

**THE EFFECTIVENESS OF HIV-AIDS
EDUCATION PREVENTION
PROGRAMMES IN ZIMBABWE: THE
ROLE OF SCHOOL HEADS IN SACMEQ
III**

by

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Summary

The research study investigates the response of the education sector to HIV-AIDS through inputs of the primary school heads in Zimbabwe from the SACMEQ III Project by describing their viewpoints and professional characteristics and also examining how the school environment, that the school heads are in charge of, were supportive in the context of HIV-AIDS.

During SACMEQ III, an additional research component on evaluating “the impact of HIV-AIDS on the functioning of the school system” was introduced as requested by the SACMEQ Ministers of Education. As a result, the SACMEQ researchers developed a range of indicators in order to evaluate HIV education prevention programmes in primary schools among the SACMEQ countries.

Findings from the research study reveals that HIV-AIDS prevention education programmes are taking place in primary schools across the provinces but their effectiveness is yet to officially acknowledged. The extent to which schools implement the HIV prevention education programmes and the programmes’ effectiveness seem to be determined by status of schools in terms of the schools’ geographical setting. To this end, more needs to done to mobilize both human and financial resources for improving the basic school infrastructure and training of teachers in Life skills HIV-AIDS education prevention.

Dedication

This memoire is dedicated to my late parents Mr. Baker Garaubikirwe Chidyamatamba and Mrs. Agnes Musawana Matsika-Chamba for providing my livelihood and window to education during trying times.

My very special dedications to my family, my wife Annah Magade-Chamba, two daughters Patience and Melody and my dearest son, Prince Chamba for their understanding and sympathetic encouragement, spiritual, motivational and moral support throughout the entire period of this programme especially during the long time I was away from home.

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Abbreviations

AIDS	Acquired Immuno-deficiency Syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral
EFA	Education For All
GDP	Gross Domestic Product
GNU	Government of National Unity
HAKT	HIV-AIDS Knowledge Test
HIV	Human Immune-deficiency Virus
IIEP	Institute of International Education Planning
MDG	Millennium Development Goal
MOESAC	Ministry of Education, Sport, Arts and Culture
MoHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
OVC	Orphaned and Vulnerable Children
PMTCT	Prevention of Mother-To-Child Transmission
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
SADC	Southern Africa Development Community
UNAIDS	United Nations Joint Programme on HIV-AIDS
UNESCO	United Nations Educational Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children Fund
VCT	Voluntary Counselling and Testing
WFFT	World Fit For Children
WHO	World Health Organization
ZNASFP	Zimbabwe National AIDS Strategic Framework Plan
ZNASP	Zimbabwe National AIDS Strategy Plan
ZNFPC	Zimbabwe National Family Planning Council
ZNHTCSP	Zimbabwe National HIV Testing and Counselling Strategic Plan

Chapter 1

Introduction

1.1.The HIV-AIDS Challenge

HIV-AIDS pandemic has increased challenges affecting communities globally over the past two decades. Productive family members are lost to the disease, leaving children and other dependents without means of support. Economically the disease wreaks havoc within the country/communities due to the high costs involved in managing the affected and infected people. HIV-AIDS are therefore fast becoming one of the World's largest humanitarian and developmental challenges generally affecting developing countries and particularly more pronounced in sub-Saharan Africa.

The Joint United Nations Programme on HIV-AIDS and the World Health Organisation (UNAIDS, 2010) report indicated that about 33.3 million people worldwide were living with HIV by the end of the year 2009, and around 2.6 million of people were newly infected with HIV in 2009. Sub-Saharan Africa continues to be the region most suffering with HIV-AIDS where 22.5 million of persons are living with HIV (this figure translates to 68 percent of the global total) and the majority of new HIV infections (1.8 million people) occurred in 2009. In this region, the principal mode of transmission is non-protected heterosexual intercourse and transmission of HIV to newborns and breastfed babies.

Although HIV infections are declining globally compared to the previous years, HIV-AIDS are still at the international agenda. The declining trend happened mainly in sub-Saharan Africa and is attributed to a combination of efforts including HIV prevention programmes implementation, antiretroviral (ARV) therapy provision and the natural course of HIV epidemics (UNAIDS, 2010). UNAIDS 2010 report anticipates the "New Vision" will chart a course to HIV-AIDS response since it advocates for zero discrimination, zero new HIV infections and zero AIDS-related deaths through universal access to effective HIV prevention, treatment, care and support of the affected and infected people.

The situation is particularly challenging in Zimbabwe, a country considered as experiencing a generalized HIV epidemic with one of the highest HIV prevalence rates in the world. In

2010, the HIV prevalence among adults aged 15-49 years was estimated at 14.3% according to the National HIV Estimates in 2010 (Zimbabwe, 2008).

Zimbabwe's living standards have fallen and the country's performance on many social and economic indicators has regressed as a result of the effects of HIV-AIDS on the population. For instance, the most recent telling statistics relate to life expectancy which the UNAIDS estimate to be less than forty-two years for men and thirty-nine years for women compared to sixty-six years in the absence of AIDS during the early 1980s. The AIDS epidemic has caused a decrease of the Zimbabwe population by four million since the last census nine years ago. Given this situation, key social sectors such as health and education are also adversely affected by the aids epidemic directly or indirectly, though the impact is multifaceted and very complex in nature.

Zimbabwe experienced its worst crisis early 2000 when it was isolated both politically and economically. World record high hyper-inflation of over one million percentage points (1 000 000%), an unemployment rate of ninety per cent and outbreaks of cholera, political instability and near-total collapse of the education and health systems characterised the nature of the crisis. This scenario made situation quite bad and unbearable for those already desperate and quickly lost hope for survival.

According to UNICEF 2008 report, Zimbabwe had the highest number of orphans in proportion to its population than any other country in the world. The report estimated that as many as 1 in 4 children were orphaned as a result of parents dying of HIV-AIDS and related diseases.

1.2.The role of education sector in responding to HIV-AIDS

As the HIV -AIDS epidemic continue to rack havoc throughout sub-Saharan Africa with no cure or vaccine on sight, education becomes the only hope for life because it plays critical roles in halting the spread of HIV-AIDS and also mitigating the effects of HIV-AIDS on people. It therefore means that schools have an important role to play as part of a national response to the HIV-AIDS. For example the "school" has to implement HIV Prevention Education in order to prevent the spread of HIV, to protect the quality of education by

improving the quality of life of the learners and school staff and to provide care and support for learners and school staff affected by HIV-AIDS.

1.3.The research problematic

The overall objective of this study is to analyse the response of the education sector to HIV-AIDS epidemic through inputs from the heads of primary schools by describing their viewpoints and professional characteristics in the context of HIV and also examining how the school environment, that the school heads are in charge of, were supportive in the context of HIV-AIDS.

Based on the research problematic, the memoire will attempt to provide answers to the following research questions:

- a) What is the demographic situation in the context of HIV-AIDS in Zimbabwe? What are the government contributions and policies of the education sector on HIV-AIDS in Zimbabwe?
- b) What are the school heads profiles at primary level in Zimbabwe, in terms of (i) personal and professional characteristics (age, gender, experience, training on HIV-AIDS, etc.), (ii) HIV-AIDS related attitudes and risk perception, (iii) sources of information on HIV-AIDS and (iv) awareness of HIV testing centres?
- c) Are the primary schools in Zimbabwe providing a supportive environment in the context of HIV-AIDS in terms of (i) school buildings and basic infrastructure provisions (water, toilet, area for guidance and counselling, etc.), (ii) learning materials resources (life skills teacher guide, posters and pamphlets), (iii) trained teachers on HIV-AIDS, (iv) delivery of HIV-AIDS lessons, (v) extra-curricular activities (discussions about stigma and discrimination and HIV testing for staff) and (vi) support for pupils/OVC and staff affected by HIV (guidance and counselling, home visits, learning materials for use at home, medication) .

1.4.Objectives

The study seeks:

- a) To compare primary school Heads' profiles, in terms of personal and professional characteristics and also their HIV-AIDS related viewpoints, in the context of HIV-AIDS.
- b) To analyse the school environment, in terms of infrastructure, human and material resources available in primary schools, in the context of HIV-AIDS.
- c) To examine the kind of supports organized in the schools for pupils/OVC and staff affected by HIV-AIDS.
- d) To draw conclusions and make suggestions for important follow ups

1.5.Research Methodology

The study will be more descriptive and analyse the data collected by researchers on Zimbabwe during the third large-scale cross-national research project conducted by the Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ). In Zimbabwe, the responses to the SACMEQ instruments were collected from a national sample of 3 021 Grade 6 pupils, 274 teachers and 155 school heads – selected among the ten education provinces in the country (Bulawayo, Harare, Manicaland, Mashonaland Central, Mashonaland East, Mashonaland West, Matabeleland North, Matabeleland South, Midlands and Masvingo).

The study will employ the descriptive survey research method to analyse the data collected by using SPSS18. The data analysis was done with assistance of the expertise of Stephanie Dolata (IIEP/UNESCO).

1.6. Structure of the memoire

The research project is made up of five chapters. Chapter One introduces the rationale and objectives for analysing the general perceptions of the primary school Heads trends on SACMEQ III and their roles and contributions in the effectiveness of HIV-AIDS prevention programmes in Zimbabwe. The research problematic as well as the structure of the research study was highlighted. Chapter Two documents an overview of planning education in the

context of HIV-AIDS. General information about Zimbabwe and its education sector's response to HIV-AIDS are outlined and documented in the third chapter. Chapter Four outlines the primary school Heads' viewpoints and Professional Characteristics on HIV-AIDS. Supportive school environment for both staff and pupils in the context of HIV-AIDS was the main focus for Chapter Five. A summary of the major findings of the study, recommendations and suggestions for further research investigations are outlined in the last chapter.

Chapter 2

An Overview of HIV-AIDS in Educational Planning Context

2.1. Introduction

With the impact of HIV-AIDS on the education sectors so severe in sub-Saharan countries, there is great need to urgently respond to these threats by developing effective and long-lasting solutions such as capacitating Education Planners and Education Administrators with requisite skills to manage and mitigate the impact of HIV-AIDS. Curriculum alteration, development of sector-specific HIV-AIDS policies and introduction of HIV-AIDS prevention education programmes have been attempted by Ministries of education in the sub-Saharan countries lately in responding the epidemic.

Therefore this chapter examines the international commitment by sub-Saharan countries to the fight against the HIV-AIDS pandemic, the role of education in prevention programmes, the impact of HIV-AIDS on the supply of education, demand for education and quality and management of education.

2.2. International commitment

The first time that international community mobilized and worked together to set a number of goals and targets to respond to the challenges of HIV-AIDS was in 2001 during the United Nations General Assembly Special Session (UNGASS). This resulted in a commitment on HIV-AIDS signed and adopted by 189 governments with the aim to reverse the spread of HIV-AIDS by 2015. Since then most of the governments of the sub-Saharan countries, Zimbabwe included have remained focused and committed on national responses to HIV-AIDS targeted at attainment of universal access to HIV prevention, care and treatment and also ensuring accessibility and affordability of HIV-AIDS services to all disadvantaged members of the community.

Kelly (2000) implores that the HIV-AIDS epidemic has impacted negatively on access to education in sub-Saharan countries due to lack of investment needed to maintain a prescribed

level of education because their economies have been weakened by HIV-AIDS-related obstacles.

The HIV-AIDS pandemics are literally revoking the hard-won development gains, with a crippling effect on future prospects. The epidemic is continuing to threaten the delivery of sustainable quality education and the achievement of Education for All (EFA) and the Millennium Development Goals (MDGs). HIV-AIDS are reducing demand for and access to education by underpinning institutional capacities, reducing the availability of financial resources for education and compromising the quality of education. The psycho-social effects of losing a parent/loved one to a debilitating illness are severe and stigmatize and traumatize both affected pupils and teachers who are therefore bound to lose concentration and end up not performing well in their studies/duties. Further, to some extent the impact of HIV-AIDS epidemic causes both teachers/pupils absenteeism, emotional and psychological stress, and negatively affects the quality of education being delivered in the schools.

2.3.The Pivotal Role of Education

Despite having already been severely affected by HIV-AIDS, it is commonly recognized that education remains the most effective tool to fight the HIV-AIDS scourge in the absence of a cure. Education ministries through school Heads and teachers can play crucial roles in limiting the spread HIV-AIDS by effectively implementing the school-based health education/HIV-AIDS- specific programmes. School heads and teachers interact with school pupils and that creates the potential opportunities for transmitting significant important information on HIV prevention and other AIDS-related information while they are in their most receptive development stage. It is also important to note that education is the most influential tool for transforming the poverty and gender inequality environment in which HIV-AIDS thrives. Through the guidance of trained and competent school heads, education curves an environment where both boys and girls grow up accepting gender equality and thus assuring the elimination of gender disparities in education.

