MoEC
Government of Tanzania

IIEP – UNESCO

THE IMPACT OF HIV/AIDS ON THE EDUCATION SECTOR IN TANZANIA

Study 1

EXPLORING POLICY, LEADERSHIP AND ADVOCACY RESPONSES

Athanas S. Kauzeni – Team Leader
Clement Kihinga – Associate Researcher

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FOREWORD

THE COLLABORATIVE ACTION RESEARCH PROGRAMME

IIEP and its partner ministries of education launched the collaborative action research programme in 2003. This initiative is designed to contribute to mitigation and prevention of the impact of the HIV/AIDS pandemic in three countries – Malawi, Tanzania and Uganda. The focus of the research activities is essentially needs assessment. This, in turn, will help to prioritize options for the development of policy, training and other measures to enable the education sector to strengthen its internal capacity in two critical areas. These are to respond to the impact of the epidemic on its staff at all levels and to maintain progress towards EFA goals.

Objectives

The collaborative action research programme is designed to achieve the following objectives:

- to identify problems related to the impact of HIV/AIDS on the education sector and to prioritise areas for action;
- to formulate responses to gaps identified in current policy, leadership practices and management capacities;
- to develop a database to track patterns and trends in HIV/AIDS-related teacher and student absence, abandonment and mortality;
- to formulate effective mitigation and prevention measures based on a qualitative assessment of the impact of HIV/AIDS on selected schools and their surrounding communities.

Expected results

The programme is expected to produce results on two levels. Initial activities will produce five diagnostic studies and recommendations for specific responses to the impact of the epidemic on the education sector. The first two studies will be carried out in all three countries. The final three studies will be implemented selectively. The studies will examine the impact of HIV/AIDS on the following areas: educational leadership and policy; educational governance; enrolment, attendance and instruction in district schools; selected schools and communities, and tertiary educational institutions. This phase will also lead to the production of a handbook of research tools, policy recommendations and best practices, to facilitate replication of the research programme in other countries.

As the research progresses, the needs identified in the diagnosis stage will be used to formulate policy frameworks and recommendations, and training and organisational development strategies. The ministries of education of the co-operating countries will implement, monitor and evaluate these strategies, in partnership with IIEP and other technical and financial partners in the donor community.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACU	AIDS Coordination Unit
AIDS	Acquired Immunodeficiency Syndrome
AMC	AIDS Management Committee
AMREF	African Medical Research Foundation
ARV	Antiretroviral
BAKWATA	Muslim Council of Tanzania
BEDC	Basic Education Development Committee
CBOs	Community-Based Organizations
CEO	Chief Education Officer
CSSC	Christian Social Services Commission
EFA	Education for All
EMIS	Education Management Information System
ESSP	Education Sector Strategic Plan
FBOs	Faith-Based Organizations
FGDs	Focus group discussions
GTZ	Germany Agency for Technical Cooperation
HIV	Human Immunodeficiency Virus
IDYDC	Iringa Development of Youth Disabled and Children Care
IEC	Information Education and Communication
IIEP	International Institute for Educational Planning
INGONET	Iringa AIDS NGO Network
MoEC	Ministry of Education and Culture
MoH	Ministry of Health
MTP	Medium-Term Plan
NACP	National AIDS Control Programme
NGOs	Non-Governmental Organizations
PLWHA	People Living With HIV/AIDS
PORALG	President's Office for Regional Administration and Local Government
SPW	Students Partnership Worldwide
STIs	Sexually Transmitted Infections
TAC	Technical AIDS Committee
TACAIDS	Tanzania Commission for HIV/AIDS
TAHEA	Tanzania Home Economics Association
TAPA	Tanzania Parents Association
TSC	Teachers Service Commission
TTU	Tanzania Teachers Union
UMATI	*Uzazi na Malezi Bora Tanzania*
UNAIDS	Joint United Nations programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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EXECUTIVE SUMMARY

This is an impact study, which examines policy framework, leadership commitment, political willingness and advocacy issues on HIV/AIDS, as well as the implementation of HIV/AIDS interventions in the education sector. It is expected to contribute to a better understanding of the role and importance of a comprehensive and effective HIV/AIDS education policy, of committed leadership and of firm and consistent advocacy against the HIV/AIDS epidemic.

HIV/AIDS continues to spread despite the use of leadership advocacy among the Tanzanian population to raise general awareness of the severity of the epidemic and knowledge of how HIV transmission can be prevented, and also in spite of the presence of a national policy for the control and prevention of HIV/AIDS.

The study was undertaken because the HIV/AIDS epidemic has emerged as a major threat to achieving Education for All (EFA) goals. Moreover no study carried out to date has considered the impact of HIV/AIDS on policy, leadership and advocacy.

Research was carried out in Iringa Urban District, Ministry of Education and Culture (MoEC) headquarters and some of its affiliated institutions in Dar es Salaam. At MoEC headquarters data and information were collected from seven heads of departments or directors, and mid-level MoEC officials from all directorates, including administrators, technical staff and peer educators. Interviews were also conducted with low-level MoEC staff, including messengers, cleaners and print assistants from all directorates. At the regional and district levels interviews were held with the Regional Education Officer, District Education Officer, District School Inspector, Acting Treasurer Iringa Urban District Council, District Medical Offer, District Teachers Union Secretary, Ward Education Coordinator, Iringa Urban District Council, Mayor and District Executive Director.

Data collection techniques used include structured and unstructured interviews, focus group discussions (FGDs), checklists and a literature review.

Globally the HIV/AIDS epidemic has proved to be much more extensive than predicted and is now reaching alarming levels. Almost every passing year sees a revision upwards of estimates and projections. At the end of 2002, 5.0 million people were newly infected with HIV, 42 million people were living with HIV/AIDS and 3.1 million people had died as a result of AIDS. By the end of 2001 there were 14 million AIDS orphans (UNAIDS and WHO, 2002).

The first HIV/AIDS case in Tanzania was diagnosed in 1983 in Bukoba District of Kagera Region. By 1986 the number of AIDS cases had risen from the initial three to tens of thousands countrywide. At the end of 2001 there were 14,449 cumulative AIDS cases. Most cases fall within the 20-49 age group, with the highest number of reported cases in the 25-34 and 30-39 age groups for females and males respectively. However, infection rates are declining in some regions (e.g. Kagera Region): a sign of hope that the devastating epidemic can be brought under control.

The education sector is one of the largest employers in Tanzania. It is particularly vulnerable to HIV/AIDS, perhaps more so than other sectors. Epidemiological reports show that the 15-24 age group is highly vulnerable to HIV, whilst demographic surveys indicate that HIV/AIDS is the greatest cause of mortality amongst adults in mainland Tanzania. One of the main causes for teacher attrition is death: in the year 2001/2002 there were 1,046 deaths of teachers, with 517 deaths for the first half of 2002/2003.

There are critical information gaps in the literature with regard to the epidemic. The national policy on HIV/AIDS is silent on such crucial issues as legislation with respect to HIV/AIDS control and prevention, and personnel matters such as care for infected and affected teachers (e.g. how medical expenses, and funeral and burial costs are handled). Information regarding political will and the leadership commitment at central, regional, district and institutional levels is also inadequate.

The absence of HIV/AIDS issues from the current education and training policy (Tanzania MoEC, 1995) poses a serious challenge to the MoEC. In the absence of a sectoral policy upon which to formulate legislation and develop a strategic framework, current approaches are neither sufficient nor effective for addressing HIV/AIDS in a wider context, or developing mechanisms for the coordination of activities and accountability at sectoral level.

The MoEC currently operates within the framework of the national policy on HIV/AIDS. The Tanzania Commission for HIV/AIDS (TACAIDS) was established to provide leadership and coordination of a multi-sectoral response to HIV/AIDS. The national policy was formulated to enforce this leadership role. It outlines the framework, direction and general principles of the national response interventions.

The day-to-day work of the MoEC in the prevention of HIV/AIDS is guided by non-formal policy documents, namely circulars, directives and guidelines. The MoEC established HIV/AIDS interventions in the education sector, through Circular No. 3 of 1993 and 2000 respectively (Tanzania MoEC 1993; 2000). As a result of these circulars AIDS education was incorporated into a number of carrier subjects and interventions were expanded to cover all employees of the MoEC at the central, regional, district and institutional levels. The management and coordination of programme activities were also strengthened. Specifically, six interventions were implemented:

- strengthening the HIV/AIDS management structure;
- school HIV/AIDS and life skills education;
- school peer education;
- school guidance and counselling committees;
- school guidance and counselling services, and
- MoEC headquarters peer education.

The resulting school-based activities were implemented at the district level by Non-Governmental Organizations (NGOs) and Community-Based Organizations (CBOs). However, gaps relating to policy, leadership and advocacy were encountered at all levels. In order to adequately address these gaps, the following measures need to be implemented:

- The MoEC should formulate a sector-specific policy on HIV/AIDS as part of a revised education and training policy. Policy development should be participatory and interactive in nature.

- MoEC peer educators should be provided with information education and communication (IEC) materials to support work with clients. As recognition of their services and as additional motivation, the MoEC should also explore the possibility of giving them token incentives.

- Education sector leaders need to be sensitized to the importance of AIDS education interventions and oriented towards the framework for a multi-sectoral response to HIV/AIDS.

- The MoEC management information system needs to be revised regarding skills, equipment and focus, so that it includes HIV/AIDS indicators. The improved Educational Management Information System (EMIS) will then be able to respond to the impact of HIV/AIDS in the sector.

- The current avenues used by the education sector to advocate for prevention and control of HIV/AIDS and impact mitigation need to be assessed as to their effectiveness. More channels for HIV/AIDS advocacy should be explored, and the level of utilization of the mass media should be maximized.

