with UNICEF is implementing out-of-school youth HIV/AIDS programmes. The programmes are being implemented through existing structures like Sports and Recreation Commission, where formal youth centres have been established in different districts. Out of school youth in the centres are supplied with materials for reading, televisions and VCR so that they can watch documentaries on HIV/AIDS. However, the facilities are available in few districts and therefore only a small percentage of out of school youth are catered for. A number of NGOs are also involved in out of school youth HIV/AIDS programmes. Many of them concentrate on prevention programmes which include raising awareness on HIV/AIDS, peer education, skills training etc. Research findings showed that there is lack of proper coordination resulting in certain programmes and areas not being covered, which excludes many out of school youth.

### **HIV/AIDS Prevention Programmes Implemented by MOHTE**

MOHTE is responsible for all tertiary institutions which include universities, teachers' colleges, polytechnic and technical colleges. However, in the case of HIV/AIDS programmes, it deals more directly with teachers' colleges, polytechnic and technical colleges.

### **HIV/AIDS and Life Skills Education in Colleges: Curriculum and Lecturer Development**

HIV/AIDS and Life Skills Education has been implemented in teachers' colleges since 1994. HIV/AIDS is part of the curriculum in pre-service programmes in teachers' colleges and student teachers are expected to acquire skills in teaching the subject. The college programme has two components. One component focuses on provision of life skills to teacher trainees to enable them address their vulnerability and exposure to high-risk behaviour. The second one provides them with participatory methodology skills to enable them to teach HIV/AIDS and Life Skills programme to the schools they will be deployed on completion of their studies. This component of the programme complements the one run by MOESC. However, the major weakness in the programme is poor assessment. MOHTE officials acknowledged that they have not put in place a uniform method of assessing students. Since each college has its own way of assessment, it is likely that many essential aspects of the programme may be neglected or overlooked. Lecturers and student teachers may also not take the subject seriously.

In technical and vocational institutions, HIV/AIDS is a

compulsory subject taken by all students. Students also sit for examinations which they are required to pass in order to graduate. However, the major challenge remains that the programme does not focus seriously on imparting life skills on students to enable them to overcome their vulnerability and high behaviour risk. It is tilted more towards preparing students to work in industries as it weighs more heavily on health and safety aspects than on personal vulnerability.

Lack of adequate skills in the implementation of HIV/AIDS programmes in colleges and technical institutions has been a major challenge. Each teachers' college has a Department which is responsible for teaching of HIV/AIDS programmes. HIV/AIDS coordinators who are also lecturers head the Departments. They have one or two assistants. Discussions with key informants in MOHTE and NGOs showed that training of college lecturers has been a major weakness in both teachers' colleges and technical institutions. College lecturers require training to enable them to acquire thorough knowledge on HIV/AIDS. The Policy on HIV/AIDS for Teachers' Colleges confirms:

Lack of qualified personnel for HIV/AIDS education has resulted in most colleges failing to put in place meaningful programmes. Student teachers are deployed without the necessary skills to handle HIV/AIDS education. There is need to introduce a format to train and prepare all stakeholders in HIV/AIDS education. Nurses and doctors affiliated to the colleges need refresher courses to prepare them to deal with HIV/AIDS (MOHTE 2004:5).

Currently, training programmes for lecturers are organised haphazardly and on *ad hoc* basis without thorough planning. In most cases, MOHTE together with approved and registered NGOs identify gaps in existing HIV/AIDS programmes in colleges after which the NGOs assist in training. At times the ministry sends some lecturers outside the country for training. On completion of the training, the lecturers train their colleagues in the colleges. Respondents provided an example where some lecturers had been sent to Malawi for training in guidance and counselling and on the cascade method were expected to train other lecturers in the colleges. Another aspect in training of college lecturers raised by officials from the ministry was that colleges are grouped in clusters where NGOs and other training organisations are able to bring together and train a large number of lecturers.