Due to a severe social, political and economic environment in Zimbabwe, non-Governmental Organizations (NGOs) and the local communities are complementing the roles of the education sector in the fight against the HIV-AIDS epidemic by funding the HIV-AIDS education prevention initiatives particularly the United Nations agencies such as the United

Nations Children Fund (UNICEF) and World Health Organization (WHO). These organisations have targeted the high prevalence provinces particularly the disadvantaged and hard-to-reach districts where the communities are also at most risk and vulnerable to the pandemic. On the other hand, the local well-to-do communities and faith-based organizations are also involved in mobilizing funds for implementing the HIV-AIDS education prevention programmes in a variety of activities such as creating child-friendly schools, provision of the teaching/learning materials and general support for those affected and infected with HIV-AIDS

2.4. Impact of HIV-AIDS on the Supply of Education

The two main impact of HIV on the supply of education are the decreased availability of qualified and experienced teachers and administrative and coordination capacity and the “negative” stress such as stigma and discrimination experienced by teachers affected and infected with HIV. All these factors have a negative impact on the quality of education.

Lose of teaching staff from HIV-AIDS-related is impacting negatively on the supply teachers in schools. The second effect of HIV-AIDS on the supply of education is teacher absenteeism. The substitution of HIV infected teachers means doubling expenditure on the education ministry. This is because while the HIV infected teachers occasionally go on paid sick leave, those that replace them also get full salaries. Due to lack of reliable data/information concerning affected teachers (NAC, 2006), it becomes difficult to come up exact figures of those sick or dying from HIV-AIDS related illnesses.

Another problem concerns the negative stress of HIV infected teachers, who are always under stress and demotivated and so cannot conduct their duties effectively due to a number of factors associated with stress, such as isolation, stigma and discrimination. All these circumstances result in teachers underperforming and thus compromising the quality of education. In addition an indirect effect occurs when teachers simply resign and take up non-teaching-jobs in the private sector where salaries and working conditions are better with prospects higher opportunities as opposed to the public sector.

2.5. Impact of HIV-AIDS on the demand of education

The impact of HIV is very critical among the demand for education. The number of school-aged children affected by HIV is important in countries considered generalized epidemic in sub-Saharan Africa and continues to increase due to new infections. For the education system, it means more challenges and accountability in taking care of an increased number of children infected with HIV and affected with HIV.

HIV-AIDS is responsible for further impoverishment of families. With no stable employment, no salary and limited access to treatment centres most HIV infected persons die leaving behind children exposed to hostile vagaries of nature. The affected orphans eventually drop out of school further exposing them to HIV infections.

Most of the orphans, especially the girl child ends up dropping out school and take full time parental responsibilities in the family. For those orphans who might remain in school for a while, their participation and concentration rates normally decrease due to stigma and discrimination particularly those confirmed HIV positive.

2.6. Main Strategies implemented by Education Sector to HIV-AIDS

In response to the HIV epidemic IIEP/ESART provide concrete tools to help planners to plan and implement specific actions to address the HIV-AIDS challenges. The key areas are the following:

- the curriculum response through HIV Prevention Education: It is proposed to the education ministry to integrate HIV-AIDS education in the school curricular through life skills aimed at reducing risk-taking.
- the teacher formation and development in the context of HIV-AIDS: The teachers have to be trained in life skills HIV-AIDS education prevention in order to teach HIV-AIDS and also to protect themselves from HIV infections.

- The development framework for orphans and vulnerable children: it is recommended to the government to develop a national framework targeted to disadvantaged children that aims to ensure that among them orphans and vulnerable children (OVC) get support and assistance to access schooling, affordable ART and that they are not subjected to stigma and discrimination.
- The provision of care, support and treatment to education staff: this is also the responsibility of the education ministry to provide enabling environments and support to education staff suffering from HIV in varied ways including access to medication.
- The role of schools as part of a national response to HIV-AIDS: Schools are crucial learning institutions where HIV-AIDS risk reduction programmes are being implemented thus; schools are managing and leading HIV-AIDS responses in order to protect the quality of education by improving the quality of life of both the learners and the educators.

2.7 The potential of school heads in strengthening school-based responses to HIV-AIDS

a) The roles and responsibilities of school heads

The success of any educational institution depends on that institution's leadership which is mostly confined to the head of that institution. York-Barr and Duke (2004:98) observed that school heads were practising more leadership functions at both instructional and organizational levels of practice. On the other hand, Murphy and Beck (1995) opined that the schools needed to shift from traditional organization/administration styles to the modern approaches which focus on shared decision-making process and team - work for the schools to be effective and efficient.

School heads are the key stakeholders of school leadership and also help shape each student globally regarding economic potential behaviour with their society and interaction with the environment. Mckon, 2006 also propounds that primary school heads enhance the preparation of future leaders, professionals and citizens of the world. In this context, the role of the school Head is very significant as it serves to facilitate the environment for the teaching learning processes both at school and classroom level.

The role of the school head is essential to the function of an educational environment which facilitates the smooth transfer of knowledge, skills and attitudes during pupils' learning processes. The primary school heads face a hoist of challenges and decisions throughout their careers and so must have the capacity to offer instructional leadership and handle the daily functions of their schools that include maintaining the academic standards of their educational institutions and more importantly implementing policies and procedures to carry out established goals.

As has already been alluded to above, the primary school head also ensures that the academic environment of a school is positive and that all the teaching learning resources are adequate.

Anderson (1979) states that modern dynamic society demands definite knowledge of school Heads' administrative roles and their leadership competence for achievement of maximum educational outcomes. School heads are responsible for creating the learning school environment that produces significant education for production of future nation builders and citizens who are acceptable by society. If the schools do not offer relevant education that train the citizen to work for set targets and goals then education becomes meaningless. Thus, the school heads should be in a position to execute government policies and decisions. William, (2000) stresses that competent primary school heads set the school tone, pace of the institution, to see that the school programmes run safely, smoothly, and efficiently.

The primary school Heads' roles have changed from the once perceived traditional role of simply implementing centrally defined guidelines and recommendations to that of virtually accounting for all initiatives aimed at improving student learning and the quality of education. School heads in most Zimbabwean schools now operate with some degree of autonomy though in more challenging circumstances.

b) Increased tasks for the school heads in the context of HIV-AIDS

In the context of HIV-AIDS a primary school Heads have basically two crucial major tasks: facilitating care and support for affected teachers and pupils/OVC and provision of child-friendly environment for pupils/orphans and vulnerable children (OVC).

School environments should/must always be child-friendly to ensure that schools are maintained and kept in functional conditions that promote all the services expected of them, in line with general Health/HIV-AIDS related provisions. Thus, educational response to the HIV-AIDS epidemic is very important aspect of the school and the community. Effective teaching of HIV-AIDS prevention education programmes also determine the quality of education each learning institution offers to its community.

Primary school heads should ensure that their schools are adequately equipped with the desired resources so that the learners acquire maximum knowledge, skills, attitudes and values that will reduce the likelihood of pupils acquiring or transmitting HIV infections. In summary, the primary school Heads facilitates the teaching/ learning response to HIV-AIDS. Thus, the school is always viewed by the community as the trusted and ideal institution for teaching children HIV-AIDS education. Consequently, within this context school Heads and teachers are perceived by the community as paramount in disseminating knowledge and information about HIV-AIDS.

Although the school heads play major roles in facilitating school climate/environment conducive for the overall delivery of effective teaching/learning processes in schools. In literature, not much is said on School Heads role/contribution to HIV-AIDS issues while a lot of focus is on pupils and teachers. In spite of this, in context of HIV-AIDS prevention, school heads still form the pillars of strength in the provision of support and child- friendly environment for orphans and vulnerable children (OVC).

2.7. Conclusion

Chapter Two documented the international commitment to HIV-AIDS, pivotal role of education in the fight against HIV-AIDS, impact of HIV-AIDS on supply, demand and quality of education. Approaches in responding to HIV-AIDS by the education sector were also highlighted. The findings of this chapter reveal that a lot has been done in terms of commitment on setting goals and targets to respond to the challenges of HIV-AIDS. What remains is for Education Planners, Education Administrators and implementers to apply sustained and dedicated effort using whatever knowledge and techniques at their disposal to ensure full implementation of programmes and accomplishment of the set goals. Chapter Three will present an overview of the HIV-AIDS setting in Zimbabwe

Chapter 3

The Education Response to HIV-AIDS in Zimbabwe

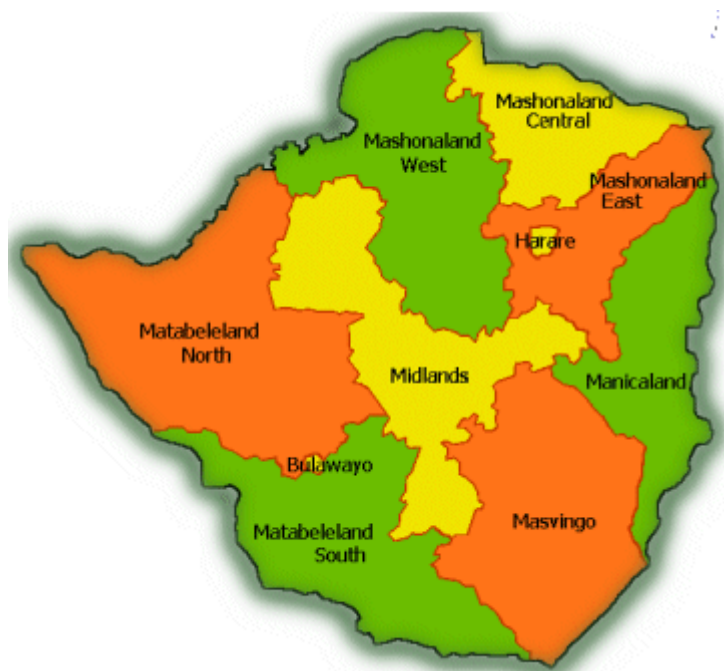
3.1.Introduction

For any country to achieve sustainable development essential for an effective response to HIV-AIDS epidemic, the pandemic needs must be managed properly through national or sectoral- specific initiatives. This chapter gives an overview of the HIV-AIDS situation in Zimbabwe in reference to the country's socio-demographic information, political and economic setting. Zimbabwe education system will be outlined leading to the findings of the monitoring and evaluation of the HIV-AIDS education: SACMEQ III

3.2.General information about Zimbabwe

Zimbabwe is a land-locked country in Southern Africa with an area of 390 757 square kilometres. It shares its borders with four of the fifteen Southern Africa Development Community (SADC) member states. These are Mozambique to the East, Republic of South Africa to the South, Botswana to the West and Zambia to the North.

Figure 1: Zimbabwe divided into 10 education administration provinces.



a) Socio-demographic information

According to 2002 population census (Central Statistical Office 2004), Zimbabwe has a population of 12 461 657. Of the nearly thirteen million people, more than half (7.1 million) is made up of young mostly school going population. This suggests why the education ministry has ever since been allocated the largest vote from the national budget annually in an endeavour to achieve both the 2010 World Fit For Children (WFFC) and the 2015 Millennium Development Goals (MDG) targets.

b) Politics and Economic situation

Zimbabwe's economy is mainly agro-based with mining and tourism coming in second and third contributors of the country's foreign earnings. For two decades from the 1980s through to 2000 Zimbabwe strove to maintain a positive economic growth. The National economy down spiralled drastically from a steady GDP per capita 5 percent in 2000 to a high of 18 per cent in 2005 due to a variety of challenges mainly attributed to mismanagement. In 2007, GDP per capita further dropped 40 percent, agriculture output dropped by 51 percent and industrial production dropped by 47 percent. Zimbabwe recorded an inflation rate of 200 million per cent, 94 per cent unemployment and 80 percent of the wage earners getting below poverty level wages. Due to the hyper-inflation, the Zimbabwe dollar was suspended indefinitely on 12 April 2009 in favour of trading in foreign currency such as the US dollar, the South Africa Rand, Euro, the Botswana Pula and Sterling. According to the 2008 World Today report Zimbabwe's socio-economic problems led to population flight. By 2007 over three million of the country's 12.5 million people had fled.