1. BACKGROUND

1.1 Introduction

The overall research project on the impact of HIV/AIDS in the education sector in Tanzania has been divided into five areas of study:

- educational policy, leadership and advocacy;
- educational governance;
- enrolment, attendance and instruction;
- selected schools and communities in Iringa Urban District, and
- tertiary education institutions.

The present study analyses the impact of HIV/AIDS on the education sector and assesses the sectoral and multi-sectoral responses to the HIV/AIDS pandemic, for example, how policies are being implemented for teacher recruitment and training and how these activities have changed in response to the epidemic. The study also explores the roles of different actors in providing leadership and advocacy on HIV/AIDS issues, on aspects of the organizational climate and on practices that favour or hinder the dissemination of information on HIV/AIDS.

The project is a collaborative venture between the Ministry of Education and Culture (MoEC) and the International Institute for Educational Planning (IIEP), which is part of the United Nations Educational Scientific and Cultural Organization (UNESCO).

1.2 Justification for the study

There is a particular need for a study of this nature on the Tanzanian education sector for four principal reasons:

- The epidemic has emerged as a major threat to achieving Education for All (EFA) goals. Therefore, responding to the epidemic is now an urgent priority, since it affects the delivery of education (i.e. supply, demand, quality and quantity).

- No study has been conducted in Tanzania to date to consider the impact of HIV/AIDS on policy, leadership and advocacy.

- The number of orphaned school children is on the increase.

- The education sector is the main instrument for developing future human resources. Therefore, the teaching profession and its management must be protected against the HIV/AIDS pandemic.

1.3 Conceptual framework

This study covers three concepts: policy, leadership and advocacy. All three are key to driving effective interventions. Government involvement is crucial in the fight against HIV/AIDS, in terms of appropriate HIV/AIDS policy formulation, leadership commitment in the prevention and control of the epidemic and strong advocacy.

1.3.1 Policy

Formulation of an appropriate and effective HIV/AIDS education policy will guide the implementation of education programmes, projects and strategies geared to the prevention and control of HIV/AIDS in the education sector. There are no easy quantitative or qualitative criteria for what constitutes appropriate planning for AIDS or for how an AIDS policy should be integrated into national planning, policy and budget systems, at both the macro and micro levels.

The national policy on HIV/AIDS was launched in November 2001. It provides the framework, direction and general principles of the national response interventions in three focus areas:

- prevention of transmission of HIV;
- care and support for those infected and affected by the virus, and
- mitigation of the impact of the epidemic.

The national policy has highlighted these areas in order to convey something of the complexity of the situation in which an education sector policy must be developed and implemented. The policy must be sensitive to the cross-sectoral impact of the epidemic; the social, ethical, legal, cultural and economic issues associated with it require differential responses from all of the affected sectors.

1.3.2 Leadership

Leadership commitment is critical for spearheading the effective and efficient implementation of HIV/AIDS interventions. In the context of this study, this commitment may be manifested through public speeches, circulars or other information that outlines priorities. Leadership may also be manifested through proactive HIV/AIDS policy formulation, the structural reorganization of the education sector or the provision of adequate funding for HIV/AIDS activities. Shellukindo, Muhondwa, Lyimo, Tibakweitira and Seikh (2000) argue that any leader who fails to view AIDS as a serious threat to the economy of the country, or as having a serious impact on the health and social welfare of the people, cannot be expected to devise and implement policies that seek to create an environment that is supportive of the attempts of ordinary people to protect themselves against HIV infection. Similarly, an elected leader who dare not speak out against cultural practices that ostensibly contribute to HIV transmission, for fear of annoying the electorate, cannot be an effective ally in the fight against HIV/AIDS. Strong leadership is required if behaviour is to change and if the spread of the epidemic at the national level is to be brought under control.

In Tanzania HIV/AIDS has been declared a national disaster, one that senior figures, like the President and the Prime Minister, are keen to engage with. The Prime Minister has directed that HIV/AIDS be placed on the agenda for all meetings. However, few

parliamentarians are supportive in public. It appears that there is much talking, but as of yet little action in the fight against HIV/AIDS.

1.3.3 Advocacy

Advocacy can be defined as "the promotion of activities or policies in defence of the interests of a particular group" (United Nations, 1995). UNESCO (2002) states that the critical factor in creating an effective strategy for the prevention and control of HIV/AIDS is the massive, unfailing and unrelenting advocacy and support of political authorities at the highest national level. UNESCO's view is that if the epidemic is to be confronted, the message to the people must be valid, must be effectively disseminated and must be acted upon.

The lack of firm, consistent and visible advocacy in the education sector's machinery creates an environment that fails to promote appropriate individual, communal and national responses to the epidemic. In this particular case, it is the leadership within the education sector that has to play the main advocacy role. Given the pivotal role of the MoEC to national development, advocacy groups from outside the education system can only provide complementary support.

The general public should be fully informed about HIV/AIDS and should be empowered against it, with those most at risk targeted as a priority. However, it appears that there is low public awareness of the disease and its effects, especially in rural areas. Campaigns using the spoken and written word favour urban over rural areas, since literacy levels are higher in the former. Other communication media (e.g. radio, television and meetings of leaders) are also concentrated in urban areas, which tend to be more affluent than rural districts.

1.4 Objectives

The general aim of the study is to examine policy, leadership and advocacy issues in terms of HIV/AIDS impact in the education sector. The specific objectives of the study are:

- to examine the HIV/AIDS policy framework in the education sector;
- to assess the leadership commitment to fighting the HIV/AIDS pandemic in the education sector;
- to examine advocacy issues pertaining to fighting the HIV/AIDS pandemic in the education sector;
- to examine the implementation of HIV/AIDS interventions in the education sector, and
- to collect information that will be used to enrich the education sector HIV/AIDS strategic framework.

1.5 Research questions

- In the absence of a formal HIV/AIDS policy in the education sector, how does the MoEC carry out HIV/AIDS interventions?

- How did the national policy on HIV/AIDS evolve?
- How has the national policy been affected by HIV/AIDS?
- What kinds of HIV/AIDS interventions are implemented at the different levels of the education sector?
- What problems have been encountered during the implementation of HIV/AIDS interventions in the education sector?
- What are the perceptions of various education sector stakeholders regarding issues related to HIV/AIDS policy, leadership and advocacy?
- What gaps still remain in HIV/AIDS interventions in the education sector?
- What internal advocacy mechanisms exist in the education sector for policy development and the implementation of interventions?
- What external advocacy mechanisms exist in the education sector for policy development and the implementation of interventions?
- What gaps exist in visible leadership and advocacy in the education sector in terms of HIV/AIDS programme implementation?
- What steps need to be taken to create an ideal environment for policy development, leadership and advocacy?

1.6 Selection of study area and samples

1.6.1 Study area

The areas selected for research were MoEC headquarters, the headquarters of education sector stakeholders and one district in mainland Tanzania.

The choice of district was reached by considering three factors: the documented deaths of teachers for the years 2001/2002 and the first half of 2002/2003 (Tanzania Teachers Service Commission, 2003); the documented HIV/AIDS prevalence in Tanzania (Tanzania Ministry of Health, 2002), and access issues relating to budgetary constraints.

Data from the Tanzania Teachers Service Commission (TSC) and Ministry of Health (MoH) reports indicate that:

- of the 1,096 deaths of teachers reported in 2001/2002 and 517 deaths reported in half-year 2002/2003, more than half (57 per cent and 60 per cent respectively) were among men. Among these deaths, the regions with the highest rates were Mbeya (143) and Iringa (135), accounting for 18.1 per cent of all teachers' deaths;
- of the 1,096 deaths of teachers reported in 2001/2002, more than two-fifths (42 per cent) would appear to have been HIV/AIDS related (i.e. causes of death included

HIV/AIDS, tuberculosis, long-term fever, cancers etc.). In Mbeya Region 35 deaths (33 per cent) were HIV/AIDS related, whilst in Iringa Region 74 deaths (73 per cent) were HIV/AIDS related;

- the prevalence of HIV among male blood donors in 2001 was highest in six regions: Kagera (23 per cent); Dar es Salaam (18.8 per cent); Iringa (17.9 per cent); Arusha (17.2 per cent); Morogoro (16.2 per cent), and Mbeya (14.4 per cent);

- the prevalence of HIV among female blood donors in 2001 was highest in three regions: Dar es Salaam (31.4 per cent); Morogoro (22.3 per cent), and Iringa (21.4 per cent);

- amongst blood donors in the 15-24 age group (which gives an approximate indication of the number of new infections), HIV prevalence was above 10 per cent in Arusha, Dar es Salaam, Iringa, Kagera, Mbeya, Morogoro, Rukwa and Ruvuma Regions;

- in 1990, 24 antenatal sentinel sites were established in 11 of the 20 regions of mainland Tanzania. Among antenatal clinic attendees in 2000 the prevalence of HIV was above 15 per cent at some sentinel sites in Iringa (32 per cent), Mwanza (16 per cent), Mbeya (23 per cent), Morogoro (18 per cent) and Kilimanjaro (17 per cent).

In view of this data, coupled with the budgetary constraints, the research team suggested Dar es Salaam, Iringa and Arusha Regions as candidate research areas. This proposal was tabled during a meeting with MoEC officials.

It was decided not to use Dar es Salaam, since the MoEC wanted to compile more information from other regions outside of the capital. Considerations of costs suggested that Arusha (850 km from Dar es Salaam) should also be rejected. Therefore Iringa (600 km from Dar es Salaam) was retained as a study site (see Figure 1.1).

Figure 1.1 Map of Tanzania, showing regional boundaries

Source: Perry-Castañeda Library Map Collection, the General Libraries, the University of Texas at Austin, 2003.