Officials from MOHTE stated that some of the departments, schools and different universities in the country made attempts to integrate HIV/AIDS in their programmes and curriculum. Respondents from the School of Social Work which is part of the University of Zimbabwe confirmed that the school has ensured that

every course that is offered has integrated aspects of HIV/AIDS. However, they emphasised the need for more support in terms of financial, human and other material resources from MOHTE, as the assistance provided currently is inadequate.

Universities, teachers' colleges and other tertiary institutions have established AIDS clubs and peer education programmes. AIDS clubs and other institutional organised structures undertake different activities to raise HIV/AIDS awareness among the student constituencies.

These activities include drama, poetry, debates, distribution of HIV/AIDS materials and workshops where people living with HIV/AIDS give testimonies. Although some of the peer education programmes and AIDS clubs are very active, many have not received follow up training, guidance and support. Discussions showed that some heads of tertiary and higher education institutions have demonstrated firm leadership in responding to HIV/AIDS within the institutions. They ensure that whenever there are gatherings they discuss HIV/AIDS issues. They have initiated and supported all HIV/AIDS activities within the institutions. Some of them have taken voluntary testing to set examples to institutional communities. Many of the institutions were also attempting to formulate institutional HIV/AIDS policies with the assistance of UNESCO.

Representatives from the Ministry and tertiary institutions acknowledged that the HIV/AIDS programmes have changed negative behaviour and reinforced positive attitudes among many of its recipients. Respondents also identified the major challenges and problems hindering the effective implementation of HIV/AIDS programmes as lack of adequate funds, lack of expertise and inadequate supply of materials and equipment.

### **Prevention Programmes for Teachers/Lecturers and other Ministerial Staff Implemented by MOESC and MOHTE**

#### **HIV/AIDS Workplace Programmes**

Statutory Instrument 202 of 1998 addresses different rights and obligations regarding HIV/AIDS and workplace issues (Republic of Zimbabwe 1999). While emphasising non-discrimination on the basis HIV status, this instrument obliges employers to provide HIV/AIDS education to employees. It defines employees' rights in relation to testing, confidentiality, promotion and training, employee benefits, and sick and compassionate leave (Republic of Zimbabwe 1999).

However, the two Ministries of Education have not yet implemented workplace programme for teachers. Most primary school teachers have only been sensitized because of the training they receive to teach the HIV/AIDS Life Skills Education. In secondary schools, the few teachers who teach the subject have also been

sensitized. This suggests the need to hold sensitization workshops and peer education programmes for all teachers. Zimbabwe Teachers' Association (ZIMTA) has developed its own programmes to raise HIV/AIDS awareness among teachers. It has also collaborated with other teacher professional associations to develop integrated HIV/AIDS modules for teachers which cover basic knowledge about HIV/AIDS prevention and positive living. With the support of American Federation of Teachers, ZIMTA held workshops which covered

HIV/AIDS workplace programmes, production of materials and training of conveners. Education International for Teachers provided funding for expansion of workplace programmes. The National Association of Primary Heads (NAPH) obtained funding from the business sector and is providing HIV/AIDS awareness and workplace programmes for its members. It has also produced a book on HIV/AIDS which is being used to educate people about the epidemic.

Discussions with teachers associations showed that lack of finances inhibit these associations from training most teachers on HIV/AIDS. Some teacher organizations are also not able to secure funding for their programmes due to political reasons. At times donors require support and endorsement from the government in order to provide funding to organisations. It was alleged that some associations have not been supported by the government in order for them to secure funding from donors. This was attributed to being associated with the opposition party, the Movement for Democratic Change (MDC).