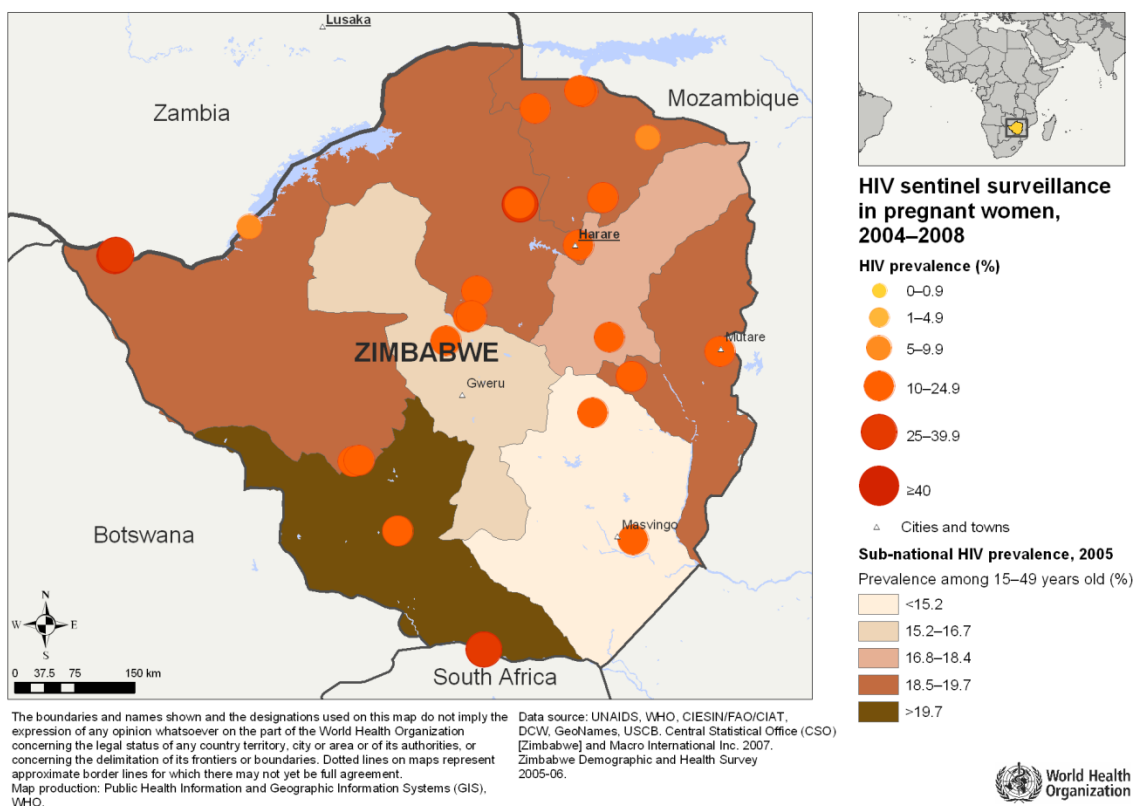
Although Zimbabwe experienced the lowest economic growth of any country in the world in the past decade with -1.9 percent GDP per capita growth per year, its economy however bounced back on track following the formation of the Government of National Unity (GNU) in 2009 which witnessed a more than 5 percent recovery of the real GDP growth to the current 4.10 percent and the GDP per capita of US\$475 for the year 2009/2010 up from US\$167 in 2008. On the same vein, the Finance Ministry pointed out that the nascent economic recovery underpinned by significant improvements in policies of 2009 had stirred a projected GDP real growth of 7.8 percent in the 2010/2011 financial year. (The Financial Gazette Zimbabwe, 2010:3}

c) HIV-AIDS : epidemiologic facts

In UNAIDS 2010 report Zimbabwe's first AIDS case occurred in 1985. By the end of the 1980s, around 10% of the adult population was thought to be infected with HIV. This figure rose dramatically in the first half of the 1990s, peaking at 26.5% in 1997. But since this point the HIV prevalence is thought to have declined, making Zimbabwe one of the first African nations to witness such a trend. According to government figures, the adult prevalence was 23.7% in 2001, and fell to 14.3% in 2010. A rise in the number of people dying from AIDS and those infected with HIV who have migrated to other countries could have possibly contributed to the decline. It is important to note that HIV is still considered to be generalized in Zimbabwe.

The map of Zimbabwe below shows the sub-national HIV prevalence in women aged 15-49 years from 2004-2008 by province.

Figure 2: HIV sentinel surveillance in pregnant women, 2004-2008.



The highest percentage of infected women (over 40%) were living in the border towns (Beitbridge and Victoria Falls) and generally the HIV infection prevalence (over 19.7%)

among women aged 15-49 where living in the Southern province of the country (Matabeleland South) which borders with South Africa. The implications might lead to suggest that because of economic hardships and political instability in the country, many people tend to favour settling in border towns with the intention of crossing into neighbouring economic stable countries. Poverty at times tend to force vulnerable women to eke out a living through commercial sex activities that further expose them to HIV infections as evidenced by the high percentages (over 55%) of HIV infections among young women aged 15-24 years (Ministry of Health and Child Welfare,2005)

Based on the Ministry of Health and Child Welfare sub-national HIV prevalence report of 2005, Matabeleland South (over 19.7%), Matabeleland North (over 18.5%), Mashonaland West (18.4%), Manicaland (18.3%) were the top four provinces with a higher HIV prevalence that ranged from 18.3 to 19.7% mainly due some socio-economic factors. These are the provinces situated within the borders of the economically crippled Zimbabwe and that is where cross-border trading thrives and forms the livelihood of the majority of the communities. In the other six provinces, the HIV prevalence ranged from less than 15.2% to 16.4%.With these high HIV infection rates across the country, the effectiveness of the HIV-AIDS education programmes remain uncertain and more effort must be exerted on attitudes and sexual behavioural change among societies through HIV-AIDS education.

3.3.Education System and Organisation

a) Structure of the education system

The Zimbabwe education system is characterized by a 2-7-4-2 formation/set up, implying that children spend two year in pre-primary school (ECD), seven years in primary school, four years in middle secondary and finally two years in upper secondary before they proceed to tertiary education. National administration and policy making is done at the central offices and then implementation cascades down through provincial offices, district offices and finally to schools.

b) Educational Policy

At attaining independence in 1980 the Zimbabwe government embarked on a mammoth expansion of the education system at all levels. This was in an effort to address the inequalities of the colonial system. In this regard, the new government announced more than ten new education policy initiatives, some of these were: compulsory free primary education, unimpeded progression from primary to secondary and the encouragement of community support for education (Nhundu, 1999).

The Nziramasanga Commission (1999) also contends that the implementation of the government policy initiatives resulted in the institution of the democratization of education policy ushering in expansive and extensive provision of education. The government also declared education to be a basic human birth right. The new policies saw an incredible expansion in the Zimbabwe education system which resulted in the allotment of not less than 24 per cent (24%) of GDP for education annually since then.

The current mission of the Ministry of Education, Sport, Arts and Culture (MOESAC) is to provide high quality and relevant primary, secondary and non-formal education in order to enrich the lives of the people of Zimbabwe. This is a slight shift from the government's previous stance on quantitative expansion to quality, equity and relevance of education.

In line with the Zimbabwean government's commitment to the Millennium Development Goals for education, the MOESAC adopted the National Action Plan (NAP) Education for All towards 2015 that aims to increase enrolment and the quality of all levels of education (SARUA 2008 – MRCI report).

The positive pace at which the Zimbabwe education system was flowing for the past two decades was beleaguered by economic, social and political turmoil during the past ten years which made the whole education system dysfunctional. The severe economic instability over the past ten years (1998-2008) almost eroded the earlier gains in access, quality and equity as many pupils dropped out of school due to high school fees with close to forty-five per cent (45%) of teachers simply leaving their jobs for greener in the neighbouring countries.

Despite the incredible expansion in education which made the country top of the continent literacy rate at ninety per cent (90%), there have been some discrepancies between educational opportunities for Zimbabwe's rural majority and those who live in the main urban centres. A closer analysis of the urban schools also reveal inequalities between the former 'Group A' schools located in the low density residential areas and the former 'Group B' schools located on the high density areas. These inequalities are in terms of resources both human and financial. The unfavourable learning and working conditions have made the education sector unattractive and has witnessed an exodus of trained and qualified teachers with some prospective learners engaging themselves in child labour instead. This scenario has further widened the gap between the well and poorly resourced schools.

3.4.The Education Sector Response to HIV-AIDS

a) Impact of HIV-AIDS on education

As was previously noted, the impact of HIV-AIDS on education is easily noticed on quality mainly due to decreased number of qualified and experienced teachers. In a UNICEF report (2000) estimated Zimbabwe's annual teacher AIDS-related death rate at 2.1 percent. Affected and infected teachers occasionally absent themselves from work due opportunistic infections. It is important to note that the efforts to develop impact studies in the education sector were mentioned in the latest National HIV-AIDS Strategic Plan 2006-2010 but, there was no specific publication on this issue for the moment.

b) Adherence to International Commitment

Currently Zimbabwe is implementing a multi-sectoral response to HIV-AIDS after the Government declared HIV-AIDS a national emergency in 2002. Further to this Zimbabwe is also committed to the "Three Ones" principles agreed upon by affected developing countries, donors and UN agencies through the facilitation of UNAIDS in 2003. One agreed HIV-AIDS action framework, one national AIDS coordinating authority and one agreed country-level monitoring and evaluation system constituted the "Three ones."

c) The HIV-AIDS Strategic Framework Plan (ZNASFP) 2006-2010

In Zimbabwe, the government launched the National AIDS Policy in 1999. Based on it, the first National HIV/AIDS Strategic Framework (2000-2004) was developed in 2000 and followed by a new Zimbabwe National HIV-AIDS Strategic Framework Plan (ZNASFP) covering the period 2006-2010. The ZNASFP is a comprehensive multi-sectoral response to HIV-AIDS that aims to guide all HIV-AIDS related interventions of all sectors – including Education. For the moment, there is no HIV policy developed for the education sector.

The ZNASP set a goal *"to reduce the spread of HIV, improve the quality of life of those infected and affected, and mitigate the socio-economic impact of the epidemic in Zimbabwe"*.

In order to achieve the goal, ZNASP lists four main strategies:

- HIV prevention to reduce the number of new infections with a focus on behavioural change. The target is to reduce the HIV prevalence among 15-24 years olds from 17% to a single digit. Within this framework, one of the most important strategies listed is the “in-school life skills program” in order to reach as many in-school young people as possible and with a particular attention to girls and young women.
- Increased access and use of treatment and care services. The target is to cover at least 75% of those in need with treatment. Although there was an effort to expand and speed up the health services towards universal access with a “Plan for the nationwide Provision of ART” in 2004, supported by NGOs and other private partners, only one third of Zimbabweans in need were receiving ARV treatment by the end of 2010 (UNAIDS/WHO, 2010). Therefore, the shortage of ARVs persists in some provinces (mainly rural and isolated areas) because of difficult economic backgrounds and geographical settings. Despite some of services being offered for free, there is still some strong reluctance to access testing amongst much of the population particularly men.
- Improved support to persons affected by HIV-AIDS – including orphans and vulnerable children. The target is to cover at least 50% of OVC and affected household with a basic package of support services (food, education support, treatment, etc.).
- Effective management and coordination of the national HIV-AIDS response

Zimbabwe’s national HIV-AIDS responses are managed by the National Aids Council (NAC), a national body with a multispectral representation at national, provincial and district levels. While there was political commitment towards fighting HIV-AIDS in Zimbabwe, the National Aids Council (NAC) co-ordination efforts have been constrained by poor organisation and lack of resources.

(d) Life-Skills based HIV-AIDS Education Programme

In response to the HIV epidemic and in an effort to consolidate the HIV risk reduction education in schools, the education ministry has declared as a compulsory component of the

curriculum to pupils from Grade 4 to Form 6 and also in tertiary education though the Education Circular No.16 of 1993. The Ministry of education expects that all teachers (100%) teach life skills HIV and AIDS education about 2 hours per week.

Consequently a pre-service training on life-Skills based HIV-AIDS Education has been implemented for all student teachers in colleges since 1994 (MOESAC- Zimbabwe, 2010). The 13 Teachers' and 11 Technical Training Colleges have at least one trained lecturer to teach the life skills based HIV/AIDS Education Programme in schools and the pre-service training on life-Skills based HIV-AIDS Education consists of 1 to 2 hours per week.

3.5. Monitoring and Evaluating the HIV-AIDS Education Programme: Findings from SACMEQ and Zimbabwe

a) SACMEQ: Members, mission, projects

In association with the International Institute for Educational Planning (IIEP), the Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) was grown and nurtured from the Zimbabwean national and international investigations into the provision of quality education and is a network of 15 Ministries of Education. The fifteen SACMEQ member education Ministries are Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zanzibar, Uganda, Zambia and Zimbabwe.

The SACMEQ mission is: (i) to train educational planners in the quantitative methods for monitoring and evaluating the quality of education and (ii) to undertake large-scale cross-national research projects that will provide valuable baseline information about the quality of the SACMEQ education system.

The SACMEQ network has completed three large-scale educational policy projects, named the SACMEQ I project (1995-1998), the SACMEQ II Project (1999-2004) and the SACMEQ III Project (2005-2011). These projects have been designed to address the following key policy issues of the state's Education Ministry (Murimba, 2005)

- Pupils' characteristics and their learning environment

- Teachers' characteristics and their views about teaching, classroom resources, professional support, and job satisfaction
- School Heads characteristics and their views about educational infrastructure, the organization and operation of schools and problems with pupils and staff
- Equity in the allocation of human and material resources, among regions
- The reading and Mathematics achievement levels of pupils and their teachers.