Of the six districts of Iringa Region, it was ultimately decided to use Iringa Urban. The decision was partly based on logistical considerations: for example, Makete Region had poor communications (high relief and impassable roads in the rainy seasons), whilst Iringa Rural was undergoing administrative restructuring. It was also felt that Iringa Urban provided a representative sample, since it encompasses both rural and urban areas, with the rural population making up approximately one third of the total district population.

1.6.2 Study samples

Structured and unstructured interviews were conducted with six heads of departments at MoEC headquarters. The senior officials were the Director of Basic Education, the Director of Administration and Personnel, the Director of Policy and Planning, the Director of Secondary Education, the Director of School Inspections and the Director of Cultural Development.

Focus group discussions (FGDs) were conducted with other MoEC staff. The sessions involved mid-level staff, peer educators and low-level staff, drawn from every directorate (see Appendix 2 for a breakdown of the numbers). The peer educators included administrators and technical staff only, whereas the low-level staff included messengers, cleaners and print assistants, in order to canvas as broad a range of experience and opinion as possible.

Structured and unstructured interviews, together with supplementary unstructured information-gathering sessions were conducted with eight senior officials working with MoEC partner institutions. The senior officers were the TACAIDS Director of Policy and Planning, the head of the Information Education Communication (IEC) unit at the National AIDS Control Programme (NACP), the Director of the Christian Social Services Commission (CSSC), the President of Tanzania Teachers Union (TTU), the Executive Secretary of the TSC, the Education Secretary of the Tanzania Parents Association (TAPA), the Education Officer of the Muslim Council of Tanzania (BAKWATA) and the Education Officer with the Agha Khan Education Foundation.

The same interview and information gathering techniques were used to collect data from regional and district level officers. The Regional Education Officer, Iringa Urban District Council Mayor, District Executive Director, District Education Officer, District School Inspector, District Medical Officer and the District Teachers Union Secretary were all questioned, along with, two directors of Non-Governmental Organizations (NGOs) and three NGO programme officers.

Four secondary schools and five primary schools were involved in institutional level research. Headmasters, headmistresses and headteachers were interviewed separately, as were two ward education coordinators (see Appendix 1 for more details). A total of 25 in-school FGDs were held, involving 81 teachers, and 159 secondary school students and primary school pupils. Male and female students and pupils were consulted separately (see Appendix 2 for a breakdown of the groups).

1.7 Primary data collection techniques

Primary data collection was accomplished by using four different techniques.

1.7.1 Unstructured information gathering sessions

Unstructured sessions were conducted with all senior officials, for the gathering of information on matters such as the organizational culture of the institutions under consideration. The sessions took place in a variety of settings, often outside the working environment, and were subject to far less advance preparation than the more formal interviews. This meant that they offered maximum flexibility to pursue information in

whatever direction appeared to be most appropriate, with most of the questions flowing from the immediate context. Follow-up contact was made with several respondents for the clarification and elaboration of issues raised in the original meeting.

1.7.2 Structured and unstructured interviews

This method of data collection was used to collect information from all senior officials and educators. The tools designed for this study utilized a combination of more and less structured interview techniques, followed with extended interview sessions to elaborate on certain areas.

1.7.3 Focus group discussions (FGDs)

FGDs utilized strong group dynamics in order to solicit information on specific sub-topics, over the course of a guided conversation. They were conducted with peer educators, middle-level and junior support staff at MoEC headquarters, teachers, students and pupils. The groups were small, with the number of participants ranging from 6 to 10 people. The participants usually had similar backgrounds with respect to the topic under discussion. Each discussion took one to two hours.

1.7.4 Checklists

Checklists were used to document the IEC materials used at MoEC headquarters. At regional, district and institutional levels they were used to establish the degree of access to copies of the Education and Training Policy of 1995, along with any additional circulars and guidelines. They were also drawn up following interviews to work out the issues that needed further elaboration.

2. MAGNITUDE OF THE HIV/AIDS PROBLEM

2.1 The global picture

Globally the HIV/AIDS epidemic has reached alarming levels. It has proved to be much more extensive than predicted: every passing year sees a revision upwards of estimates and projections. In 1991 the World Health Organization (WHO) expected that by the year 2000 some 20 million individuals worldwide would be infected with the Human Immunodeficiency Virus (HIV). That prediction was almost three times short of the mark. By the end of 2001, almost 22 million people had already died of the disease, whilst more than 40 million adults and children were living with HIV/AIDS (UNESCO, 2002).

Recent estimates indicate that by the end of 2002 42 million people were living with HIV/AIDS, of whom 38.6 million were in their most productive years, that is between the ages of 15 and 49, and 3.2 million were children aged 15 years or younger (UNAIDS and WHO, 2002). The worldwide infection rate stood at 0.4 per cent. In 2002 alone, 5 million people (including 800,000 children) became infected with HIV/AIDS and 3.1 million died of AIDS (see Table 2.1).

Table 2.1 The global HIV/AIDS situation at the end of 2002

People newly infected with HIV	**Total**	**5.0 million**
	Adults	4.2 million
	Women	2.0 million
	Children under 15 years	800,000
Number of people living with HIV/AIDS	**Total**	**42.0 million**
	Adults	38.6 million
	Women	19.2 million
	Children under 15 years	3.2 million
AIDS-related deaths	**Total**	**3.1 million**
	Adults	2.5 million
	Women	1.2 million
	Children under 15 years	610,000
Number of AIDS orphans since the beginning of the epidemic until the end of 2001	**Total**	**14 million**

Source: UNAIDS and WHO, 2002

About half of all people living with HIV/AIDS (PLWHA) became infected before the age of 25 and died approximately 10 years later. By the end of 2001 there was a cumulative

total of 14 million AIDS orphans (defined as children who have lost their mothers before reaching the age of 15). Many of these maternal orphans however, had also lost their fathers. Approximately 95 per cent of the global number of PLWHA live in developing countries (Amani, 2003). It is expected that this proportion will rise further, as a result of poverty, poor health systems and the limited resources available for prevention and care. With the HIV-positive population still expanding, the annual number of AIDS deaths worldwide can also be expected to increase.

It is very likely that the situation will deteriorate further before there is any improvement. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has warned that the damage already incurred will seem minor compared with that which lies ahead, unless action against the epidemic is scaled up dramatically. Furthermore, HIV/AIDS continues to spread rapidly into new populations, particularly in Africa, Asia, the Caribbean and Eastern Europe. A recent report (Gordon, 2002) predicts that the spread of the disease will accelerate in Asia and Africa over the next decade, with the possibility that by 2010 there will be 75 million people living with HIV/AIDS in five of the world's most populous countries (i.e. China, India, Russia, Ethiopia and Nigeria).

Although the most direct consequences of the spread of HIV/AIDS are the increases in morbidity and mortality, in severely affected countries the epidemic has already led to significant economic, social and security setbacks. The adverse effects of the epidemic ripple out across society, leaving no sector untouched. It is a comprehensive tragedy that calls for a comprehensive response (UNAIDS and WHO, 2002).

2.2 The national HIV/AIDS situation

Like many other sub-Saharan countries, there is a relatively high level of HIV/AIDS infection in Tanzania. The first case was diagnosed in 1983 in a village on the Ugandan border in Bukoba District of Kagera Region. By 1986 the number of AIDS cases had risen from an initial three to number tens of thousands countrywide.

According to a 1991 NACP report, by 1990 Tanzania had 21,175 officially reported AIDS cases, of which more than 90 per cent were in adults between 15 and 55 years of age. In a 1997 report on HIV prevalence among antenatal clinic attendees, the figures ranged from 4 to 44 per cent (UNAIDS and Economic Commission for Africa, 2000).

Table 2.2 shows the cumulative AIDS cases since 1993. It is worth noting that the distribution of AIDS cases by region is based on where the diagnosis was made and therefore does not necessarily reflect the place of usual residence of the person. High prevalence in Mbeya might therefore reflect the region's high number of migrant workers. In addition, the NACP estimates that only one out of five AIDS cases are reported, due to under-utilization of health services, under-reporting and delays in reporting. Despite these limitations however, it is believed that the data do reflect the trend of cases in the country.

The table shows that until 1998, compared with the rest of the country Iringa had just over the average number of cases of HIV – approximately 5 per cent of the total cases in Tanzania. From 1998 onwards however, the rate of growth in Iringa was much slower compared to the country as a whole, so that by 2001 only 3.7 per cent of the total number of AIDS cases were found in the region. This is mainly due to the explosion in the number of