In 2003, sensitisation and HIV/AIDS awareness programmes were offered to all MOESC head office, provincial and district staff. There were plans to train some of the staff as peer educators. The intention was also to train district peer educators who would train teachers at cluster level. However, by 2004/2005 the peer education programme had not started due to lack of funding. Discussions with officials from MOHTE showed that there have been HIV/AIDS sensitisation and awareness programmes for teachers' college lecturers, those from other tertiary institutions and other staff in the Ministry. However, the implementation of some of the programmes has either been ad hoc or not properly planned and coordinated. UNESCO is currently working with MOHTE to coordinate the programmes properly. Although there were also plans in 2004 to train some of the lecturers and other staff as peer educators, the programme had not taken off due to lack of funding. Other ministries assist both MOESC and MOHTE in providing training. Health professionals provide assistance in some of the workplace programmes for MOESC and MOHTE staff. They also provide advice and feedback on the HIV/AIDS Policy for Tertiary Institutions and the strategic plans of both ministries. The Ministry of Home Affairs (Police) provides assistance on HIV/AIDS training of teachers in schools by providing information on child abuse and rape and reporting procedures.

sensitised through workshops to enable them to make informed decisions. The main challenge, however, has been the negative attitudes held by most senior management staff in both Ministries. It was also acknowledged in the discussions that many of them lack commitment and will to address the epidemic.

### **Intervention Mechanisms: Vulnerable Groups**

#### **Programmes Addressing Problems of Orphans and Other Vulnerable Children**

##### **Legislation and laws**

Orphaned children require a lot of care and support and measures have been taken by MOESC and other stakeholders to implement different programmes to address their plights. Zimbabwe is a signatory to a number of conventions on the rights of child, in particular, the UN Convention on the Rights of the Child (1989) and the African Charter on the Rights and Welfare of the Child (1992). It is also a party to the International Convention on Economic, Social and Cultural Rights (1966). Pursuant to its international and regional treaty obligations, the Government has put in place legislation and laws to promote and protect the rights of children and ensure their development and protection against ill treatment, exploitation, neglect and abuse.

However, it was acknowledged that many people do not know about those rights. Ignorance of the laws and legislation by communities has led to rights of many children being violated by members of the community, relatives and caregivers. The need to educate and involve communities, law enforcement agencies and other institutions in all activities that address the HIV/AIDS pandemic is crucial. However, there have been efforts to educate communities, learners and other stakeholders on a number of rights among them: the rights of girl child; gender rights and HIV/AIDS, and citizens' rights particularly those associated with assessing HIV/AIDS grants. Teaching materials and syllabus produced by MOESC include those that cover some of these rights. Some registered NGOs are working in the communities and schools to educate and also perform advocacy function in the area. AIDS clubs in some of the schools and tertiary institutions share information and educate members on different rights. However, most of the work is done on *ad hoc* basis and covers limited geographical scope particularly urban areas.

##### **Basic Education Assistance Module (BEAM)**

MOESC in conjunction with other ministries is providing support to vulnerable children. The Social Development Fund (SDF) which was established to assist the poor

needy families with basic social services, including education, operated from 1991 to 1995 when it was replaced by Basic Education Assistance Module (BEAM).

BEAM provides direct support to school going children from Grade I to Ordinary Level. The children who receive support are orphans, children of unemployed families, children whose bread winners are chronically ill, and children from poor families that have no disposable assets. BEAM seems to be an appropriate programme that has provided the required assistance to meet the key needs of orphans in many schools. However, a number of observations have been made by HEAT (2002) regarding its implementation:

- There have been low levels of implementation in some regions and districts; and delays in processing of applications and disbursements.
- Problems encountered in selection mechanisms, namely, inadequate definition of selection criteria, lack of transparency and review mechanisms that would ensure the most needy get preference.
- Factors such as fear of witchcraft, pressure from men and women of influence, political partisanship, and lack of awareness on the part of parents with deserving children, have been cited as influencing the choice of children to benefit.
- The fact that selection process takes place only once a year, means that new cases which come up after the allocations are made will not be considered until the following year. Moreover budgets do not give consideration to varying levels of need in different regions and districts.
- Secondary and special needs learners receive limited benefits because of logistical problems when learners attend school outside their community. Moreover, there is tendency to approve large numbers of lower cost applicants rather than fewer, high cost ones. Hence secondary school and learners with special needs are vulnerable to exclusion.
- Many priority areas like food, accommodation, clothing etc. that are essential to orphans and other vulnerable children are not addressed through BEAM. Assisting with school fees and other related expenses are inadequate taking into consideration that the main problem remains poverty where most of the children are not able to acquire basic needs. The need to examine strategies of tackling poverty within communities remains crucial. Moreover, properly coordinated feeding schemes and income generating activities need to be established.
- The programme is not adequately monitored in terms of expenditure, beneficiaries, current systems of disbursements and so forth.
- It is not clear whether the programme addresses

the needs of girls adequately and equitably as they are supposed to receive half of all budgets.