As already been alluded to earlier, data for this research study which is descriptive in nature was collected, captured, cleaned and presented by SACMEQ researchers using sophisticated software. Authority to access the data was done through IIEP/UNESCO from SACMEQ regional Offices in Harare, Zimbabwe. For this study, it is important to note that the main research instruments used were Questionnaires administered in 2007 on a national research sample of 3 021 Grade 6 pupils, 274 Grade 6 teachers and 155 primary school Heads. The study was conducted in all the country's ten (10) education administration provinces and the selected schools were randomly sampled using a complex SACMEQ sampling design.

During SACMEQ III, an additional research component on evaluating "the impact of HIV-AIDS on the functioning of the school system" was requested by the SACMEQ Ministers of Education. As a result, the SACMEQ researchers have developed a range of indicators in order to evaluate HIV prevention education programmes in primary schools among the SACMEQ member countries.

b) Low knowledge level about HIV-AIDS among pupils but high level among teachers

Trends across the SACMEQ countries

In the paper by Dolata and Ross (2010), the first research findings from SACMEQ III about the HIV-AIDS component revealed there was relative mismatch on HIV-AIDS knowledge levels between the pupils and the teachers across the SACMEQ countries. It was cause for concern since authors had assumed that if teachers had high levels of knowledge about HIV-AIDS then they would be able to transmit this knowledge to their pupils.

On overall, the general knowledge about HIV-AIDS of the pupils across SACMEQ countries was relatively low with only 36% of pupils knowing at least half of the curriculum on HIV-

AIDS education implemented across the SACMEQ countries (minimum level) and a paltry 7% of the pupils knowing three quarters of the same curriculum (desirable level). In contrast, their teachers exhibited a relatively high knowledge of HIV-AIDS with a very high national average of 785 and 99% of them reached the minimum level of knowledge about HIV-AIDS.

When comparing the countries, the pupils in Zimbabwe had very low knowledge about HIV-AIDS with an average transformed score of 477 (below the SACMEQ III average of 500), and 30% and 4% of pupils reached the minimal and desirable knowledge levels about HIV-AIDS, respectively.

Trends among the provinces in Zimbabwe

In the SACMEQ national policy brief on “Pupil and teacher knowledge about HIV-AIDS in Zimbabwe” (Chitiga and Chinoona, 2011), the authors have analyzed the Zimbabwe pupil and teacher knowledge levels about HIV-AIDS by provinces and the results have been presented in table 3.1.

Table 3.1 Knowledge level about HIV-AIDS among Grade 6 pupils and teachers

Province	Grade 6 Pupils				Teachers			
	Transformed score		Reaching minimum level		Transformed score		Reaching minimum level	
	Mean	SE	%	SE	Mean	SE	%	SE
Bulawayo	523	10	47	4	772	20	100	0
Harare	532	11	53	5	770	18	97	3
Mashonaland Central	476	7	27	4	780	25	96	4
Mashonaland East	443	16	17	6	851	34	100	0
Mashonaland West	481	22	29	8	788	16	100	0
Midlands	505	17	39	7	813	23	100	0
Manicaland	447	12	18	4	752	12	100	0
Matabeleland North	431	13	17	4	792	33	100	0
Matabeleland South	413	14	7	5	787	15	100	0
Masvingo	496	19	39	9	771	19	100	0
Zimbabwe	477	5	30	2	785	7	99	0

At province level, the percentage of pupils reaching the minimum knowledge level ranged between 7% in Matabeleland South and 53% in Harare. Although there is a large variation in Grade 6 pupil knowledge about HIV-AIDS, the knowledge level among pupils is very low in Zimbabwe. Concerning the teachers, almost all of them (99%) reached this level and this is consistent across the provinces.

The large variation in Grade 6 pupil knowledge about HIV-AIDS and that of their teachers suggest that teachers are not transmitting the HIV-AIDS knowledge to the pupils for unknown reasons. Therefore there is need for close monitoring of the implementation of the school - based HIV-AIDS policies by the education ministry's Inspectorate. Teachers should be sensitized on attitude change towards the integration of HIV-AIDS in the school curricular to achieve the ZNASP targets.

3.6 Conclusion

This chapter gave an overview of the HIV-AIDS situation in Zimbabwe in reference to the country's socio-demographic information, political and economic setting. It has emerged that national policies and strategic action plans on HIV-AIDS prevention have been developed due Zimbabwe's commitment to achieving the 2015 Millennium Development Goals (MDGs). What remains to be done by the education ministry is to collaborate with other relevant ministries in coming up with strengthened implementation programmes to deliver effective prevention, treatment and care services to all people in need across the whole country. Zimbabwe education system was also outlined leading to the findings of the monitoring and evaluation of the HIV-AIDS education prevention: SACMEQ III. Analysis of data will be presented in the next chapter.

Chapter 4

School Heads' Viewpoints and Professional Characteristics In the Context of HIV-AIDS

4.1. Introduction

For primary school heads to be able to work out action plans to respond to HIV-AIDS at school level, they must be capacitated to conceptualise, manage and lead the responses in ideal/appropriate contexts. Hence this chapter presents, analyse and develop inference from the data/information describing the school heads in terms of personal and professional characteristics as well as their awareness and viewpoints in the context of HIV-AIDS.

Therefore, the findings will be interpreted according to the demands of the research questions tabulated below:

- What were the personal characteristics of school heads (in terms of age and gender)?
- What percentage of school heads has attended in-service training on HIV-AIDS? And what were the preferred activities during these courses?
- What were school heads' attitudes towards persons infected with HIV? And how did school heads rate their own risk of becoming infected with HIV?
- Did School Heads have sufficient awareness of HIV testing centres in order to be tested? What were their attitudes to being tested for HIV? Had they been tested for HIV before?
- What were the common sources of information about HIV-AIDS for the school heads? Which source is considering being the best by the school heads?

a) Note on the interpretation of the data

Before presenting the results, it is very important to draw the attention of the reader on two points for interpreting the estimates. First, each estimate presented in the memoire should be interpreted with its sampling error (SE). Indeed, the data of SACMEQ III Project were collected using a complex sample design from multiple sources (pupils, teachers and school heads). The detailed information about the sampling procedures has been presented in the SACMEQ III National Report in Zimbabwe (in preparation).

The second point to note is that the values of all tables throughout the memoire have been presented in terms of “Grade 6 Pupils”. That is, pupils were the **units of analyses** chosen in the SACMEQ III Project –even though most of the variables presented in the memoire refer to the school heads and teachers. Where a percentage refers to a pupil characteristic then this means that it is “the percentage of pupils having this characteristic”. Where a percentage for a variable refers to the school heads then the percentage should be interpreted as “percentages of pupils were in schools with a school head having the particular characteristic”. Same approach should be done with a percentage describing teachers. Similarly, a mean for a variable presented for a school head should be described as “average pupil in the province or Zimbabwe was in schools with the particular characteristics”.

To illustrate the above points, consider the percentages and means presented in Table 4.2:

- For Zimbabwe overall the **sample mean** of pupils who were at primary schools where the age of the school heads was 47.6 years with the sampling errors of 0.62. In other words, these figures indicate that we can be confident at 95% that the mean age of Zimbabwean’s Primary School Heads was $47.6 \pm 2 (0.62)$ years, that is, it lies between 46.4 years and 48.8 years.
- For Zimbabwe overall the **sample percentage** of pupils who had a female school heads was 27.2 percent with a sampling errors of 3.92 percent. In other words, these figures indicate that we can be confident at 95 percent that the **population percentage** of pupils who had female school heads was $27.2 \pm 2 (3.92)$ years, that is, it lies between 19.4 percent and 35.0 percent.

This should be taken into account even when it is not explicitly mentioned in the main text.

b) Some contextual information about the localisation of the schools

The following section provides some contextual information about the schools. The percentages of pupils in schools that their school heads describe as being in an “urban” area are presented in Table 4.1. In the same table, an indicator of the average distance to social service centres such as clinics, post office and secondary schools was also been presented. This gave an indication of the magnitude of the isolation of the schools across the provinces.

Table 4.1 School location

Province	Urban		Distance (km)	
	%	SE	Mean	SE
Bulawayo	100.0	0.00	14.9	8.02
Harare	100.0	0.00	27.7	17.46
Mashonaland Central	9.5	9.30	21.3	3.83
Mashonaland East	0.0	0.00	41.6	15.40
Mashonaland West	35.8	13.78	31.9	5.71
Midlands	32.7	12.70	33.3	6.91
Manicaland	7.5	7.46	24.7	4.09
Matabeleland North	0.0	0.00	100.0	41.33
Matabeleland South	9.8	9.70	38.1	5.93
Masvingo	11.8	11.12	20.1	4.85
Zimbabwe	28.9	3.09	28.2	3.15

In Zimbabwe, less than one third (28.9 %) of pupils were in primary schools located in the urban areas and the national mean distance from one school to the social service centres was 28.2 kilometres.

It can be seen that there are major differences across the provinces. As expected, all the schools (100%) in Bulawayo and Harare which are urban centres had shorter mean distances to the selected amenities.

4.2. What were the personal characteristics of school heads?

Before analysing the HIV-AIDS related viewpoints and professional characteristics of the school heads, it was important to have a general picture of the personal characteristics of the school heads such as age and gender. The figures presented in table 4.2 provide information about the age and gender distribution of the school heads.

Table 4.2 School Head Age and Gender

Province	Age (years)		Gender (female)	
	Mean	SE	%	SE
Bulawayo	52.0	1.00	50.3	12.92
Harare	48.8	1.31	35.4	12.52
Mashonaland Central	46.4	1.46	17.3	10.83
Mashonaland East	46.0	2.06	25.8	16.18
Mashonaland West	43.6	2.95	30.2	13.48
Midlands	49.2	1.60	31.0	12.38
Manicaland	50.7	2.07	0.0	0.00
Matabeleland North	48.2	1.80	47.8	14.92
Matabeleland South	47.3	1.84	55.5	16.07
Masvingo	46.0	1.85	4.5	4.65
Zimbabwe	47.6	0.62	27.2	3.92

In Zimbabwe, the Grade 6 pupils attended schools where the average age of school heads was 47.6 years. In short, there was not much variation in the average ages across the provinces except that the School heads in Bulawayo and Manicaland were slightly older than those in other provinces.

Female school Heads constituted only 27.2 percent of the whole. There were large variations across the provinces, Matabeleland South and Bulawayo Provinces had slightly more than fifty percent of female school heads while Masvingo had only 4.5 percent and Manicaland had zero percent female school heads.

4.3. What percentage of school heads has attended in-service course on HIV-AIDS? And what were the preferred activities during these courses?

a) Coverage of school heads trained on HIV-AIDS

The school heads were asked about their attendance to in-service courses on HIV-AIDS. They were supposed to respond with either “no” meaning they had not attended or “yes” meaning that they had attended. Their responses are presented in table 4.3(a).

Table 4.3(a) Coverage of school heads trained on HIV-AIDS

	School Heads having attended in-service courses on HIV & AIDS	
	%	SE
<u>Province</u>		
Bulawayo	81.6	9.95
Harare	100.0	0.00
Mashonaland Central	87.9	7.34
Mashonaland East	57.2	15.58
Mashonaland West	61.5	14.69
Midlands	73.4	11.86
Manicaland	65.5	21.56
Matabeleland North	67.1	13.78
Matabeleland South	83.9	11.45
Masvingo	81.3	12.27
<u>Gender</u>		
Male	74.5	4.93
Female	84.6	5.68
<u>School Location</u>		
Rural	74.6	4.89
Urban	83.0	6.43
Zimbabwe	77.2	3.95

In Zimbabwe, nationally more than three quarters (77.2%) of the school heads had attended in-service training courses on HIV-AIDS. Female school heads (84.6%) was much higher than the national average and that of male school heads (74.5%) The education ministry targets 100% participation by teachers currently in service like in the case with Harare province. Therefore in order for Grade 6 pupils in other provinces like Mashonaland East (57.2%) and all those below the national average (77.2%) to get the much needed exposure to life skills HIV-AIDS education, more school heads must be encouraged to participate in in-service training programmes.

There were significant variations among the provinces in the coverage of in-service courses on HIV-AIDS by the school heads. In Harare province, all school Heads (100%) had attended in-service training on HIV-AIDS while in Mashonaland West there were around half of the school heads (57.1%) trained on HIV-AIDS. Hence concerted effort should always be exerted on school heads in the following provinces: Mashonaland East, Mashonaland West, Manicaland and Matabeleland North, to encourage them taking up in- service training on life skills based HIV-AIDS education to enhance effective implementation of similar school based programmes for the benefit of both the pupils and the local communities.

b) Common activities during the in-services on HIV-AIDS

Two additional questions based on fourteen possible activities carried out during the training courses were posed to the school heads that had attended in-service courses on HIV-AIDS. The respondents were tasked to:- (i) to indicate whether these activities happened or not and (ii) to specify the activity that they considered as “best”. The analyses of their responses are summarized in tables 4.3(b) and 4.3(c).