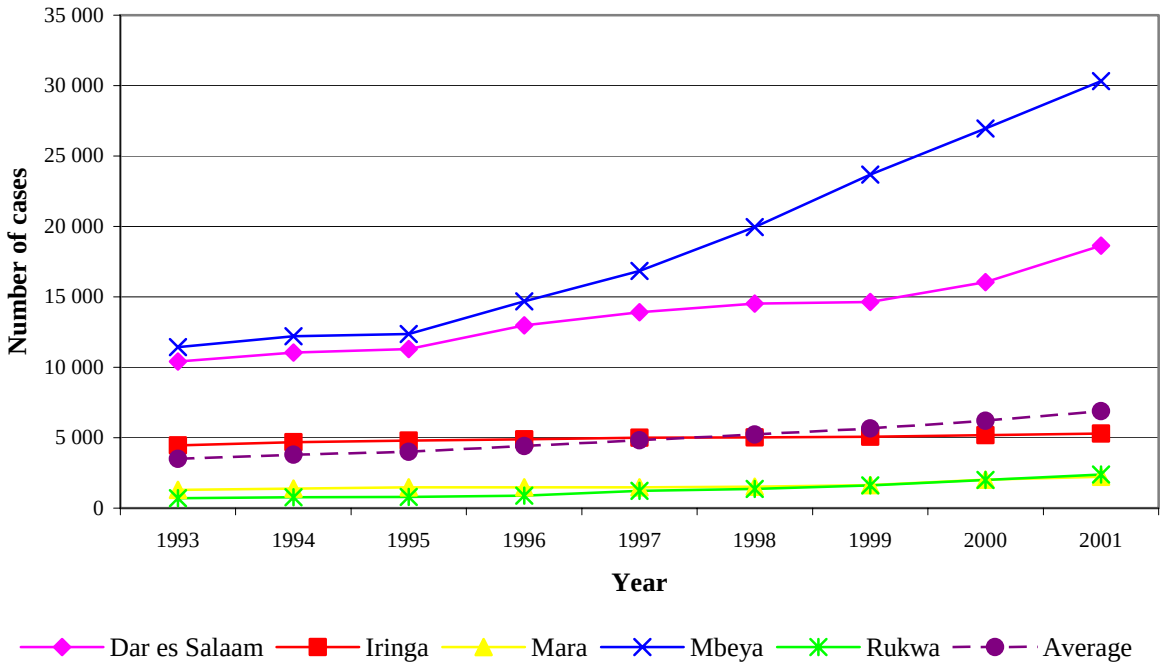
cases in Mbeya Region (see Figure 2.1 for a graphical representation of this). In addition to hosting a large number of migrant workers, Mbeya borders both Zambia and Malawi and has a major railroad running through it. All of these factors conspire to produce a situation where there is a high degree of population movement, in other words, a situation in which HIV can spread very rapidly. Dar es Salaam also has a large number of PLWHA, although since it is a major urban centre, it is expected that prevalence will be higher than average. The lowest prevalence rates are found in Mara and Rukwa. In the case of Mara, this partly reflects the small size of the region. Rukwa is much larger and although it has a low overall prevalence compared with the national average, the rate of increase is higher than even in Iringa. One possible explanation of the low number of cases is that there are fewer screening centres in Rukwa compared to other regions. Therefore, the figures may represent a low incidence of diagnosis, rather than low prevalence.

Table 2.2 Cumulative AIDS cases by region, Tanzania 1993-2001

Region	Year								
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Arusha	2,185	2,368	2,615	2,787	3,244	3,567	3,948	4,196	4,688
Coast	2,740	3,023	3,268	3,559	3,796	4,266	4,375	5,348	5,580
Dar es Salaam	10,406	11,050	11,302	12,983	13,899	14,517	14,643	16,053	18,627
Dodoma	1,028	1,294	1,608	1,938	2,517	2,641	2,748	2,941	3,170
Iringa	4,462	4,674	4,785	4,883	5,008	5,031	5,076	5,179	5,298
Kagera	6,646	7,064	7,223	7,426	7,671	7,881	8,310	8,529	8,976
Kigoma	1,920	2,070	2,257	2,280	2,426	2,481	2,613	2,732	2,815
Kilimanjaro	4,699	5,119	5,513	5,991	6,618	7,375	7,766	8,088	9,097
Lindi	1,691	1,966	2,173	2,480	2,712	3,074	3,559	4,155	4,710
Mara	1,304	1,393	1,486	1,486	1,486	1,515	1,634	2,021	2,229
Mbeya	11,439	12,214	12,371	14,685	16,835	19,949	23,688	26,952	30,320
Morogoro	4,328	4,575	4,903	5,189	5,438	5,534	5,863	6,388	6,820
Mtwara	2,090	2,201	2,267	2,444	2,569	2,843	3,000	3,262	3,638
Mwanza	5,349	5,731	5,974	6,365	7,006	7,384	7,884	8,338	8,752
Rukwa	715	777	801	882	1,227	1,359	1,621	1,997	2,382
Ruvuma	2,480	2,847	3,087	3,345	3,752	4,260	4,760	5,406	6,381
Shinyanga	2,624	3,062	3,361	3,824	4,217	4,515	4,861	5,440	6,310
Singida	1,472	1,688	1,908	2,135	2,167	2,262	2,329	2,396	2,692
Tabora	2,786	3,075	3,428	3,805	4,278	4,733	5,199	5,946	6,349
Tanga	3,207	3,475	3,793	4,062	4,278	4,632	4,792	4,975	5,620
Unspecified	1	2	44	44	44	44	44	44	44
Total for Tanzania	**73,572**	**79,668**	**84,167**	**92,593**	**101,188**	**109,863**	**118,713**	**130,386**	**144,498**

Source: Amani, 2003

Figure 2.1 Cumulative AIDS cases in Iringa Region, compared with the national average and the regions with the highest and lowest prevalence, 1993-2001



Source: Data from Figure 2.2

Table 2.3 shows the age and sex distribution of the reported cases in 2001. Most fall within the 20-49 age group, with the highest number of reported cases in the 25-34 and 30-39 age groups for females and males respectively. Assuming a medical incubation period of around ten years, this pattern suggests that most individuals acquire the infection during late adolescence (Amani, 2003). It also confirms that the productive and reproductive age group is the hardest hit by the disease.

The data in Table 2.3 also show that women in the 20-34 age group have a higher prevalence rate than men of the same age. However, males generally have a higher case rate than females, particularly for those aged 35 years and over. The information currently available indicates that women tend to become infected far younger than men, for both biological and cultural reasons. Amani (2003) reports that according to recent studies of several African populations, girls aged 15-19 are five to six times more likely to be HIV positive than boys of the same age.

Table 2.3 Distribution of reported AIDS cases by age and sex, Tanzania 2001

Age group	Male		Female		Unknown		Total	
	No.	%	No.	%	No.	%	No.	%
0-4	198	3.2	186	2.4	4	10.0	388	2.7
5-9	116	1.9	101	1.3	6	15.0	223	1.6
10-14	66	1.1	91	1.2	0	0.0	157	1.1
15-19	139	2.2	418	5.4	1	2.5	558	4.0
20-24	479	7.7	1,095	14.0	8	20.0	1,582	11.2
25-29	894	14.3	1,656	21.2	2	5.0	2,552	18.1
30-34	1,247	19.9	1,710	21.9	6	15.0	2,963	21.0
35-39	1,131	18.1	1,135	14.5	4	10.0	2,270	16.1
40-44	809	12.9	662	8.5	3	7.5	1,474	10.4
45-49	479	7.7	346	4.4	2	5.0	827	5.9
50-54	306	4.9	191	2.4	4	10.0	501	3.6
55-59	157	2.5	91	1.2	0	0.0	248	1.8
60-64	123	2.0	59	0.8	0	0.0	182	1.3
65+	85	1.4	22	0.3	0	0.0	107	0.8
Unknown	32	0.5	48	0.6	0	0.0	80	0.6
Total	**6,261**	**100.0**[1]	**7,811**	**100.0**	**40**	**100.0**	**14,112**	**100.0**

Source: Tanzania MoH, 2001

However, there are signs of hope that this devastating epidemic can be brought under control. In countries such as Uganda and South Africa the situation does seem to be improving. In several regions of Uganda, the number of HIV infections appears to be on the decline: there is a steady drop in HIV prevalence among 15-19 year-old pregnant women (Rugalema and Khanye, 2002). In South Africa HIV prevalence rates among pregnant women under 20 fell from 21 per cent in 1998 to 15.4 per cent in 2001, although overall growth rates are still increasing. In Tanzania the challenge is how to sustain the low prevalence rates of some regions, whilst decreasing the current high prevalence rates in others (e.g. Mbeya, Dar es Salaam and Kilimanjaro). NACP documents indicate that the pattern of infection is also changing, as a result of greater coverage in Voluntary Counselling and Testing (VCT), coupled with the increased use of antiretroviral (ARV) therapy and higher levels of condom use.

[1] If the percentages given here are added up, the total percentage comes to 100.3. However, this is because the figures have been rounded to 1 d.p., rather than because of any inaccuracy in the statistics. For this reason, all of the total percentages have been given as 100.0.

2.3 The HIV/AIDS situation in the education sector

In the education sector the prevalence of HIV and the impact of AIDS are measured through a combination of indicators, ranging from trends in the morbidity and mortality of teachers, to the proportion of orphans in enrolments. However, record keeping is poor and the data needed to measure the indicators are lacking. For example, although there are indications that AIDS may have become the greatest cause of death among adults in mainland Tanzania, empirical data are not yet conclusive about this issue. Estimations of AIDS-related mortality rates can only be proximate: symptoms that point to AIDS or HIV infection, for example long-term illness and wasting, are also indicative of many other diseases (Bicego, Curtis, Raggers, Kapiga and Ngallaba, 1997).

The education sector, which is one of the largest employers in Tanzania, faces particular problems for two basic reasons:

- Schools and educational institutions enrol young people in the 7-24 age group, from basic education through to tertiary level. Epidemiological reports show that the 15-24 age group is highly vulnerable to HIV (Tanzania MoH, 2001). Data from other research findings corroborates this, showing that both girls and boys in primary and secondary schools are sexually active. A knowledge, attitudes and practices baseline survey conducted by the German Agency for Technical Cooperation (GTZ) Reproductive Health Project amongst 1,560 primary school pupils in Lindi Region indicated that 45 per cent of pupils were sexually active. The mean age for first sexual intercourse was 11.2 years for boys and 14 years for girls (Tautz, 2001).

- If ignored, the high rate of disease and death among teachers and other trained professionals will make replacements increasingly hard to find and train. Moreover, the death of just one teacher deprives a whole class of children of education. Therefore, it erodes access to education and interferes with the functioning capacity of key institutions.

2.3.1 Cultural practices that increase the risk of HIV infection

There are a number of cultural practices that can increase the risk of infection among the wider community and that also affect education sector staff, students and pupils. These include:

- casual sexual intercourse during tribal festivals and social gatherings;
- sexual intercourse to remove curses and taboos;
- sex with minors for the purpose of curing disease;
- wife inheritance, and
- acceptance of sexual intercourse with in-laws.