- The fact that the programme make use of community based system of allocating funds, it has resulted in the exclusion of most needy students particularly for those who do not live and attend school in the same district. Community committees have not been willing to use their funds to subsidise children who attend school outside their districts.

Given the above observations, the main challenge remains the need to strengthen BEAM to enable the programme to achieve its objectives effectively.

### **Assistance provided to Orphans and other vulnerable children at the school level**

Findings showed that in most schools, there has not been well-planned and coordinated action for orphans and other vulnerable children. According to HEAT (2002), a variety of spontaneous activities have been initiated by some schools and teachers, namely: provision of material needs in the form of bursaries; feeding schemes; nutrition gardens and income generating activities; clothes; food; materials and uniforms. In some cases there have also been provision of psychosocial support and counselling services by guidance and counselling teachers, NGOs and other teachers who have received training; and in other schools AIDS clubs provide peer support. Some schools make special concessions for orphans and other vulnerable children, for example, excluding them from paying school fees or providing orphans with holiday work to assist them pay their school fees. HEAT made some observations regarding assistance for orphans and other vulnerable children at school level:

- For a long time there had not been effective methods of identifying orphans and other vulnerable children by schools to enable them to receive required support and assistance.
- There is no specific policy on orphans and vulnerable children who have become household heads due to HIV/AIDS. Most of them have managed to attend and stay at school because of assistance like BEAM, NGOs, CBOs etc. However, lack of parental supervision at home put them in very vulnerable positions.
- The capacity of other Ministries, Government Departments, and communities to meet the needs of orphans and other vulnerable children is limited given the magnitude of the problem.
- Schools do not have the required skills and capacity to handle all essential issues of orphans and other vulnerable children. For example it is not possible for guidance and counselling teach-

ers to attend to all emotional and material requirements of the affected children.

- The actions taken in most schools have been haphazard, ad hoc and without proper coordination. There is need of proper role definition and coordination between different groups within and outside schools.

However, discussions with Ministry officials and representatives from UNICEF and UNESCO showed that measures are being put in place to address some of the observations. Some of the training workshops held in the districts include sensitizing schools on issues regarding orphans and other vulnerable children. These sensitization sessions are geared towards providing assistance to HIV/AIDS orphans and other vulnerable children in schools. Schools that attend sessions are provided forms to be filled and procedures that are required to be followed in order for orphans and other vulnerable children to receive the necessary government assistance. Teachers and affected children also attend these training/sensitization workshops. The process enables the Ministry and schools to obtain the number of learners who require assistance. It also enables NGOs and teachers with skills to provide counselling and psychosocial support to affected children.

Consequently, measures are being taken to strengthen the Education Management and Information System and to improve the recording and reporting system by schools. UNESCO in collaboration with MOESC has established District Education Management Information System (DEMIS) to capture the numbers of affected children in schools. The project has been implemented in 16 districts. UNICEF is also currently looking for ways of extending to other districts. There have been efforts by the MOESC to train teachers in psychosocial support and counselling. Most of those trained are guidance and counselling teachers.

### **Programmes implemented by NGOs to assist orphans and other vulnerable children**

The findings showed that there are a number of NGOs and CBOs that provide assistance to orphans and other vulnerable children in different provinces and districts. Among them are: the Red Cross, Catholic Relief Services, Action Aid, Family AIDS Caring Trust and other CBOs and businesses. The organisations assist with provision of blankets, school uniforms, books, immunisation, payment of school fees including examination and boarding fees. The European Union (EU) is paying fees for learners in 8 districts in the country. These organisations are, however, concentrated only in a few areas, particularly in urban areas and places which are most accessible. This means that many remote rural areas are left out. There is also lack of proper

coordination and collaboration between organisations themselves and between organisations, schools and other communities.