Table 4.3(b) Activities conducted during the in-service courses on HIV-AIDS

Activities during the in-service on HIV-AIDS	Percentage of school heads indicating “yes”	
	%	SE
Reading materials (s)/pamphlet(s)	76.4	4.06
Lecture	73.5	4.15
Contact addresses given	59.3	4.57
Watch a vidéo / film	42.7	4.63
Listen to a radio and/or recorded programme	32.0	4.39
Ask questions	76.4	4.04
Talk by a person living with HIV	28.2	4.26
Group discussion	76.4	4.16
Hospital / care centre trip	16.0	3.34
Complete a questionnaire	51.6	4.74
Participâtes in rôle Play	64.2	4.46
Learn to respond to sensitive questions	67.8	4.50
Practical demonstrations – for example, of condom usage	59.5	4.62
Distribution of male/female condoms	54.4	4.70

Primary school heads participated in all the fourteen activities in varied degrees or intensities. Asking questions (76.4%), Reading materials (s)/pamphlet(s) (76.4%), Group discussion (76.4%) and Lecture (73.5%) were the major forms of information dissemination used during school heads in-service training. On the other hand, activities that had direct interaction with people infected with HIV were the least conducted as evidenced by the following percentages: Hospital / care centre trip (16.0%), Talk by a person living with HIV (28.2%). Although activities like Distribution of male/female condoms (54.4%), Listen to a radio and/or recorded programme (32.0%), and Watch a video / film (42.7%) were the second least conducted. However, more could have been encouraged since these offer more effective prevention solutions.

Policy suggestion: The education ministry should introduce strengthened HIV-AIDS prevention programmes where the latest social and scientific knowledge on the subject is delivered to the trainees for onward transmission to teachers, pupils and the community.

Table 4.3(c) Preferred HIV-AIDS related training activities of school heads

<u>Best activities during the in-services courses on HIV-AIDS</u>	Indicating “best”	
	%	SE
1. Group discussion	18.4	3.99
2. Reading materials (s)/pamphlet(s)	16.6	4.13
3. Lecture	13.8	3.70
4. Watch Video / film	13.6	3.68
5. Participate in role play	13.6	3.79
6. Learn to respond to sensitive questions	9.4	3.45
7. Talk by a person living with HIV	7.5	2.77
8. Ask questions	3.8	1.80
9. Practical demonstrations – for example, of condom usage	2.6	1.83
10. Trip to Hospital / care centre	0.7	0.73
11. Contact addresses given/ Questionnaire/ Radio / Recorded programme / Condom distribution	0.0	0.00

Sharing information on HIV-AIDS among peers through group discussions during in-service training courses came out most popular (18.4%) followed by reading materials/pamphlets (16.6%), lecture (13.8%), watching video/film (13.6%), learning to respond to sensitive questions (9.4%) and talk by a person living with HIV (7.5%). The trend of the preference by school Heads on training activities suggests that those “inter-active” participation activities with prompt feedback and dialogue were the most preferred compared to “passive” participation activities such as to complete a questionnaire and listen to a radio/recorded programme.

Policy suggestion: Ministry of Education, Sport, Arts and Culture intensify the regular provision of in-service courses related to HIV-AIDS for school Heads and put in a lot of emphasis on interactive activities rather than passive activities.

4.4. What were school heads' attitudes towards persons infected with HIV? And how did school heads rate their own risk of becoming infected with HIV?

The education sector has an important role to play in addressing HIV-AIDS related stigma and discrimination in Zimbabwe. HIV-AIDS related stigma and discrimination are different but interrelated phenomena that refer to a “process of devaluation of people either living with or associated with HIV-AIDS...Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status.” (UNAIDS, 2003). It is highly human rights violation to discriminate someone on perceived HIV status.

The effects of HIV-AIDS related stigma and discrimination in the education sector are a major cause for concern in countries considered with generalized epidemic. For example, it can result in social exclusion, marginalization of infected and affected children; negative learning environment; absenteeism of pupils and teachers and drop-outs; poor adherence to treatment; and psychological damage. Therefore, education has a unique opportunity to effect change among the children and young people, future adults, by passing knowledge, attitudes and skills they need to make informed decisions and develop positive attitudes.

The school Heads who are managers of educational institutions should lead by example to enhance similar involvement by their subordinates. If the school leadership lacks the knowledge and information on HIV-AIDS prevention education and/or have negative attitudes, the implementation of HIV-AIDS prevention education programmes could be compromised. Hence the accomplishment of National AIDS Goal will also be dampened.

a) Attitudes towards a person infected with HIV

The school heads were asked about their attitudes concerning pupils who are infected with HIV being allowed to continue attending school. There were three possible responses to the question: “no” meaning that the infected pupils should not continue with school, “yes” meaning that they did not mind that the infected pupils continued with school and “I am not sure”. Another question (with the same focus) on attitudes towards teachers infected with HIV being allowed to continue to teach were also asked to the primary school heads.

Table 4.4(a) School Heads Attitudes towards a person infected with HIV

	School Head Having a Positive Attitude towards			
	Pupil Infected with HIV		Teacher infected with HIV	
	%	SE	%	SE
<u>Province</u>				
Bulawayo	93.7	6.27	87.5	8.57
Harare	91.2	8.60	100.0	0.00
Mashonaland Central	95.5	4.61	95.5	4.61
Mashonaland East	89.7	10.05	88.8	10.09
Mashonaland West	100.0	0.00	100.0	0.00
Midlands	92.5	7.37	92.5	7.37
Manicaland	100.0	0.00	100.0	0.00
Matabeleland North	100.0	0.00	100.0	0.00
Matabeleland South	100.0	0.00	100.0	0.00
Masvingo	94.6	5.44	94.6	5.44
<u>Gender</u>				
Male	95.3	2.43	94.6	2.48
Female	94.3	4.42	98.5	1.47
<u>School Location</u>				
Rural	96.6	2.06	96.4	2.06
Urban	91.5	5.12	94.1	3.76
Zimbabwe	95.0	2.16	95.7	1.86

The figures in Table 4.4(a) present the percentages of pupils who were in schools where the schools heads agreed that a pupil and a teacher infected with HIV should continue to come at school, meaning having positive attitudes. It clearly shows that almost all school heads (more than 95%) had positive attitudes towards both pupils and teachers infected with HIV.

There were minor variations observed across the provinces in spite of their different geographical settings. All school heads (100%) in four provinces (Mashonaland West, Manicaland, Matabeleland North and Matabeleland South) agreed that HIV positive persons should continue coming to school. It was also interesting to note that 98.5% of female school

heads against 94.6% male, strongly agreed that HIV infected teachers be allowed to continue with their school duties. Schools Heads in rural school had more positive attitudes towards both pupils (96.6%) and teachers (96.4%) infected with HIV against (91.5% and 94.1%) respectively of their urban counterparts.

Policy Suggestion: Having policy that endeavour to embrace and strengthen the positive attitudes meant to eliminate stigma and discrimination that traumatize persons affected and infected with HIV.

b) Self-risk assessment by school heads

The self-perception of risk of being infected is considered as an important factor that can influence positive behaviours. Indeed, several theories of “health behaviour” suggest that it is an individual's perception of risk rather than the actual risk involved that determines behaviour. In Table 4.4(b) the responses of school heads about their own perception of being infected with HIV are summarized.

Table 4.4(b) School Heads' Self risk assessment of being infected with HIV

	Self-risk assessment of being infected with HIV by the school heads					
	No/ Low Risk		Medium Risk		High/Very High Risk	
	%	SE	%	SE	%	SE
<u>Province</u>						
Bulawayo	62.5	12.51	12.7	8.64	24.9	11.14
Harare	54.2	13.26	20.9	11.28	24.9	11.42
Mashonaland Central	35.6	13.74	48.5	15.72	15.8	9.58
Mashonaland East	66.9	14.25	10.7	7.40	22.4	12.84
Mashonaland West	74.2	12.91	12.7	8.88	13.1	10.85
Midlands	74.1	11.64	0.0	0.00	25.9	11.64
Manicaland	29.4	18.89	0.0	0.00	70.6	18.89
Matabeleland North	48.6	14.91	18.0	11.80	33.5	13.83
Matabeleland South	58.9	15.65	7.0	7.15	34.1	15.09
Masvingo	33.4	12.79	18.5	10.22	48.1	13.66
<u>Gender</u>						
Male	48.2**	5.60	16.0	4.27	35.8**	5.45
Female	68.8**	7.89	14.4	5.95	16.8**	6.14
<u>School Location</u>						
Rural	50.0	5.72	16.7	4.36	33.3	5.41
Urban	62.1	5.58	13.2	5.58	24.7	7.69
Zimbabwe	53.8	4.66	15.6	3.47	30.6	4.37

More than half (53.8%) of school heads indicated that they had no or very little chance of them being infected with HIV, 15.6 percent stated that there was medium chances and 30.6 percent showed that there were very high possibilities that they could be infected with HIV. In Manicaland pupils were attending schools where 70.6% of the teachers said to be at very high risk of being infected by HIV, an indicator of lack of knowledge on prevention measures and behaviour change prevailed in the province.

Female school heads 68.8% as opposed to 48.2% male indicated low risk of infection while only 16.8% female against 35.8% male school heads indicated very high risk of being

infected. At this stage, it is not possible to make inference on the reasons that are beyond the scope of the study.

Policy suggestion: It is suggested that further research be instituted to establish reasons for the high self-risk perception on being infected with HIV by the school heads

4.5. What was the level of awareness, attitude and use of HIV testing places by the school heads?

In the context of generalized epidemic, the voluntary and counselling testing (VCT) is an important component of the national response that gives opportunity to the persons to have information about HIV-AIDS and to learn about his/her HIV status. In Zimbabwe, a “National HIV Testing and Counselling Strategic Plan (ZNHTCSP) 2008-2010” was launched in 2008 - where there was an emphasis on the need to increase the percentage of the Zimbabwean population who know their status from 20% to 85% in 2010 and also to expand HIV Testing and Counselling services (UNGASS, 2010). All this was aimed at reducing HIV infections among infants and young adults, improvement in HIV-AIDS education, health care and treatment and improvement in orphan support.

In the SACMEQ III instrument, the responses of the school heads about their awareness of HIV testing places, attitudes on having HIV tests and behaviour in terms of being tested for HIV in the past have been analysed in this section.

a) Awareness of a HIV testing place

Information on table 4.5 summarizes the responses of the school heads to two questions of knowing whether there were HIV testing places within walking distance or nearby towns/trading centres close to homes where an HIV test could be done and also the distance to the nearest HIV testing place to the school.

Table 4.5(a) School Heads' Awareness of HIV testing places

	Awareness of HIV testing		Distance of the nearest HIV testing place to the school (Km)	
	%	SE	Mean	%
<u>Province</u>				
Bulawayo	100.0	0.00	6.3	1.41
Harare	100.0	0.00	5.0	1.42
Mashonaland Central	100.0	0.00	15.7	4.41
Mashonaland East	87.9	8.30	23.9	8.01
Mashonaland West	88.1	11.29	29.3	8.78
Midlands	86.5	9.23	24.8	6.69
Manicaland	100.0	0.00	28.2	7.70
Matabeleland North	61.9	14.58	162.1	123.25
Matabeleland South	82.3	12.22	48.9	8.99
Masvingo	78.0	10.62	22.1	7.78
<u>Gender</u>				
Male	88.4	3.52	24.3	3.16
Female	89.6	4.40	21.7	5.39
<u>School Location</u>				
Rural	83.6**	4.00	32.0**	3.65
Urban	100.0**	0.00	5.7**	0.95
Zimbabwe	88.7	2.80	23.4	2.53

Note: (**) Significant at 95% of confidence

Nationally a vast majority of school Heads (88.7%) indicated knowing a place to have an HIV test in a nearby town/trading centre or walking distance from their homes. The overall awareness and responses by gender was well balanced at 89.6% female and 88.4% male. The national mean/average travelling distance between the school and the HIV testing place was 23.4 kilometres.

There were some variations among the provinces. All school heads (100%) in four provinces; (Bulawayo, Harare, Mashonaland Central and Manicaland) indicated knowing the existence of a place to be tested for HIV. And, the distance between schools and HIV testing place was small in Harare and Bulawayo are small (around 5-6 km) due to their geographical setting. In contrast, the situation in Matabeleland North (162km) and South (48.6km) was particularly worrisome because the distances between schools and testing centres were far above the national mean. This might explain the low level of HIV testing place awareness among school heads in Matabeleland North. This same disadvantaged scenario for rural areas emerged when analysing the responses in terms of awareness and distance to HIV testing place by location

Naturally, the long distance between the schools and the HIV testing centres would have negative bearing on the dissemination of information on HIV-AIDS prevention in the provinces. This is also cause for concern since encouraging school Heads to regularly visit the HIV /AIDS centres for testing and information on the pandemic becomes a difficult task. It is also suggested there should be more publicity/communication about the existing of VTC centres in school and expanding the establishment of VTC centres and mobile VTC especially in Matabeleland North and South provinces.

b) School Heads Attitude of being tested on HIV

The school heads were asked whether they would have taken an HIV test free of charge and by paying for the test. The possible responses for both questions were “no” and “yes”. Based on these responses, an index was constructed that identified the school heads that would take an HIV test (free of charge or not) and the school heads that would not take an HIV test. The results are summarized in table 4.5(b).