In addition to these practices, certain factors may put teachers at special risk of contracting HIV, particularly in rural areas. Here, poverty levels are high but teachers are perceived as well to do and have high social status in their teaching environment. Receipt of a regular cash income also gives them resources to buy sexual favours in an environment with little liquidity for most of the year. Consequently, some interviewees and participants in the discussion groups felt that education sector leaders and teachers lack the moral authority to advocate for HIV/AIDS prevention, because of their own high-risk behaviour.

The lack of attention given to the vulnerability of teachers to HIV/AIDS and the inability of most to access ARV treatment, mean that many die every year. According to Galabawa and Mbelle (2002), the teaching force is disappearing at a rate of 0.8 per cent. Data from the TSC reveals that most teacher attrition caused by death is due to HIV/AIDS and its related diseases (e.g. TB, typhoid, diarrhoea and long-term fevers). The cumulative number of deaths of teachers between January 1999 and December 2002 was 2,873. Of these, 49 (17.3 per cent) occurred in 1999, 708 (24.6 per cent) occurred in 2000, 730 (25.4 per cent) occurred in 2001 and 938 (32.6 per cent) occurred in 2002, indicating an upward trend. During the financial year 2001/2002, 1,046 deaths of teachers were recorded, as Table 2.4 shows.

Table 2.4 Percentage distribution of deaths of teachers by age group, financial year 2001/2002

Age Category	Number	Percentage
Under 30 years	71	6.8
31-40 years	219	21.0
41-50 years	603	57.6
Over 50 years	153	14.6
Total	**1,046**	**100.0**

Source: Tanzania TSC, 2003.

Taking into account the causes of death recorded and the profiles of terminal diseases, it is probable that some of the deaths among teachers aged 30-40 were HIV related. The majority of deaths however, occurred in the 41-50 age group. This has two major implications:

- It is likely that many of these older teachers had a high degree of experience in the classroom, so their deaths represent a high level of wastage in terms of human resources.

- It is likely that by that stage of their lives, many would have established families of their own, thus adding to the burden of AIDS orphans.

Therefore, in Tanzania, just as in many other countries, AIDS has already had an unprecedented institutional and sectoral impact. Moreover, the organizations and individuals that it affects are not only those that are most needed for development; they are also vital for the prevention of the spread of the epidemic itself. Education has the potential to be the single most powerful weapon at the disposal of those fighting HIV/AIDS (Kelly, 2000).

3. EVOLUTION OF THE HIV/AID INTERVENTIONS IN THE EDUCATION SECTOR

3.1 National policy on HIV/AIDS

Tanzania's national policy on HIV/AIDS has been in place since November 2001. It is intended to provide a framework for the leadership and coordination of the multi-sectoral response to the epidemic. The policy calls on all sectors to formulate appropriate interventions to prevent, control and mitigate the impact of HIV/AIDS. The specific objectives are:

- to prevent the transmission of HIV/AIDS;
- to promote HIV testing;
- to provide a framework of care for people living with HIV/AIDS;
- to stipulate sectoral roles and financing mechanisms;
- to promote HIV/AIDS research;
- to advocate for HIV/AIDS legislation, and
- to stipulate cross-cutting issues of national interest.

Before 2001 and the advent of the national policy, the fight against HIV/AIDS was guided by the NACP. This programme was formed in 1985. Its initial activities were set out in a two-year short term plan (1985-1986), which was then followed by three successive Medium-Term Plans (MTPs), each lasting five years (MTP–I 1987-1991, MTP–II 1992-1996 and MTP–III 1998-2002).

The first two MTPs identified national responses to be guided and coordinated by the health sector. MTP–III however, was formulated with an expanded multi-sectoral vision and called for the wider participation of both the public and private sectors, including NGOs, Community-Based Organizations (CBOs) and Faith-Based Organizations (FBOs). However despite this expanded framework, the NACP was still viewed principally as a health sector initiative, incapable of coordinating a multi-sectoral response to HIV/AIDS. Therefore, in 2001 TACAIDS was established under the Prime Minister's Office to provide the leadership and coordination of such a response. The national policy was formulated to facilitate the ability of TACAIDS to assume this rule.

The policy directs central and local government, NGOs, CBOs, FBOs and the general public to develop IEC interventions to promote safe sex practices, including the correct and consistent use of condoms. As part of this, the national policy mandates the MoEC to work closely with TACAIDS and NGOs to accelerate the provision of HIV/AIDS information in schools and to promote safe sex amongst staff. Further mandates to the education sector are provided in the 2003-2007 national multi-sectoral strategic framework on HIV/AIDS, which calls on all sectors to develop seperate strategic frameworks. In response to this, the MoEC began working on the Education Sector Strategic Plan (ESSP) on HIV/AIDS, 2003-2007.

3.2 Education sector HIV/AIDS policy

The education sector's activities are laid out in the education and training policy of 1995. This policy guides the provision of education in Tanzania, focussing principally on increasing enrolments and improving quality, equitable access and resource distribution. It does not however deal with issues relating to HIV/AIDS.

The cause for the lack of a dedicated HIV/AIDS policy for the education sector and the absence of HIV/AIDS from the current education and training policy can be traced back to the early categorization of the epidemic as a health sector issue. During those early years (1985-1991), the education and health sectors did work closely together on some issues, for example, in primary schools to prevent and control the spread of Sexually Transmitted Infections (STIs). However, it did not occur to the government of the day that the education sector required an individual response to the epidemic. This was still the case in 1995 when the education and training policy was finalized.

3.2.1 Initial interventions in the education sector

The education sector interventions that have taken place were based on two pivotal circulars, formulated and released in 1993 and 2000 respectively. Active participation on the part of the MoEC began in 1993 with the release of Circular Number 3 for the establishment of an HIV/AIDS intervention in the education sector. The MoEC subsequently released Circular Number 3 of 2000, to redefine the nature and scope of those interventions. The contents of the two circulars are summarized in Table 3.1.

Table 3.1 Education sector HIV/AIDS policy evolution

Education Circular Number 3 of 1993

Contents

- Establishment of an HIV/AIDS intervention in the education sector. The major focus was primary schools and grade A and B teacher training colleges.
- The intervention was designed to educate students and pupils to adopt and maintain behaviour that would reduce the spread of HIV.
- The intervention initially adopted a campaign approach, whilst awaiting the AIDS curriculum component to be introduced later. Campaign elements included the dissemination of IEC materials (teachers guides, picture charts and flyers etc.) and running orientation seminars at zonal and district levels.
- NGOs were invited into secondary schools to assist with HIV/AIDS education.

Remarks

- The circular directed zonal and district school inspectors to train primary school teachers in AIDS Education, without stipulating how they were to be trained themselves.
- The circular did not institute a monitoring and evaluation plan or commit funds for this activity.
- The circular did not give explicit directions to heads of secondary schools to invite NGOs to extend their interventions to schools.
- The circular did not provide unified guidance on how the activities of NGOs in secondary schools were to be coordinated.

Education Circular Number 3 of 2000

The circular redefined the nature and scope of the school HIV/AIDS education intervention. Copies were distributed to all school heads by the regional and district education officers and it became effective on 1 December 2000.

Contents

- The target group of the 1993 intervention was expanded to cover teachers and MoEC employees, in addition to school pupils.
- The intervention was designed to educate the target audience to adopt behaviour and practices that would prevent infections and curb the spread of HIV/AIDS and STIs.
- AIDS education was incorporated into carrier subjects rather than treated as a separate subject.
- Peer education was advocated as one of the methods used to educate primary school pupils, secondary school students and teacher trainees.
- Zonal and district school inspectors were directed to monitor the provision of in-school HIV/AIDS education.
- The intervention was teacher centred. Only teachers and trainee teachers were responsible for delivering in-class AIDS education, although other experts could be invited to make special one-off presentations.
- The circular directed that NGOs could be invited to extend their interventions to schools after obtaining permission from the MoEC, based on submitted proposals.
- Heads of schools and teacher training colleges were directed to identify ‘AIDS days’, dedicated to educating pupils, students and the wider school community on HIV/AIDS issues.
- Heads of MoEC departments and institutions affiliated to the MoEC were directed to form HIV/AIDS advisory committees.
- Heads of schools and teacher training colleges were directed to form counselling and education committees.
- Zonal school inspectors were directed to work with other facilitators to provide

HIV/AIDS education to schoolteachers, through training and orientation programmes.

Remarks

- There was no consultation with other actors, such as CBOs, FBOs and PLWHA, whose experiences and different perspectives could have made a valuable contribution.
- The circular did not consider how the education system should handle orphans, or how AIDS orphans differ from others. AIDS orphans are consequently treated just like any other orphan, despite their specific needs and ever-increasing numbers.
- The circular did not address issues connected with PLWHA, particulary those related to the stigma attached to the disease. As a result of this omission, administrators at all levels are forced to rely on common sense only, when such issues arise amongst their own staff.
- Unlike district school inspectors, district education officers did not automatically receive copies of the circular, as had been the case in 1993. It is therefore suspected that acquisition of this circular by district education officers depended on their immediate managers, the regional education officers and district executive directors.

3.2.2 The AIDS education programme

The release and dissemination of the circulars culminated in the formulation and implementation of the AIDS education programme. This programme is divided into six components:

- **Strengthening the HIV/AIDS management structure**
  The circulars called for the strengthening of the HIV/AIDS management structure to facilitate the organization of the interventions. Two new bodies were formed: the AIDS Management Committee (AMC), and the Technical AIDS Committee (TAC). The School AIDS Education Programme was reformulated, becoming an independent unit, the AIDS Coordination Unit (ACU), located in the office of the Chief Education Officer (CEO). The AMC is the highest HIV/AIDS management body in the MoEC. It is composed of the heads of departments and institutions and chaired by the Permanent Secretary. The TAC is the second highest body and is composed of HIV/AIDS focal points nominated by the heads of departments and institutions. The two committees are served by a single secretariat, the ACU. The evolution of the ACU is described in Table 3.2.