Another programme is the school-feeding scheme organised by the World Food Programme (WFP). The WFP identified districts that were experiencing acute food shortage and then commissioned some NGOs to distribute food in schools in those districts. In areas where WFP was not working, CARE handled the responsibilities of school feeding schemes. The programme, however, has had to be scaled down following the declaration by the Government of Zimbabwe that it had sufficient food. The concerned organisations, then, have had to target only the very needy learners while many who also require assistance are left out.

### **Programmes Addressing Problems of Teachers/Lecturers and Other Employees infected with HIV**

Discussions with officials from both Ministries showed that there are no specific policies that target teachers/lecturers and other staff infected with HIV. Like all the other public servants in different ministries and public Organisations, they follow civil service regulations that have been put in place by the government. The situation is exacerbated by the fact that those infected are not open about their status because they fear being discriminated and rejected by colleagues, relatives and other members of the community.

### **Counselling**

It was acknowledged that counselling of teachers and other employees infected and affected with HIV has not been properly planned and organised. Respondents from tertiary institutions indicated that staff members and students who are infected with HIV receive counselling. However, this is only done to those who have disclosed their status and these are very few. HEAT (2002:76) observed that stigma and lack of knowledge on how to handle HIV/AIDS had reportedly led to some HIV positive employees committing suicide or resigning prematurely from their positions. The report suggests the need for systematic counselling and advice on employment and other services such as medical care, pensions, life planning, positive living, nutrition, coping with stigma and disease management. Voluntary testing and counselling (VCT) is another aspect that both MOESC and MOHTE have failed to promote widely and effectively despite the fact that some of the members of parliament and heads of tertiary institutions have been tested openly to set examples to other people. VCT enables people to know their status and therefore be able to either protect themselves if they are HIV negative, or live positively, if

they are HIV positive.

### **Health Care**

Health care and treatment plays a crucial role in managing the health of those who are infected. Psychosocial support, treatment of opportunistic infections, proper nutrition and an emphasis on positive living provide relief to those infected with HIV/AIDS. Anti-retroviral drugs (ARVs) have proved to be effective in reducing illness and prolonging the lives of those infected with HIV/AIDS. They are provided in both the public and private sectors (government hospitals or clinics and private hospitals and chemists) but they are costly and sometimes not available at all the times in government hospitals. Zimbabwe launched a public ARV programme for the poor and vulnerable people aiming to roll out ARVs to some 100 000 by the end of 2005, but less than 20 000 were receiving the drugs during that time.

Teachers/lecturers and other staff have a choice of obtaining medical cover from any medical aid of their choice. Most employees are members of the Public Services Medical Aid Society where the Government pays 60% of membership contributions. The scheme pays for doctors' consultations, hospitalisation, tests and X-rays (MOESC 2003; HEAT 2002). Although HIV/AIDS and terminal care are covered, there are limitations. There are certain problems associated with the medical scheme, among them, rising cost of medicines and hospitalisation as HIV/AIDS related illnesses are likely to raise the medical aid premiums steeply. It also means that at times, financial limits on a number of benefits may leave members without cover, particularly those living with HIV/AIDS. Moreover, limits on prescription medication raise problems for people with chronic illness, given the high cost of medicines like anti-retroviral drugs. Hence there is need to strengthen access to medical aid and medical cover as one of the crucial factors in successful management of the impact of HIV/AIDS.

### **Absenteeism and sick leave**

Respondents from both Ministries stated that teachers are entitled to 90 days sick leave with full pay and a further 90 days half pay subject to medical opinion that such persons will not be able to resume their duties. However, respondents from teachers unions and tertiary institutions expressed dissatisfaction with the way the Ministry handles employees living with HIV/AIDS. Often sick teachers remain in their positions or on long-term sick leave when they are unable to perform their teaching duties. This affects pupils and colleagues, the former not receiving high quality education and the latter being overworked. In most cases services of temporary teachers are enlisted only when teachers are on long

extended sick leave. This suggests the need to provide incentives and training to temporary teachers in order to retain them for longer periods and also enhance quality education in schools. Issues regarding temporary teachers were discussed above.