Table 4.5(b) School Heads Attitude on Having an HIV Test

School Heads Attitude on Having a HIV Test		
	%	SE
<u>Province</u>		
Bulawayo	69.0	11.93
Harare	94.0	6.03
Mashonaland Central	87.5	11.87
Mashonaland East	81.0	12.64
Mashonaland West	95.8	3.18
Midlands	100.0	0.00
Manicaland	88.6	12.10
Matabeleland North	91.0	8.83
Matabeleland South	89.3	10.55
Masvingo	81.3	12.27
<u>Gender</u>		
Male	87.2	4.14
Female	92.3	3.27
<u>School Location</u>		
Rural	87.2	4.14
Urban	92.3	3.27
Zimbabwe	88.6	3.16

Nationally an average of 88.6 percent of primary schools Heads indicated they who would opt to take an HIV test for free, with female heads (92.3%) against male (87.2%) indicating that they would take an HIV test. The implication here is that female heads have much stronger positive attitudes towards their HIV status. Primary school heads in the Midlands province had 100 percent (100%) positive attitude towards taking HIV tests. While there were marginal positive variations in attitudes towards taking HIV tests across the provinces, Bulawayo province (69%) was the only province that had the highest negative attitudes towards taking even the free HIV test.

c) HIV testing coverage among the school heads

Primary school heads were asked to respond to whether they had ever been tested for HIV and their responses are presented in table 4.5(c)

Table 4.5(c) HIV testing coverage among the school heads

	School Heads who have had an HIV test	
	%	SE
<u>Province</u>		
Bulawayo	56.7	12.79
Harare	39.1	13.01
Mashonaland Central	29.9	12.37
Mashonaland East	51.8	16.19
Mashonaland West	38.1	14.38
Midlands	30.1	12.18
Manicaland	18.3	17.95
Matabeleland North	69.4	13.66
Matabeleland South	37.9	15.75
Masvingo	20.0	11.86
<u>Gender</u>		
Male	33.7	5.34
Female	43.8	8.52
<u>School Location</u>		
Rural	32.0	5.14
Urban	46.1	8.39
Zimbabwe	36.4	4.52

Grade 6 pupils in Zimbabwe were in schools where less than forty percent of the school heads (36.4%) had been tested for HIV. While the coverage among the school heads was larger than the population coverage (20%) in 2007, the coverage still remained low. Female school heads (43.8%) had taken tests for HIV compared to their male counterparts (33.7%)

seem to suggest they could be spreading information on HIV-AIDS prevention awareness to pupils more than their male colleagues.

From the above figures, it can be easily seen that there are large variations of the HIV testing coverage among the school heads across the provinces. In particular, the coverage seemed to be very low within two provinces (Manicaland- 18% and Masvingo- 20%) Ironically these two provinces had very high percentages of school Heads who indicated very high risk of being infected with HIV. An investigation is necessary to find out why some key administrators and influential members in society are still behaving negatively regarding issues such as HIV testing.

Policy suggestion: Education ministry should facilitate more publicity/communication about the importance of being tested and promote the existing VCT centres among education staff.

Policy suggestion: Ministry should also endeavour to expand the establishment of VCT and mobile VCT especially in Matabeleland North and South provinces.

Policy suggestion: Ministry to undertake further research to understand the reasons and barriers why the school heads are reluctant to being tested for HIV.

**4.6. What were the main sources of information about HIV-AIDS for the school heads?
And, which sources were considered as the best by the school heads?**

The percentages of pupils where the school heads received information about HIV-AIDS from different sources are presented in table 4.6(a) and ranked according the school heads preferences in table 4.6(b).

Table 4.6(a) Source of information on HIV-AIDS for School Heads

Source of information on HIV & AIDS	Indicating “yes”	
	%	SE
Radio	97.3	1.5
TV	95.2	1.95
Video player (VCR/DVD, etc.)	55.6	4.69
Internet	17.6	3.39
Computers	22.4	3.67
Posters / Billboards	91.4	2.84
Books	98.5	0.95
Magazines/ Newspapers	99.3	0.49
Dramas/ Plays / Concerts	99.2	0.76
Cinema	49.4	4.76
School Club	86.1	3.25
Recreational activities	75.7	3.97
Pre-service teacher training	48.9	4.63
In-service teacher training	83.7	3.55
Hospital / Clinic	92.7	2.41
Teachers / Other School Heads	95.3	2.38
Friends	94.9	2.47
Counsellors	76.4	4.02
Peer educators	81.3	3.87
Doctors	70.6	4.26
Community health workers	90.9	2.67
Persons from church, mosque, temple, etc.	82.4	3.74
A person living with HIV	62.5	4.59
Family / Relatives	87.6	3.54

It can be clearly seen from the results in table 4.8(a) that the school heads received information about HIV-AIDS from different sources. The majority of the school heads received information through print media such as magazines and newspapers (99.3%) and books (98.5%), dramas/ plays / concerts (99.2%) and audio-visuals means such as radio (97.3%) and TV (95.2%). In contrast, very few school heads had been exposed to HIV-AIDS

related information through internet (17.6%) and computers (22.4%) because the education sector's ICT is not developed and as such inhibits efficient Information Technology operations. Although school heads received 83.7% information about HIV-AIDS through in-service training programmes a paltry 48.9% had received the same information through pre-service training. This suggests that some education sectors are yet implement the National Strategic Action Plans on HIV-AIDS.

The responses presented in the table 4.6(b) were among the sources of information identified by the school heads, when they were asked to indicate the “best” source.

Table 4.6(b) Best source of HIV-AIDS information for School Heads

Best Source of Information on HIV-AIDS	Indicating “best”	
	%	SE
1. TV	17.2	3.46
2. Magazines/ Newspapers	15.0	3.43
3. Dramas/ Plays / Concerts	12.0	3.17
4. Books	10.3	2.80
5. Radio	9.1	2.75
6. A person living with HIV	8.1	2.40
7. Peer educators	6.7	2.47
8. Counsellors	5.3	2.25
9. In-service teacher training	4.1	1.77
10. Doctors	2.2	1.34
11. Family / Relatives	1.7	0.87
12. Video player (VCR/DVD, etc.)	1.6	1.16
13. Community health workers	1.3	0.90
14. Cinema	1.3	1.29
15. Persons from church, mosque, temple, etc.	1.2	0.88
16. Hospital / Clinic	1.0	0.76
17. Posters / Billboards	0.9	0.68
18. Friends	0.9	0.77
Internet /Computers/ School Club / Recreational Activities / Pre-service training/ Teachers / Other School Heads	0.0	0.00

The best source of information for the school heads were mainly audio-visual and print media: TV (17.2%), Newspapers / Magazines (15.0%), Dramas / Plays / Concerts (12.0%), Books (10.3 %), Radios (9.1%) and a person living with HIV (8.1 %). It was also interesting to observe that although the coverage of school heads having information about HIV-AIDS from a person living with HIV was quite limited (62.5%) compared to the other others sources, discussions with a person with HIV was part of the “best” sources (it was ranked at the 6th position). In contrast, it was disconcerting to see that very few school heads (4.1%) had indicated ”in-service teacher training” as the best referral source of information on HIV-AIDS and none on pre-service teacher training.

It is recommended that education ministry based surveys to establish whether life skills based HIV-AIDS education is being carried out as well as coordinating with the Higher Education /tertiary institutions sector in strengthening the implementation of pre-service teacher training in life skills based HIV-AIDS education introduced under the HIV-AIDS Life Skills Strategic Plan for the 2006 to 2010 continues to bear fruits. Exchange and sharing of information on HIV-AIDS could be done through groups, clubs, private and public organizations networking with the education ministry being the focal/linking pin.

Policy suggestion: Education ministry to carry out ministry based surveys to establish the extent to which life skills based HIV-AIDS education is being carried. There must be coordination with the Higher Education /tertiary institutions sector in strengthening the implementation of pre-service teacher training in life skills.

4.7. Conclusion

Chapter Four presented, analysed and developed inference from the information collected from the respondents based on variables such as the school heads' personal and professional characteristics, their awareness and viewpoints in a context of HIV-AIDS.

Based on the above observations, it may be suggested that the Education ministry empower the school heads through regular in-service training to develop school-based intervention HIV-AIDS policies and other related initiatives to strengthen their response and better prepare the teaching staff counter-attack HIV-AIDS.

On average over 95 percent of the primary school heads indicated very positive attitudes towards persons affected or infected with HIV-AIDS. But, it was somewhat worrisome that in some provinces pupils are attending schools where as high as 70.6 percent of the school heads indicated to be at very high risks of being infected by HIV. Although an average of 88.7 percent school heads knew the existence of HIV testing centres and had a positive attitude on having a HIV test, only 36.4 percent of them have had an HIV test.

It was also observed that the traditional sources of information (radios, television, newspapers, magazines, dramas/concerts, direct/one-on-one interactions, and books) still remain predominant sources for information on HIV-AIDS compared to the modern-day ICT-computers and the internet. On the whole, female school heads tended to have more positive attitudes in almost all the HIV-AIDS related activities that heads were involved in.

It is suggested that the ministries of education continue to offer regular in-service training where modern social and scientific content/knowledge is availed to reduce fear and ignorance evolving HIV-AIDS and also to empower the school heads in responding to the challenges that come with epidemic.

Chapter Five outlines the descriptive analysis of the supportive school environment in the context of HIV-AIDS in terms of general school infrastructure, provision of teaching/learning resources, support and care of both school children/OVC and teachers affected and infected with HIV.

Chapter 5

Supportive School Environment in the Context of HIV-AIDS

5.1. Introduction

The introduction of HIV-AIDS prevention education programmes in school curriculum called for additional support to educational institutions to enable the administrators manage the challenges that came with the new approach, particularly in human resource management and Information and financial management. This chapter outlines the descriptive analysis of the supportive school environment in the context of HIV-AIDS in terms of general school infrastructure, provision of teaching/learning resources, support and care of both school children/OVC and teachers affected and infected with HIV. Findings of chapter five should help establish how effective school heads roles are with regards to the creation of supportive environment for halting the spread of HIV-AIDS, provision of information to reduce stigma and trauma and provision of care and support for the affected pupils/OVC ,teachers and communities through multi-sectoral approaches.

In this chapter, data presentation and analyses address the following research questions:

School infrastructure

- What were the school heads' viewpoints on general condition of school buildings? And did the schools have the basic sanitary facilities and specific health equipment?

Life-skills based HIV-AIDS education

- What was the coverage of teachers who had received specialized life-skills-based HIV-AIDS education training?
- Did the teachers have access to HIV-AIDS related teaching materials at schools?
- What percentage of Grade 6 pupils had attended lessons on HIV-AIDS?

Extra-curricular activities in the school

- What kind of extra-curricular activities, in terms of combatting HIV-AIDS related stigma and discrimination and HIV testing for staff, were organized by the schools?

Support to OVC and pupils and teachers affected by HIV-AIDS

- What kind of support were provided to OVC and pupils and staff affected by HIV-AIDS by the schools?

School Feeding programme

- How many pupils were in schools that had provided school feeding/nutrition programme for pupils during the school year?

5.2.What was the general condition of school buildings? And did the schools have the basics sanitary facilities and specific health equipment?

a) School heads' views on school buildings and basics facilities

The basic sanitary facilities include toilet provision and water. Therefore, the schools should be places to promote good health and hygiene. This is especially important for girls in order to retain them at schools and also for some children living with HIV, who are more vulnerable to other infections, are assured to stay healthy and productive.

Table 5.1(a) General condition of buildings, toilet facilities and water supply

Province	Need repair		Toilet provision		Piped water/ well or bore-hole	
	%	SE	Mean	SE	%	SE
Bulawayo	12.3	8.35	45.7	14.49	100.0	0.00
Harare	12.0	8.29	46.2	14.50	100.0	0.00
Mashonaland Central	58.7	16.12	54.4	24.82	88.2	8.79
Mashonaland East	69.9	14.35	41.6	10.76	60.6	18.40
Mashonaland West	44.8	15.01	36.5	6.58	70.4	14.55
Midlands	54.3	13.40	33.7	4.13	92.4	7.57
Manicaland	82.2	18.71	23.7	1.92	100.0	0.00
Matabeleland North	54.0	15.11	21.8	8.25	67.1	14.12
Matabeleland South	32.4	15.01	21.6	2.24	72.0	15.10
Masvingo	55.3	14.01	23.4	2.66	95.5	4.61
Zimbabwe	47.9	4.59	35.1	3.63	86.1	3.28

From table 5.1(a) it can be established that nationally 47.9 percent of school infrastructure were in need of repair. Manicaland Province had the highest percentage of infrastructure in a state of despair (82.2%). There were mixed variations among the provinces. Mashonaland Central, Mashonaland East, Masvingo, Midlands and Matabeleland North provinces had more than fifty percent (50%) of their infrastructure in a state of despair. The two major urban provinces Harare (12.0%) and Bulawayo (12.3%) had the least number of infrastructure needing repair.