Table 3.2 The evolution of the AIDS Coordination Unit of the MoEC

Original inception	The ACU began in 1993 as the School AIDS Education Programme, under the office of the Commissioner of Education (present CEO).
Restructuring	In 2001 the School AIDS Education programme was upgraded into a full-fledged HIV/AIDS Coordination Unit, under the office of the CEO. The unit is supported by two MoEC steering committees: ▪ AIDS Management Committee (AMC); ▪ Technical AIDS Committee (TAC).
Present function	▪ Serves as the secretariat to the AMC and TAC. ▪ Initiates and coordinates planning for HIV/AIDS- and other STI-related activities. ▪ Initiates and harmonizes sector strategic plan activities. ▪ Coordinates the implementation of the ESSP between the various stakeholders. ▪ Conducts regular supervision and follow-up of AIDS education implemented by departments, institutions and collaborators. ▪ Prepares consolidated quarterly, mid-year and annual progress reports for submission to the appropriate authorities. ▪ Mobilizes resources. ▪ Identifies areas for research and coordinates existing research into the impact of HIV/AIDS on the education sector.
Future role	The role of the HIV/AIDS Coordinating Unit is expected to expand as the ESSP develops. This will necessitate: ▪ an adequate number of qualified staff (education specialists, sociologists, public health experts etc.); ▪ adequate supplies and equipment, including data processing equipment, stationery, IEC materials etc.; ▪ additional staff training, especially related to HIV/AIDS and monitoring and evaluation.

- **School HIV/AIDS and life skills education**

  This component of the HIV/AIDS programme is based in primary and secondary schools and teacher training colleges. HIV/AIDS, other STIs and life skills education curriculum requirements are treated as topics in the syllabi of carrier subjects: primary science for primary education; biology for secondary education; civics for the Certificate in Education, and general studies for Advanced Level and the Diploma in Education. In-service and pre-service training sessions have been provided for teachers. As a result, 80 teacher training college tutors, 1,460 secondary school teachers and 21,000 primary school teachers nationally have been trained in HIV/AIDS and life skills education.

- **School peer education**

  This component is based at the institutional level. Fellow pupils, students and teacher trainees usually nominate and vote for peer educators, who are then trained. The core functions of peer educators are to promote responsible sexual behaviour and to provide support against peer pressure.

- **School guidance and counselling committees**
  This is a 10 to 12 member sub-committee of the school committee or board, which supports, supervises and monitors the in-school implementation of the HIV/AIDS education programme. The committee is also responsible for coordinating the involvement of the surrounding community.

- **School counselling and guidance services**
  This component utilizes the services of teachers, known as guardians, who are trained in guidance and counselling techniques. Pupils and students can seek advice and assistance on a wide range of issues, including adolescent reproductive health, HIV/AIDS and other STIs, sexual abuse and the rights of the child.

- **MoEC headquarters peer education**
  Introduced in February 2003, this is the newest component of the HIV/AIDS education programme. It utilizes the services of 65 trained peer educators, selected by popular vote from all departments at MoEC headquarters and all affiliated institutions. The prospective educators receive one-week's training, covering areas of sexual behaviour, HIV/AIDS education, peer education and the responsibilities of peer educators in the workplace. The peer educators were then given the task of educating fellow workers on HIV/AIDS and providing a role model for fellow workers. The majority (80 per cent) came from MoEC headquarters, with the rest from various affiliated institutions (Tanzania Library Services, the TTU, the Institute of Adult Education, Bagamoyo School of Arts, the Films Censorship Board, *Baraza la Kiswahili Tanzania*, the TSC and the Tanzania Institute of Education).

3.2.3 Further guidelines for HIV/AIDS-related interventions

In October 2002 a document was produced and distributed stipulating further guidelines for the implementation of HIV/AIDS, other STIs and life skills education in schools and teacher training colleges. The guidelines were distributed to all actors in the education sector, with the hope that they would reduce the extent of transmission of HIV/AIDS amongst the public in general and in educational institutions in particular. The document noted that the health of young people has become a subject of increasing importance in Tanzania, partly because of a greater understanding of the importance of this age group to public health and partly due to the changing conditions surrounding sexual and reproductive health issues.

3.3 Implementation of HIV/AIDS interventions in the education sector

Effective implementation of HIV/AIDS interventions at all levels of the education sector requires the full involvement of all schools, departments, partners and affiliated institutions.

3.3.1 Interventions at the central level

In addition to the specific tasks of strengthening the HIV/AIDS management structure and introducing peer education schemes for ministry staff, the MoEC is responsible for the

overall implementation, coordination, monitoring and evaluation of the six components of the AIDS education programme.

All national and local NGOs and CBOs wishing to implement school-based activities must also be registered with, and cleared by, the MoEC.

3.3.2 Interventions at the district level

At the district level the education sector implements MoEC circulars, directives and guidelines pertaining to the interventions. It also collaborates with NGOs, CBOs, FBOs and other sectors on HIV/AIDS school-based activities.

This study established that the Iringa Regional Education Officer and Iringa Urban District Education Officer did receive copies of the 1993 and 2000 circulars, which represent the cornerstones of the AIDS education programme. The subsequent implementation of the stipulated interventions involved:

- arranging training seminars and workshops for teachers, in collaboration with zonal and district school inspectors. The sessions mostly concentrated on school HIV/AIDS and life skills education. Carrier subject teachers at primary and secondary schools received further training on how to teach the new parts of the syllabus. Only one primary and two secondary teachers were trained per school. Other public sector bodies and NGOs were also invited to make technical presentations on issues relating to health, community development and social welfare. The local NGOs invited were *Uzazi na Malezi Bora Tanzania* (UMATI) and the African Medical Research Foundation (AMREF);

- establishing inter-sectoral collaborations, mainly with the health sector, to run HIV/AIDS interventions in schools. For example, doctors, nurses and health officers were invited to schools to make technical presentations;

- identifying NGOs and CBOs to participate in the prevention of HIV/AIDS and impact mitigation in the education sector. The normal arrangement in Iringa Urban District is for CBOs and NGOs to submit their proposed school-based work plans and budgets to the district authorities, following clearance from MoEC headquarters. The authorities analyse the proposal, advising changes as necessary and then select the school to participate in, and benefit from, the proposed scheme. Of the 26 national and local NGOs working in the district, six NGOs – Iringa AIDS NGO Network (INGONET), Students Partnership Worldwide (SPW), Iringa Development of Youth, Disabled and Children Care (IDYDC), Tanzania Home Economics Association (TAHEA), UMATI and AMREF – are actively working in district schools. The details of their activities are summarized in Table 3.3;

- conducting HIV/AIDS sensitization seminars. These seminars involved two to four secondary school teachers and all headmasters or headmistresses. Unfortunately, not all primary school head teachers could attend.

3.3.3 Interventions at the institutional level

Although all secondary school heads received copies of the two circulars, it was noted that none of the primary schools had copies of them. The implementation of the institutional level interventions stipulated in the circulars involved:

- integrating HIV/AIDS into the school curriculum, following the attendance of carrier subject teachers at the HIV/AIDS and life skills education seminars;

- establishing HIV/AIDS days (*Siku za UKIMWI Shuleni*). In collaboration with school committees and boards, schools identified two days per term to be dedicated to HIV/AIDS-related activities. These included debates, discussions, drama, choir, art or games, poems, cultural dances etc. Guests from the health sector were also invited to give talks. Teachers interviewed felt that this intervention worked more successfully at secondary than at primary level. One possible reason for this difference is that secondary heads know what is required of them at first hand, as they receive their own copies of the circulars. Primary head teachers can only implement what they are directed to by the office of the District Education Officer; directives may be coloured by the interpretation of someone else. According to some respondents the other reason is that secondary schools are semi-autonomous authorities and can thus choose to invite NGOs and CBOs to participate themselves. Primary schools have to depend on prescriptions from the office of the District Education Officer;

- establishing in-school peer education interventions. Two peer educators were chosen from each class (classes V to VII in primary schools, forms I to VI in secondary schools). Carrier subject teachers, guidance and counselling teachers, NGOs and CBOs (including UMATI, TAHEA and SPW) then trained those selected;

- establishing STI, including HIV/AIDS counselling and guidance interventions. The heads of schools, in collaboration with district authorities, were involved in the identification of teachers to be trained in counselling and guidance. Training was coordinated by the education department, in collaboration with NGOs and CBOs (UMATI, TAHEA, SPW and AMREF).

3.4 Policy and practices supported by other education sector actors

The MoEC collaborates with a number of education sector and HIV/AIDS stakeholders. The partners include TACAIDS, the President's Office for Regional Administration and Local Government (PORALG), the NACP of the MoH, the World Bank, UNESCO, UNAIDS, the United Nations Development Programme (UNDP), the United Nations Children's Fund, CSSC, the Red Cross, the Agha Khan Foundation, BAKWATA, TAPA, TTU and the TSC. A number of local NGOs also work at the regional and district levels.

TACAIDS supports all MoEC initiatives for the development of an HIV/AIDS education sector policy, principally through the 2001 national policy and the 2003-2007 national multi-sectoral strategic framework. NACP works with the MoEC to prepare

HIV/AIDS IEC materials for schools and has steadily supported other HIV/AIDS education sector initiatives.

Other partners provide support by implementing AIDS education programmes in schools. For example, schools owned by BAKWATA, TAPA, the Tanzania Episcopical Conference and the Christian Council of Tanzania follow the national curriculum, tackling HIV/AIDS issues in carrier subjects as stipulated by Circular Number 3 of 2000. CSSC reported that the introduction of HIV/AIDS education in church-owned seminary secondary schools had the secondary effect of creating a climate of more open discussion amongst staff, most of whom were missionaries. HIV/AIDS had formerly been a taboo subject in such institutions. Table 3.3 summarizes the partnerships established at the district and institutional levels.