Due to HIV/AIDS epidemic, the number of funerals/burials has increased substantially, and is likely to affect teaching and learning in schools and colleges. Funeral ceremonies often take a number of days, and teachers and lecturers attending funerals may have to apply for short leave. The implications are that pupils/students may not be taught for a number of days. It also means that colleagues who are already overworked might have to take additional teaching responsibilities when bereaved teachers or lecturers are away. In most cases bereaved teachers or lecturers have to meet the costs of funerals or burials of members of their families, relatives and even colleagues since they might be obliged to make contributions. Respondents acknowledged that this poses a heavy financial burden on teachers and lecturers. The latter and other staffs are encouraged to join funeral policies through their organisations. ZIMTA has a funeral policy where members contribute monthly. This assists teachers who are members to defray costs of funerals which have risen dramatically.

### **Pensions and other benefits**

According to officials from both Ministries, the government has established the State Services Pension Scheme which covers all education sector employees. The government and employees each pay half of the monthly contribution which is 15% of salary. Those who retire on health grounds get a limited lump sum gratuity for the first five years of employment and thereafter a pension. What an employee gets for pension depends on the number of years of service and final salary. Funeral assistance is provided for members who are above 55 years of age. In case of retirement on grounds of ill health, benefits are very limited and for people suffering terminal illness, it will not suffice to pay for health care and family support. The situation is worse for younger staff and those who have worked for less than five years. The processing of claims takes long and for a terminally sick person, the process may cause more mental suffering. Some teachers, particularly those in the rural areas, are not even aware of their full benefit entitlements. This suggests a need to re-examine and restructure benefits as part of addressing the management of the impact of HIV/AIDS epidemic.

### **Recruitment and appointment**

Respondents from both Ministries acknowledged that because of HIV/AIDS there has been a high level of

attrition among staff. Some of the teachers who are sick move from the rural areas to urban areas to look for better health care services. The infected in the urban areas may also return to their rural villages to be close to their homes or to be near their spouses or relatives. This movement of teachers with HIV/AIDS creates many vacant positions in schools. The process of filling vacant positions takes long (on average 2-3 months and in some places 3-5 months) and this has the potential of adversely affecting the quality of education (HEAT 2002). To counter the growing shortage of teachers in schools and other staff, both Ministries have resorted to increasing in-service training programmes for teachers and other staff in colleges and schools. There have also been measures to increase the intake of student teachers in colleges and reducing the time spent in colleges on pre-service training.

### **Budget**

As shown in the above discussions, the implementation of most HIV/AIDS programmes is affected by inadequate funding. The two education ministries have not yet provided direct budget line for HIV/AIDS prevention and mitigation programmes save for paying salaries for government employees that are responsible for implementation of HIV/AIDS programmes at regional, district, cluster, college and school levels and ministerial head offices. Almost all the ongoing programmes are funded by outside donors. These include: production of materials (books, charts, syllabus) for the HIV/AIDS Life Skills Education and Workplace Programmes; peer educator programmes in schools and tertiary institutions; training of teachers; HIV/AIDS workplace programmes; community sensitisation programmes; programmes for orphans and other vulnerable children; information management systems; and HIV/AIDS for out of school youth programmes. However, due to the prevailing political climate, most donors have not been willing to provide the required funding to the Government as they used to. Some of them have threatened to withhold funding until the political situation has stabilised. This poses a major limitation on the implementation of very vital HIV/AIDS programmes.