The national mean pupils per toilet was 35.1, a figure slightly higher than national recommended ratio of twenty pupils to one hole (20:1) Apparently the table shows that the two major urban centres Harare and Bulawayo had fewer toilets per pupil 46.2 and 45.7 respectively. The two provinces being the major urban centres, the situation is cause for concern since it falls below the minimum sanitation requirement in terms of toilet provision.

In Zimbabwe, nearly 86 percent of the primary schools had water supply. These estimates vary across the provinces between 100% in Harare, Bulawayo and Manicaland provinces, meaning that all schools (100%) had water supply, and 60.6% in Mashonaland East and 67.1% in Matabeleland North, which lies in one of the country's perennial dry areas.

b) Specific health equipment in the school

In the SACMEQ III questionnaire, the school heads were asked about the availability of the following health equipment: a special area for guidance and counselling, sick bay and first aid kit. The availability of the general health facilities in schools could also be interpreted as the degree to which the school Heads in provinces endeavour to promote healthy school environments. The provision of general health facilities in primary schools in the country varied significantly from province to province as displayed on table 5.1(b).

Table 5.1(b) General health equipment in the school

Province	General Health Facility					
	Special area for guidance and counselling		Sick bay / sick room		First aid kit	
	%	SE	%	SE	%	SE
Bulawayo	12.4	8.46	18.5	18.4	100.0	0.00
Harare	26.6	12.09	21.8	21.9	76.9	10.80
Mashonaland Central	18.4	18.53	2.1	2.1	82.3	9.36
Mashonaland East	23.8	15.88	0.0	0.00	28.6	17.54
Mashonaland West	12.8	8.95	6.0	6.0	37.2	14.48
Midlands	4.7	4.86	7.3	7.2	70.1	11.99
Manicaland	0.0	0.00	0.0	0.00	0.0	0.00
Matabeleland North	0.0	0.00	2.5	2.2	55.3	15.30
Matabeleland South	0.0	0.00	10.4	10.2	53.8	16.41
Masvingo	13.9	9.52	11.9	11.8	41.4	13.82
Zimbabwe	12.8	3.52	8.6	8.5	55.4	4.43

On average there was 12.8% availability of Special area for guidance and counselling in the primary schools. This is too far below the expected average percentage considering the high HIV-AIDS prevalence in the country. It is also disheartening to observe that Manicaland, Matabeleland North and Matabeleland South did not have (0%) any provision for guidance and counselling facility in their schools.

Another grey area was the provision of the sick bays/sick rooms for partial observation of ill pupils or teachers which accounted for a mean average of 8.6 percent with some provinces such as Mashonaland East and Manicaland registering none facilities (0%).

However the provision of First Aid kits was averagely better with an average of 55.4 percent may be due the influence/popularity of sporting activities in the schools. There were also variations in the provision of the First Aid kits across the provinces ranging from zero percent (0%) Manicaland, Mashonaland East (28.6%) to one hundred percent (100%) in Bulawayo. The zero percentage points (0%) systematically appearing in Manicaland province calls for

an investigation to establish why schools in the province are ill equipped in general health facilities.

Policy suggestion The Ministry of Education, Sport, Arts and Culture should identify all provinces with less than fifty percent (50%) first aid kits and where other health facilities are lacking and find ways of assisting to bring them in line with others as per ministry baseline benchmark.

5.3. What was the coverage of teachers who had received specialized life-skills-based HIV-AIDS education training?

The percentage of schools with at least one teacher trained on life-skills based HIV-AIDS education in 2007 has been presented in the table 5.2. There was a significant inflow of qualified teachers with Life skills based HIV-AIDS education in schools since the introduction of a pre-service teacher training on life skills based HIV-AIDS education in 1994 by the education ministry. This is also confirmation of implementation of ZNASP aimed at achieving UNGASS targets.

Table 5.2 School coverage of teacher specialised on HIV-AIDS

Province	School with at least one specialist teacher	
	%	SE
Bulawayo	75.6	6.53
Harare	95.6	5.16
Mashonaland Central	64.7	10.89
Mashonaland East	64.1	1.54
Mashonaland West	53.9	4.28
Midlands	65.4	9.60
Manicaland	71.3	5.66
Matabeleland North	94.1	3.61
Matabeleland South	74.4	6.38
Masvingo	67.6	5.06
Zimbabwe	71.7	2.44

In Zimbabwe, less than three quarters (71.7%) of pupils are in schools with at least one teacher specialised in Life- skills based on HIV-AIDS Education. Comparison of the availability of specialist teachers with Life-skills on HIV-AIDS by province shows some degree of variation. The coverage was quite comprehensive in Harare province (95.6%) and Matabeleland North (94.1%). But, Mashonaland East (64.1%) and Mashonaland West (53.9%) were the two provinces which critically needed specialist teachers on Life-skills on HIV-AIDS.

Policy suggestion: There must be policy on Life Skills schools based HIV-AIDS risk reduction education for all practicing teachers.

5.4. Did the teachers have access to HIV-AIDS related teaching materials at schools?

Information concerning the teaching materials that can be accessible by the teachers in the school, such as teacher guide, posters, pamphlets and brochure on HIV-AIDS, have been presented in the table 5.3. Teacher Guides are important because they form the basis for standardised national HIV-AIDS content at different levels.

Table 5.3 Teacher access to learning materials related to Health/HIV-AIDS

Province	Teacher access to learning materials					
	Teacher guide on Life Skills/ Health Education		Posters on HIV-AIDS		Pamphlet(s)/ brochure(s) on HIV-AIDS	
	%	SE	%	SE	%	SE
Bulawayo	39.1	9.88	46.0	10.23	44.1	10.07
Harare	42.1	9.40	72.9	8.66	71.1	9.23
Mashonaland Central	31.3	7.99	46.9	10.54	50.2	7.36
Mashonaland East	42.8	12.83	50.3	14.93	61.0	14.85
Mashonaland West	19.8	8.64	44.7	13.23	53.0	13.43
Midlands	37.3	10.27	33.9	11.47	40.7	11.90
Manicaland	17.0	6.81	7.6	5.61	29.9	12.42
Matabeleland North	46.0	15.28	52.8	15.27	50.9	15.26
Matabeleland South	0.0	0.00	25.8	12.14	37.9	12.44
Masvingo	27.3	11.64	68.8	12.32	68.1	13.75
Zimbabwe	29.6	3.21	43.0	3.50	50.2	3.91

The low percentage averages of teacher access to learning materials related to Health/HIV-AIDS of 29.6% Life Skills Health Education, 43.0% Posters on HIV-AIDS and 50.2% Pamphlets/brochures on HIV-AIDS may suggest that nationally, teachers in Zimbabwe have limited access to learning materials related to Health/HIV-AIDS as shown on table 5.3.. Normally the more pupils are exposed to literature/material related to a subject (HIV-AIDS), the more they develop interest in reading further to acquire more information about the subject.

It is disconcerting to note that there are such vast variations in the availability of Teacher Guides on Life Skills/Health Education across the provinces with none in Matabeleland South (0%) and even low level such as in Manicaland (17%) and Matabeleland South (46%).

In terms of posters and pamphlets/brochures on HIV-AIDS, it appears that almost half of schools have the information aids. There were variations among provinces where some teachers had limited access to teaching/learning materials related to Health/HIV-AIDS. For instance, Manicaland (7.6% posters and 29.9% pamphlets) compared to Masvingo (68.8%

posters and 68.1% pamphlets) shows the inequitable allocation of teaching/learning materials related to Health/HIV-AIDS, hence the disparities access across the provinces.

Policy suggestion: The education ministry should address the inequitable allocation of teaching/learning materials related to Health/HIV-AIDS by increasing the production of such materials through its materials production unit-the Audio Visual Services (AVS).The teaching/learning materials should then be allocated and distributed equitably across the provinces.

5.5.What percentage of Grade 6 pupils had attended lessons on HIV-AIDS?

The policy on Life skills based HIV-AIDS education in schools (Circular 16 of 1993), stipulated that all teachers (100%) should give lessons on life skills HIV-AIDS education of around 2 hours per week and starting at Grade 4 (NAC, 2006). This is critical to provide and promote protective skills and reduce stigma.

In the SACMEQ III questionnaire, a question was asked to the Grade 6 pupils about their attendance to HIV-AIDS classes /lessons during the school year. The possible responses were “no” meaning “I did not attended classes /lessons on HIV-AIDS this school year” or “yes” meaning “I did attend it”. The percentages of pupils who attended these classes/lessons during the school year are presented in table 5.4.

Table 5.4 Pupil attendance of HIV-AIDS related classes/lessons during the school year

Province	Pupil attendance of classes / lessons on HIV-AIDS during the school year	
	%	SE
Bulawayo	80.2	6.54
Harare	88.3	3.80
Mashonaland Central	84.0	6.90
Mashonaland East	89.4	5.42
Mashonaland West	83.4	8.14
Midlands	85.3	6.57
Manicaland	84.2	7.25
Matabeleland North	83.9	6.45
Matabeleland South	47.1	12.65
Masvingo	89.1	6.88
Zimbabwe	83.3	2.33

Although the vast majority of Grade 6 pupils (83.3%) countrywide had attended the lessons on HIV-AIDS, this was not satisfactory. There are around 20% of the Grade 6 pupils that had no lessons on HIV-AIDS. This was a surprising result knowing that HIV-AIDS education is a compulsory topic in Zimbabwe. It seemed there was still very little attention on HIV-AIDS education or at times not considered a priority.

The situation was particularly alarming in **Matabeleland South** where less than fifty percent of the pupils had attended these lessons. This was a worrisome development considering the high HIV-AIDS prevalence rate and the lowest level of knowledge among pupils (Chitiga and Chinoona, 2011) in the Matabeleland province as has been alluded to earlier in this paper.

Policy suggestion: The Ministry of Education, Sport, Arts and Culture should use the inspectorate or whatever resources at its disposal to try to expand and intensify the delivery of HIV-AIDS prevention education programmes particularly in poor and isolated communities.

5.6. What kind of extra-curricular activities, in terms of combatting HIV-AIDS related stigma and discrimination and HIV testing for staff, were organized by the schools?

In addition to providing lessons on HIV-AIDS, schools could also provide opportunities in reducing fears and ignorance around HIV-AIDS by organizing peer-group discussions among pupils and teachers as well as HIV testing for staff.

The percentages of pupils who were in schools where discussions about stigma and discrimination related to HIV-AIDS and HIV testing for staffs were organized during the school year are presented in table 5.5.

Table 5.5 Extra-curricular activities on HIV-AIDS organized in the schools

Province	Extra-curricular activities on HIV&AIDS					
	Discussions among <u>pupils</u> about combating stigma and discrimination against HIV-AIDS		Discussions among <u>staff</u> about combating stigma and discrimination against HIV-AIDS		HIV Testing Staff	
	%	SE	%	%	%	SE
Bulawayo	87.6	8.48	75.8	10.96	19.3	10.34
Harare	57.1	13.18	75.1	11.52	9.7	6.79
Mashonaland Central	76.7	12.57	72.9	12.64	27.8	17.74
Mashonaland East	31.3	17.03	46.5	17.47	0.0	0.00
Mashonaland West	49.2	15.00	53.2	15.27	22.4	12.96
Midlands	66.1	12.80	77.7	11.66	15.2	10.25
Manicaland	70.3	21.41	70.3	21.41	0.0	0.00
Matabeleland North	60.9	14.93	70.2	13.96	50.0	15.26
Matabeleland South	77.5	12.93	67.0	15.08	27.5	14.56
Masvingo	60.3	13.44	38.0	13.09	20.3	11.13
Zimbabwe	62.1	4.61	63.4	4.54	17.9	3.66

a) Discussions about combatting stigma and discrimination against HIV-AIDS

At national level, an average of more than sixty percent of Grade 6 pupils (62.1%) were in schools where discussions about HIV-AIDS related stigma and discrimination were organized among pupils and teachers. There were variations in the degree of organisation of such discussions across the provinces. Bulawayo (87.6%) is topping all the provinces in discussions among pupils and Mashonaland East (31.3%) and Mashonaland West (49.2%) having least discussions.

Concerning the discussions among teachers, Midlands province (77.7%) had the highest percentage of schools discussing about combating stigma and discrimination against HIV-AIDS, while the bottom three were Mashonaland West(53.2%), Mashonaland East(46.5%) and Masvingo (38%), anchored the list of ten provinces respectively.

b) HIV testing for staff

The national average of only 17.9% of schools organizing HIV testing for staff showed that there were negative attitudes towards knowing their HIV testing. The situation was even gloomy in Manicaland and Mashonaland East provinces registering nil (0%) activity on HIV testing for staff.