Table 3.3 Partnerships established in Iringa Urban District

Iringa AIDS NGO Network (INGONET)	
Description	▪ Established on 26 April 1994 with the objective of reducing the impact of HIV/AIDS and other STIs in Iringa, through empowering member NGOs to work with communities.
School-oriented activities	▪ Shows videos on HIV/AIDS and other STIs to secondary school students. ▪ Provides HIV/AIDS education for secondary school students. ▪ Actively participates in school AIDS days, especially in secondary schools. ▪ Designs, develops, produces and disseminates HIV/AIDS IEC materials (leaflets and flyers) for schools. ▪ Provides material support for orphans (school uniforms and exercise books) through NGOs and CBOs affiliated to INGONET.
Other activities	▪ Organizes HIV/AIDS advocacy seminars for public sector staff, including those working in the education sector. ▪ Offers psychological training to guardians of orphans, including schoolteachers.
Remarks	▪ INGONET concentrates on the training of teachers, so that they can then train the learners, especially at primary school level. ▪ INGONET is not staffed with an adequate number of personnel to implement the interventions. It depends on staff from affiliated NGOs and CBOs. ▪ In-school INGONET activities were sometimes met with resistance from teachers, who observed that their interventions were too open (e.g. talking about condoms, sexual intercourse etc.).
Students Partnership Worldwide (SPW)	
Description	▪ An international educational charity registered in the United Kingdom, with established youth-led programmes in many countries, including Tanzania. ▪ In Iringa Region, SPW implements two interventions: the School Health Education Programme at secondary level, and the Community Resource Programme at primary level and in the wider community. ▪ In Iringa Urban District SPW concentrates on the School Health Education Programme.

School-oriented activities	▪ Recruits and trains volunteers to teach a specially designed adolescent sexual and reproductive health module covering sensitive topics such as teenage relationships, HIV/AIDS and other STIs, teenage pregnancy and family planning. ▪ Places emphasis throughout the teaching sessions on the development of life skills, employing non-formal education techniques such as debates, role-plays and audio-visual aids to stimulate discussion and active participation. ▪ Runs one resource room or youth development centre per school. These centres are stocked with IEC materials from other NGOs that work with young people. ▪ Facilitates a wide range of sports and artistic clubs during out-of-school hours to keep students active and to further develop their skills. ▪ Coordinates and organizes four-day intensive youth festivals that offer students a rare chance to compete with other schools in arts, sports and leading public campaigns against HIV/AIDS. ▪ Participates in the training of peer educators at secondary level. ▪ Participates in HIV/AIDS days in secondary schools.

Iringa Development of Youth, Disabled and Children Care (IDYDC)

Description	▪ A local NGO founded in 1991 with the aim of supporting children in need. ▪ Registered as an Iringa-based NGO in 1994.
School-oriented activities	▪ Provides practical assistance to orphans and children from poor families, by distributing school uniforms (shorts and shirt or skirt and blouse) and basic educational supplies. In both 2002 and 2003 1,000 uniforms were distributed to needy school children, most of whom were orphans. ▪ Sets up and equips football and netball teams and drama groups in schools and the surrounding communities, with the objective of using games as an entry point for disseminating information about HIV/AIDS and other STIs. To date 80 25-person football squads have been formed in Iringa Urban District. One peer educator has been trained for each team. ▪ Designs and disseminates STI including HIV/AIDS and life skills educational materials aimed at pupils and students aged 6-17 years. ▪ Encourages school dropouts to return to the classroom through a drop-in or open door programme, in association with *Mpango wa Elimu ya Msingi kwa Walioikosa*. Those returning also receive STI and life skills education.

Tanzania Home Economics Association (TAHEA)

Description	▪ Established in 1980 with the objective of improving the quality of community life, particularly for women. ▪ TAHEA now has branches in all of the regions of mainland Tanzania.
School-oriented activities	▪ Provides training for teachers in peer education techniques. In 2003 12 primary and 12 secondary school teachers were trained as peer education trainers (three per school). They went on to train 50 peer educators overall. ▪ Provides in-school psychosocial support to orphans. ▪ Mitigates the impact of HIV/AIDS by assisting orphans in school. In Iringa Urban District TAHEA has assisted orphans at 15 primary schools. It has reached 2,250 orphans in the region as a whole. Assistance may include paying fees and providing uniforms, school bags and exercise books.
Other activities	▪ Provides psychological training to guardians of orphans, including schoolteachers.

Uzazi na Malezi Bora Tanzania (UMATI)	
Description	▪ Established in 1957 with the core aim of providing family planning services. ▪ UMATI headquarters are in Dar es Salaam. It has zonal offices across Tanzania, including one in Iringa municipality.
School-oriented activities	▪ Trains secondary school teachers in counselling and guidance techniques and the rights of the child. ▪ Trains peer educators at primary schools. ▪ Develops, produces and disseminates IEC materials (leaflets and flyers) on adolescent reproductive and sexual health and HIV/AIDS for schools. ▪ Encourages schoolteachers, students and pupils to check their HIV status by visiting the UMATI VCT centre in Iringa municipality. ▪ Participates in school AIDS days at primary and secondary level when invited.
Other activities	▪ Runs a VCT centre in Iringa municipality. Services are free for young people including those still at school and cost 1,000 Tanzanian shillings (TZS) for adults.

African Medical Research Foundation (AMREF)	
Description	▪ An independent, non-profit NGO founded in 1957 with the aim of improving healthcare for the underserved throughout Africa, through service delivery, training and research. ▪ AMREF headquarters are in Nairobi, Kenya. It has country offices in four African countries, including Tanzania. ▪ AMREF's national headquarters are located in Dar es Salaam. There is a regional branch in Iringa municipality.
School-oriented activities	▪ Trains secondary school teachers in counselling and guidance techniques and in the rights of the child. ▪ Trains peer educators at primary level. ▪ Develops, produces and disseminates IEC materials (leaflets and flyers) on adolescent reproductive and sexual health and HIV/AIDS for schools. ▪ Encourages school teachers, students and pupils to check their HIV status by visiting the ANGAZA VCT Centre owned by AMREF. ▪ Participates in school AIDS days at primary and secondary schools when invited.
Other activities	▪ Runs a VCT centre in Iringa municipality. Services are free for young people, including those still at school and cost TZS1,000 for adults.

3.5 Problems in implementing interventions

The implementation of the HIV/AIDS interventions stipulated by the 1993 and 2000 circulars has not been without its problems. The same complaints recurred throughout the interviews and discussions that took place at all levels and can be grouped into several broad themes.

3.5.1 Financial and resource constraints

Financial constraints impact on all components and all levels of the AIDS education programme. For example, it was felt that there were inadequate resources for the training and

support of subject teachers and peer educators. As a result, peer educators in school and at the MoEC complained that without teaching manuals and instructional materials it was difficult to lead topical discussions with participants.

3.5.2 Morale

Low staff morale was also found to be a serious problem at all levels of the education sector. In addition to the funding and resourcing criticisms, those involved in implementing HIV/AIDS interventions at the 'front line' (e.g. school AIDS counsellors, subject teachers and MoEC peer educators), complained that responsibilities had simply been added onto their existing tasks, were not reflected in their job descriptions and were not considered as criteria for promotion. The resulting motivation and recruitment problems have been further exacerbated by the perceived lack of informed support and guidance from education managers. Teachers also feel that they receive minimal attention from the pupils themselves. AIDS is not an examinable subject, so pupils are not motivated to work.

The epidemic itself has also had a negative impact on morale. In the course of interviews and discussions, staff articulated concerns that nothing substantial was being done in the sector; that there were no comprehensive programmes to control the spread and effects of AIDS. It has already been demonstrated that HIV/AIDS depletes the education sector workforce in terms of numbers, skills and experience, and affects manpower planning. Recruitment and training, particularly of specialist subject teachers, have not reacted to the impact of HIV/AIDS on the sector. As a result it is likely that posts will not be filled, placing further strain on existing staff.

3.5.3 Coordination and co-operation

Coordination and co-operation are vital for the effective implementation of programmes, projects and interventions. However, the fieldwork revealed that there were coordination problems between and amongst the different levels of the MoEC, as well as the other organizations implicated in the interventions. One possible reason for this was that the implementation framework described in the HIV/AIDS programme guidelines did not delineate clearly enough the roles and responsibilities of the different structures within the MoEC at central, regional and district levels, let alone its linkages with partners outside the Ministry (Muhondwa and Mhina, 2003).

NGOs, CBOs and FBOs make a valuable contribution to the fight against HIV/AIDS. However, the 2000 circular directed that only teachers and trainee teachers could be responsible for delivering in-class AIDS education. Other experts could make special presentations, but only at the invitation of the MoEC. Both teachers and NGO personnel felt that exclusion of NGOs and other organizations from the classroom in this way was tantamount to reducing the number of soldiers on the battlefield right in the middle of the fight. NGO participation was further limited by poor communications between Dar es Salaam and the regions, slowing down the clearance process.

However, where NGOs were active in school, it was observed that their interventions were not necessarily complementary to the official instruction given by teachers (Muhondwa and Mhina, 2003). In addition to this, some NGO pilot projects did not take into consideration the degree of teacher training required or the constraints of working within the structures of the education sector, rendering them unworkable or unsustainable.

Furthermore, the lack of mechanisms for the exchange of information and ideas also meant that there was frequent duplication of activities between the different organizations (see Table 3.3 for examples), whilst conflicts of interest and priorities created additional coordination issues (Tanzania MoEC, 2001). For example, one source of friction was the policy of promoting condom use to curb the spread of HIV. Some FBOs were not prepared to support this policy and refused to encourage condom use amongst secondary school students.