### **Research and Monitoring**

Research and monitoring are very essential aspects in tracking the impact of the HIV/AIDS epidemic. Currently, each school is required to keep individual record books for each student/learner in which some aspects like absenteeism, payment of fees, medical history, and orphans are recorded. Schools submit their records to their respective districts which pass them on to provinces and head office. The records are reviewed by the ministry

monthly and at the end of each term. Respondents from MOHTE, teachers' colleges and other tertiary institutions acknowledged that the HIV/AIDS epidemic is not sufficiently monitored. Due to lack of resources and staff, record keeping is not accurate and systematic. UNESCO has established district education management information system (DEMIS) in 16 districts. Data is collected from schools on gender, teacher: learner ratio, absenteeism, learner drop out, ages and orphans. UNESCO is also supporting online database programme. UNICEF plans to assist MOESC in establishing DEMIS in other districts in the country. Both projects are in their infancy and it is too early to make conclusions on their progress.

There are challenges in effective collection, processing and storage of data. The work of EMIS is being affected by turnover of skilled experienced staff. Lack of information, incomplete and sometimes inaccurate information is also a major challenge. Other key challenges outlined by HEAT (2002:97) include "use of EMIS to track impacts which may not immediately be apparent, obtaining more non-routine and qualitative information to inform planning and monitoring and ensuring timely analysis and feedback of information to cope with information needs in a period of change and uncertainties". The education sector has also put emphasis on research to track the impact of the HIV/AIDS epidemic. Officials from both Ministries stated that commissioned and other research is conducted by higher and tertiary education institutions; teachers; education officers; heads of schools and independent consultants. The Ministries in collaboration with UNESCO also identify priority research areas.

## Conclusion

Zimbabwe has had the highest HIV/AIDS prevalence among the countries in the southern African region. The epidemic has had a devastating impact on the education sector. Already there are adverse effects on the demand and supply in education. The government has put in place strategic plans and policies with clear and sound aims and objectives to address the HIV/AIDS epidemic in the education sector. The policies and strategies draw a lot of aspects from the national HIV/AIDS Policy and the national HIV/AIDS Strategic Plan. The policies and strategies are currently being implemented by both Ministries of Education with the assistance of partner organisations and NGOs. Structures have been established at different levels to manage the implementation of the HIV/AIDS policies and programmes in the education sector. Although the country need to be commended for making a lot of effort to reduce the HIV/AIDS prevalence from over 30 per cent to close to 20 per cent, there are still a number of challenges which have affected the implementation of

policies and programmes. Among the challenges are lack of capacity in terms of skills, human and financial resources, lack of proper monitoring and follow up partly due to inadequate staff and transport. Consequently, there has been a heavy dependence on partner organisations, mainly UNESCO, UNICEF and NGOs. Some of the NGOs have been curtailed from doing effective work because of stringent control measures introduced by the government. Moreover the prevailing political climate in Zimbabwe has led to donors withholding or reducing their funding, and putting on hold the implementation of some of the projects and programmes. Stigmatisation and lack of political commitment among some of the government officials and lack of proper coordination of some of the programmes on the ground are among other obstacles observed.