Policy suggestion: The education ministry should encourage sector harmonization to the Provider Initiative Testing and Counselling (PITC) and also national and institution based policies on behaviour change initiatives.

Policy suggestion: Ministry of Education, Sport, Arts Culture should have a strategic plan guiding HIV testing on staff. There must be immediate support in all forms available for all members of staff found to be infected with HIV.

5.7. What kind of support were provided to OVC and other pupils and staff affected by HIV-AIDS by the schools?

The SACMEQ research teams were interested to know specific supports, such as guidance and counselling, home visits, learning materials for use at home and medication - that were provided by schools to orphans and vulnerable children (OVC) and pupils and staff affected by HIV-AIDS during the school year. The school heads were supposed to tick “yes” or “no” for each specific support. Their responses have been summarized in the table 5.6.

Table 5.6 Specific School support in the context of HIV-AIDS

Support in the school during the school year	Indicating “Yes”	
	%	SE
Support to Orphans and Vulnerable Pupils		
Guidance and counselling	55.3	4.64
Home visits	33.3	4.14
Learning materials for use at home	33.7	4.45
Support to Pupils with HIV-AIDS		
Guidance and counselling	21.8	3.89
Home visits	23.6	3.75
Learning materials for use at home	20.2	3.96
Medication	23.2	4.10
Support to Pupils caring for Relatives with AIDS related diseases		
Learning materials for use at home	22.7	4.04
Support to School Staff with HIV-AIDS		
Guidance and counselling	18.6	3.80
Home visits	11.4	2.88
Medication	15.7	3.43

a) Support to Orphans and Vulnerable Pupils

Among the specific supports, half of the schools in the sample had provided support to OVC and mainly guidance and counselling (55.3%) followed by learning materials for use at home (33.7%) and home visits (33.3%). The figures are way below expectations for the national policy requirements where good quality education should be provided to ensure that OVC realize their education rights.

b) Support to Pupils affected by HIV-AIDS

Concerning pupils with HIV-AIDS and to pupils caring for relatives with AIDS related diseases, there were only one fifth of schools that provided learning materials for use at home for them. The meagre support in the form learning materials for use at home was mainly from Non-Governmental Organisations (NGOs).

c) Support to School Staff with HIV-AIDS

Generally, support to school staff with HIV-AIDS was quite marginal with Guidance and counselling (18.6%), Home visits (11.4%) and Medication (15.7%) This implies that more has to be done by the responsible ministry for guiding the response and supporting HIV-infected teachers.

Policy suggestion: Ministry of Education, Sport, Arts and Culture must come up with policies that ensure that the needs and rights of OVC are well represented

Policy suggestion: There must be strong campaigns by the ministries of Education Health and Child Welfare to encourage the Government and the private sector to come up with support particularly for vulnerable children and other people affected and infected with HIV so that the pupils caring for a persons ill of HIV-AIDS are kept in schools.

Policy suggestion: The Ministry should make an audit of the teachers infected with HIV and put in place lasting solutions with regards to national mandate of supporting the public servants while they are still in and as well as out of service.

5.8. How many pupils were in schools that provided school feeding/nutrition programme for pupils during the school year?

A question was asked to the school heads about the organisation of feeding / nutrition programme for pupils and that is not paid for by the pupils, at the school during the school year. This programme is important because it enables the children remain in school well nourished, socialized and protected from HIV infections. The responses of the school heads are presented in the table 5.7

Table 5.7 Schools Providing Feeding / Nutrition Programme for Pupils

Province	Schools Providing Feeding / Nutrition Programme for Pupils during the school year	
	%	SE
Bulawayo	80.3	10.56
Harare	23.1	10.85
Mashonaland Central	10.9	7.94
Mashonaland East	27.8	18.98
Mashonaland West	44.3	14.47
Midlands	28.6	11.92
Manicaland	53.4	13.80
Matabeleland North	21.9	21.82
Matabeleland South	100.0	0.00
Masvingo	44.5	16.17
Zimbabwe	42.1	4.7

Nationally an average of 42.1% Grade 6 pupils was on the schools providing Feeding/Nutrition programme. Matabeleland South (100%) and Bulawayo province (80.1%)

had well pronounced school feeding nutrition programmes for pupils with similar numbers of pupils presumably benefiting from the scheme. While the other seven provinces had less than fifty percent (50%) of pupils benefiting from the feeding/nutrition programmes, Mashonaland Central (10.8%) had the least beneficiaries on the feeding programmes.

5.9. Conclusion

Chapter Five provided a descriptive analysis of the supportive school environment in the context of HIV-AIDS in terms of general school infrastructure, provision of teaching/learning resources, support and care of both school children/OVC and teachers affected and infected with HIV. Findings of chapter five shall help education ministries strengthen Education Planners, Administrators and School Heads' roles in facilitating the creation of supportive environment for halting the spread of HIV-AIDS, provision of information to reduce stigma and trauma and provision of care and support for the affected pupils/OVC ,teachers and communities through multi-sectoral approaches.

The provision of school infrastructure and general basic sanitary health facilities in primary schools varied significantly from province to province with notable discrepancies always emerging between schools in the rural and the (100%) urban provinces (Harare and Bulawayo).The later having better facilities than the later. For the education ministry to fully implement the ZNASP and achieve EFA, UNGASS and MDGs targeted goals it must address the inequitable distribution of critical resource/facilities currently prevailing across the provinces in the country. The inequitable distribution of resources/facilities particularly those related to Health/HIV/AIIDS seem to be impacting negatively on the implementation of the Health/HIV/AIIDS education programmes in most of the disadvantaged provinces as was expounded earlier in the previous chapters.

It was also noted that there was high participation by Grade 6 pupils in HIV-AIDS-related activities in schools across the provinces despite the limited finding for the national HIV-AIDS response human resource challenges all attributed to the country's current unfavourable economic environment. It is recommended that the education ministry seek partnership with the private sector to fund the Health/HIV/AIIDS education prevention programmes. Funding of the School Feeding scheme programmes was heavily affected by lack of lack of funding in almost three quarters of the county's ten education provinces

thereby compromising the supportive environment for pupils/OVC and teachers affected and infected with HIV-AIDS. Summary of the major findings of the study, recommendations and suggestions for further research investigations are outlined in the next chapter.

Chapter 6

Conclusion and Recommendations

This chapter presents a summary of key outcomes of the research study and recommendations emerging from the findings. Findings of the study have revealed that generally responses to HIV-AIDS have not yet met the expected demands of the education ministry and society in halting the spread of the HIV infections because there is still very little evidence to suggest any attitudes or sexual behavioural change in schools and communities. The school-based HIV-AIDS risk reduction programmes aim to equip the pupils and teachers with knowledge on basic ways of halting the spread of HIV infections, attitudes and sexual behaviour change. An assessment of the knowledge about HIV-AIDS among pupils and teachers revealed an alarming knowledge gap between the learners and the educators. Generally the teachers' knowledge about HIV-AIDS was more than 90 percent higher than of that of their Grade 6 pupils. However, it was disheartening to note that despite being so highly knowledgeable about HIV-AIDS, an average of 30.6 percent of the teachers indicated that they were at very high risk of being infected by HIV at their schools. That shows resistance to attitudes and sexual behavioural change considering that 77.2 percent of the school heads had attended in-service training courses on HIV-AIDS risk reduction education.

On average over 95 percent of the primary school heads indicated positive attitudes towards persons affected or infected with HIV-AIDS. But, it was somewhat worrisome that in some provinces pupils are attending schools where as high as 70.6 percent of the school heads indicated to be at very high risk of being infected by HIV. Although an average of 88.7 percent school heads knew the existence of HIV testing centres and had positive attitudes on having a HIV test, only 36.4 percent of them have had an HIV test.

On the other hand, the research findings also revealed that school-based risk reduction education programmes are improving pupils' knowledge about HIV-AIDS and partially halting the spread of HIV infections. On the same vein, the effectiveness of HIV-AIDS prevention education programmes on these other UNGASS and MDGs targeted goals - access to services, decreasing pupils' vulnerability to infections and decreasing the prevalence of HIV among pupils are not yet very clear because of the complexity in assessing and measuring outcomes such as, skills, vulnerability and HIV prevalence.

It also emerged that although national policies and strategic action plans on HIV-AIDS prevention have been developed due Zimbabwe's commitment to achieving the 2015 Millennium Development Goals (MDGs), more still has to be done on the implementation side considering that at basic education level, Grade 6 pupils in Zimbabwe exhibited very low knowledge about HIV-AIDS in SACMEQ III. The implication here is that if primary school children have limited knowledge about HIV-AIDS, they then become susceptible to HIV infection rendering the HIV-AIDS prevention education programmes a futile exercise.

For the Ministry of Education, Sport, Arts and Culture to ensure effective and efficient participation of the education sector in the national response to HIV-AIDS, the impact of the epidemic on the sector needs to be addressed, and in particular, the impact on pupils/OVC and teachers affected by HIV. It may be suggested that the Education ministry empower the school heads through regular in-service training to develop school-based intervention HIV-AIDS policies and other related initiatives to strengthen their school-based response and better prepare the teaching staff counter-attack HIV-AIDS. The education ministry could also collaborate with other relevant ministries in coming up with strengthened implementation programmes to deliver effective prevention, treatment care services to all people in need across the provinces since the fight against HIV-AIDS was declared a national emergency.

Nationally, the general school infrastructure, provision of teaching/learning resources, support and care of both school children/OVC and teachers affected and infected with HIV is inadequate and also inequitably distributed. Urban provinces had better infrastructure, teaching/learning resources provision, implying that the majority of the Grade 6 pupils were attending schools with child-unfriendly environments. On the one hand it also emerged

traditional modes of communication still remained predominantly the sources for transmitting information on HIV-AIDS across the provinces compared to the modern-day ICT-computers and the internet, a development that might be inhibiting the fast spreading of information about HIV-AIDS across to schools and communities.

Finally, with Zimbabwe's societal and political will blossoming, there are very strong chances of finding lasting responses to the HIV-AIDS epidemic which will strengthen the country's efforts towards universal access to HIV prevention, treatment, care and support for all pupils/OVC and teachers affected and infected with HIV. And this would be the strong basis for effective HIV-AIDS education prevention programmes.

Recommendations

From the findings presented in the summary, one of the main recommendation is for the Ministry of Education, Sport, Arts and Culture to strengthen the education sector's capacity to respond to the fight against HIV-AIDS epidemic is by establishing integrated and well-coordinated HIV-AIDS education prevention programmes at all levels, thus from the Central Office through Provincial Offices, District Offices down to the schools. The enunciated programmes should set priorities to ensure that available resources are invested appropriately in cost effective programmes. The education ministry should strengthen/organize its structures so that the inspectorate division establishes mechanisms to regularly and efficiently monitor and evaluate the implementation of the HIV-AIDS education prevention programmes.

The education ministry needs to equitably allocate more resource and support to the HIV-AIDS risk reduction education programmes in all the provinces across the country and grant the relevant authorities the autonomy to mobilize resources from the cooperate world for the programmes. The education ministry should also through the Director of Planning and Policy Studies establish a National School Maintenance Programme backed by a school rehabilitation plan that prioritize those schools identified as being in general state of despair. District Education Officers and School heads should be granted autonomy to fundraise for the money to build new infrastructure and maintain the existing ones since the government has financial constraints to meet the demands of all ministries. The education ministry should also set benchmarks on the provision of basic school infrastructure as part of a comprehensive strategy for reducing the inequalities in the distribution of teaching/learning materials which should be monitored and reviewed regularly at all levels.

As was observed from the findings that while positive behavioural change can alter the course of the HIV-AIDS epidemic, stigma and discrimination and bad laws can make the epidemics worse. It is against this backdrop that the researcher recommends the education ministry to craft and put in place national policies on enhanced social support for orphans and vulnerable children (OVC). These policies would guarantee the OVCs continued consolidated food, health and education support. Since HIV-AIDS was declared a national emergency in 2003, it therefore follows that financing responses to HIV should be a shared responsibility. As such, the Ministry of Education, Sport, Arts and Culture should collaborate with other relevant ministries in financing and implementing the programmes to deliver effective prevention, treatment, care and support services to all pupils/OVC and teachers in need in the whole country.

Areas for further study

A number of issues that need further research were raised during analysis of data from the respondents. And some of them are:-

- i) Why Grade 6 (70%) pupils lack minimal knowledge about HIV-AIDS when their teachers are highly knowledgeable?
- ii) Investigate the possible reasons that discourage many male teachers/ school heads from taking HIV testing even if offered for free.
- iii) To what extent is education ministry/school authorities supporting pupils/OVC and teachers affected and infected with HIV.
- iv) The impact of HIV-AIDS on pupils' achievement at primary /basic education level.

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