## REFERENCES

- Economic Commission for Africa (2000). *The Leadership Challenge and the Way Forward: HIV/AIDS and Education in Eastern and Southern Africa*. Addis Ababa Ethiopia.
- Barnett T Whiteside (2002). *AIDS in the Twenty First Century: Diseases and Globalisation*. Palgrave Macmillan Hampshire.
- Central Statistical Office (2000): *Zimbabwe: Facts and Figures*. Harare : Government Printer
- Chisholm L, Makwati G, Marope P, Dumba-Safuli (1998). *SADC Initiative in Education Policy Development, Planning and Management*. Mbabane.
- Constitution of Zimbabwe (1996). Revised Edition Harare: Government Printer Harare.
- Department of Education, South Africa (2001). *Education for a Global Era: Challenges to Equity, Opportunities for Diversity*. Globalisation, Values and HIV/AIDS. Country Paper: South Africa.
- Hatendi F (2001). *Assessment of the Level of Implementation of the Zimbabwe National HIV/AIDS Policy and Accessibility of the National AIDS Trust Fund by Civil Society*. Harare.
- HIV/AIDS, STI, TB Fact Sheet 2000 (June). Planning, Monitoring and Evaluation Research Unit National AIDS Coordinating Program, Ministry of Health and Child Welfare. Harare: Government Printer
- HIV/AIDS in Assessment Team (2002). *The Impact of HIV/AIDS on Education in Zimbabwe*. Harare: Government Printer
- Hunter S (2000). *Reshaping societies HIV/AIDS and Social change: A resource book for planning, programs and policy making*. New York: Hudson Run Press.
- Kelly M (2000a). *The encounter between HIV/AIDS and Education*. UNESCO; Harare Zimbabwe.
- Ministry of Education, Sport and Culture (2001): *Education Millennium Report*. Statistics Unit. Harare: Government Printer.
- Ministry of Education, Sport and Culture (2002): *HIV/AIDS Life Skills Education Strategic Plan 2002 – 2006*. Harare: Government Printer
- Ministry of Education, Sport and Culture (2002): *AIDS Support Organisations Working with Schools on HIV/AIDS in all the Regions*. Harare: Government Printer
- Ministry of Education, Sport and Culture (2003): *Terms of Reference for AIDS Support Organisations wishing to participate in the Ministry's HIV/AIDS and Life Skills Education Program*. Harare: Government Printer
- Ministry of Higher and Tertiary Education (2004): *Policy on HIV/AIDS for Teachers' Colleges (Final Draft)*. Harare.
- Ministry of Education, Sport and Culture (2002): *HIV/AIDS and Life Skills Education Strategic Plan 2002 – 2006*. Harare: Government Printer
- Ministry of Education, Sport and Culture (2002): *AIDS Support Organisations Working with Schools on HIV/AIDS*. Harare: Government Printer

- National AIDS Coordination Program (1998); HIV/AIDS in Zimbabwe: Background, Projections, Impact, and Interventions. Ministry of Health and Child Welfare. Harare: Government Printer.
- National Health Information and Surveillance Unit (1998): Zimbabwe National Health Profile 1998. Ministry of Health and Child Welfare. Harare: Government Printer<sup>1</sup>
- National AIDS Coordination Program (2000): HIV/AIDS, STI and TB fact sheet 2000 (June). Ministry of Health and Child Welfare.
- National AIDS Council; National AIDS Trust Fund and the Zimbabwe Women's Resource Centre (2003) Gender and HIV/AIDS: An Analysis of Zimbabwe's National Policies and Programmes on HIV/AIDS/STIs. Harare.
- Newsletter of the National AIDS Council of Zimbabwe volume 1 Number 1 December 2003. Harare : Government Printer
- Republic of Zimbabwe (1999): National HIV/AIDS Policy. Harare : Government Printer.
- Republic of Zimbabwe (1999): National HIV/AIDS Strategic Framework 2000 – 2004. Harare: Government Printer
- SADC Human Resources Development Sector (2001) SADC HIV/AIDS in Education Strategic Framework (<http://www2.ncsu.edu/aern/sadc.html>).
- SAfAIDS News Volume 10 Number 4 2002.
- The Commonwealth Regional Health Community Secretariat (2001) Regional HIV/AIDS Strategy for East, Central and Southern Africa, 2002 – 2006. Arusha, Tanzania.
- The EFA 2000 Assessment Team (2000): The EFA 2000 Assessment Country Report, Zimbabwe. Harare 2000.
- UNAIDS (2000) HIV/AIDS and Educational Planning in Africa. Geneva.
- UNAIDS (2000) HIV/AIDS and Educational Planning in Africa. Geneva.
- United Nations (2001) Declaration of Commitment on HIV/AIDS. New York.
- UNAIDS (2002) Zimbabwe Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections. Geneva: UNAIDS, UNICEF & WHO.
- UNAIDS (2002) Report on the Global HIV/AIDS Epidemic 2002. Geneva.
- UNAIDS (2002) Report on the Global HIV/AIDS Epidemic 2002. Geneva.
- HIV/AIDS and Nutrition Newsletter – Issue 6, August 2004 ([www.psi.org/news/](http://www.psi.org/news/)).

---

\*BA, MA, MEd, PhD; Senior Lecturer, School of Postgraduate Studies, University of Fort Hare South Africa.