3.5.4 Disparities in coverage and dissemination

It was found that the distribution of circulars, directives and policy guidelines was not satisfactory. Documents sent out to schools by MoEC staff often could not be located upon request. It was not clear whether they had been misplaced or whether they had simply never arrived in the first place. Such occurrences however, do clearly reduce the effectiveness of the mechanisms and structures put in place to fight the HIV/AIDS epidemic. Dissemination of information also varied according to level. For example, the disparity between what primary and secondary schools receive at first hand was thought to have negatively impacted on the success of some school-based initiatives in primary schools. Linked to this, NGO-led peer education was found to be more visible in secondary than in primary schools, since secondary schools have a greater degree of autonomy in selecting external organizations themselves.

There are also disparities between schools of the same level. During visits to primary schools in Iringa Urban District, it was found that school guidance and counselling committees and services, and peer education programmes had taken hold in very few institutions. The low profile was thought to be due to inadequate monitoring and evaluation. The mechanisms for enforcing at the local level policy guidelines developed at the central were also felt to be inadequate and consequently to have affected the extent to which interventions had been implemented.

3.5.5 Target age group

Where peer education schemes, and HIV/AIDS education and life skills programmes had been implemented in primary schools, they were confined to classes V to VII. This exclusion of younger pupils can be criticized for several reasons:

- Preventive education can only be truly effective if young people are informed and protected right from the start. Therefore AIDS education must be introduced before children become sexually active.

- Pregnancy cases prove that some children do become sexually active before they reach class V. This may be out of choice or they may be forced into it: unfortunately cases of rape against young girls are now very common.

- Although primary education is supposed to start at the age of six, some children begin much later. Furthermore, Tanzania does not practice a policy of automatic promotion. Therefore, it is likely that classes I to IV will contain pupils of mixed ages, including many children who are much older than the ‘normal’ age for each class and who are already sexually mature. Following this argument it would be more constructive to institute a policy of age- rather than class-based counselling and education, to ensure that such children are not excluded.

3.6 Additional problems

3.6.1 Educational Management Information Systems (EMIS)

The combined activities of the MoEC, NGOs, CBOs, FBOs and other agencies generate huge amounts of data. This may only be adequately captured and monitored through the use of an effective Educational Management Information System (EMIS). An EMIS is required to ensure that information reaches its destination, is stored correctly, is easily retrievable and that the receiver and originator are kept abreast of any new developments. However, research findings reveal that no such system currently exists.

Creating an EMIS will not be an easy task, since district education departments and institutions are poorly equipped to handle education sector data. For example, districts and institutions do not maintain records on staff morbidity and absenteeism, or costs connected to treatment, funerals and burials As a result, the MoEC can not accurately track and document trends in staff supply and demand (see also Government of Malawi and UNDP, 2002), or effectively budget for additional costs incurred.

3.6.2 Policy issues

As discussed above, the approach of the education sector has been to implement HIV/AIDS interventions based on non-formal policy documents. However, this has been neither sufficient nor effective in addressing HIV/AIDS in a wider context, because circular and guidelines lack the legal backing for wider application and accountability.

All of the issues raised in these final two sections will be further discussed in the chapter outlining the conclusions of the study, and will be used to draw out recommendations for improving the sector response.

4. LEADERSHIP AND ADVOCACY

4.1 Internal advocacy for policy development and implementation of interventions

The senior officers of the MoEC, that is the Permanent Secretary (the chief executive officer), the CEO (responsible for the administration of the Ministry), and the departmental directors take the principal leadership roles in advocating for policy development.

After a policy gap has been identified, the department or set of departments and institutions with the requisite technical expertise are directed by the Permanent Secretary to prepare a concept paper. In the case of HIV/AIDS policy, this paper is then presented to the AMC for discussion and approval. The CEO is the current focal point for the development of the ESSP for the period 2003-2007. It is likely that the CEO will also take the leadership role in advocating for the development of a dedicated education sector HIV/AIDS policy. Eventual policy implementation will be coordinated by the ACU. However the progress and outputs of the ACU need to be discussed by the TAC and then vetted by both the AMC and the Basic Education Development Committee (BEDC). The BEDC is the body responsible for overseeing the development of education at all levels, from pre-primary to adult, ensuring that it complements wider sector development goals. Within the framework of local government reform, PORALG leaders acting as administrators of the education sector at regional and district levels, also have powers to advocate for the implementation of an education sector intervention.

Therefore, advocacy for the implementation of interventions is the combined responsibility of leaders at many different levels of the system. It is far more effective, however, when it comes from leaders positioned at upper levels of the MoEC hierarchy, as witnessed by the speeches that they make and guidelines that they give to officials at lower levels.

In the civil service there are established mechanisms for both internal and external communications. In the case of internal advocacy (i.e. practices directed at ministry staff) these include speeches, seminars, workshops, guidelines and memos and are the responsibility of all officials, from the Permanent Secretary down to the peer educators.

A number of practices have been initiated or enhanced at MoEC headquarters and in the districts to further improve internal advocacy:

- Leaders continually talk about issues and promote activities related to HIV/AIDS, during internal meetings, workshops, festivals, seminars and graduation ceremonies.
- District leaders communicate education sector needs and strategies on HIV/AIDS to staff members, pupils and students.
- Education sector needs related to HIV/AIDS are communicated to the full council with the objective of raising awareness and of soliciting funds and inter-sectoral support for strategies.

- Leaders keep HIV/AIDS in the education sector on the political agenda by consistently explaining issues and arguing for action.

- Workshops and seminars serve to communicate education sector needs and explain the associated issues to school heads and teachers.

4.2 External advocacy for policy development and implementation of interventions

External advocacy, directed at NGOs, school pupils and the wider community, is the responsibility of senior officials, including the Communications Officer, Permanent Secretary and Minister. Officials communicate with the general public through the mass media, as well as by preparing speeches, cabinet papers, memos and press releases. Care is taken to ensure that these remain in line with the strategies agreed upon by the AMC and BEDC.

In addition to the practices described in the last chapter, the following practices have been established or enhanced at all levels to facilitate external advocacy:

- Leaders explain issues and promote activities related to HIV/AIDS during external meetings, workshops, festivals, seminars, and graduation ceremonies.

- The MoEC solicits funds for HIV/AIDS interventions from development partners.

- District level officials appeal for funding of in-school HIV/AIDS activities in presentations to full council meetings.

- NGOs, mandated by the MoEC, advocate pupils and students to adopt safe sex practices, including promoting the routine use of condoms.

4.3 Visible gaps in leadership and advocacy

Despite the commitment of education sector leaders at all levels to the prevention and control of HIV/AIDS and impact mitigation, a number of leadership and advocacy gaps were identified:

- insufficient interest in the impact of HIV/AIDS from some leaders in the education sector;

- mistrust of HIV/AIDS prevention and control interventions in the education sector, particularly of the policy of promoting the use of condoms;

- a lack of initiatives among education sector leaders to advocate for prevention and control of HIV/AIDS and impact mitigation;

- inadequate numbers of leaders at all levels with HIV/AIDS skills and knowledge;

- inadequate financial resources to tackle prevention and control of HIV/AIDS and impact mitigation in the education sector;

- failure to use existing radio programmes for schools to widely disseminate HIV/AIDS information;

- a lack of capacity and skills at the district and institutional levels to coordinate HIV/AIDS prevention, control and impact mitigation activities between different actors (NGOs, CBOs, FBOs etc.).

In the opinion of the authors, these points of weakness can be principally attributed to the lack of a sector-specific HIV/AIDS policy, as highlighted in the proceeding chapter. This lack of policy, coupled with the gaps identified, is also evidence of the insufficient commitment of many in the sector to fighting the epidemic, as well as of the more practical lack of information and knowledge about the sectoral impact of the epidemic. Both of these problems urgently need to be remedied if the issues identified above are to be remedied.

4.3.1 Tackling cultural practices

Various cultural practices that contribute to the spread of AIDS were briefly outlined in Chapter 2. Behaviours resulting from long-established cultural assumptions and beliefs, for example that sex with a minor may cure disease, tend not to be discussed in advocacy campaigns. However, education sector leaders must ensure that they are fully debated and that the risks involved are highlighted to young people, for example through peer education sessions.

4.4 Steps needed to create a conducive environment for effective leadership and advocacy

Effective leadership and advocacy are characterized by the firm, consistent and visible support of leaders at all levels. Although senior leaders in Tanzania, such as His Excellency the President and the Honourable Prime Minister, have been consistently highlighting HIV/AIDS prevention, control and impact mitigation in their speeches and press conferences, research findings have indicated that the overall steps taken have not been adequate. The situation could be improved by:

- implementing an effective monitoring and evaluation plan to track the progress of the AIDS education programme over time;

- ensuring that the current EMIS incorporates information on HIV/AIDS, so that leaders have adequate information upon which to base action in the sector;

- sensitizing leaders at all levels to the importance of AIDS education in their respective areas of jurisdiction;

- providing instruction for senior leaders in the MoEC with the aim of improving their knowledge of the HIV/AIDS multi-sectoral framework, including the structural location, scope and functions of TACAIDS;

- encouraging education sector leaders at all levels to act on the presidential directive that required them to make HIV/AIDS a key topic at all available opportunities;

- exploring the use of wider forums to share HIV/AIDS issues, rather than being limited to traditional avenues such as seminars and conferences;

- encouraging MoEC officials to make maximum use of the mass media and to make periodic press statements that stipulate HIV/AIDS interventions in the sector.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Policy

The Ministry has been active in prevention, control and impact mitigation ever since the inception of the national programme against HIV/AIDS in 1985. Interventions are delivered through the national HIV/AIDS policy of 2001, which prescribes and empowers the MoEC to work closely with TACAIDS to deliver appropriate in-school interventions. A further mandate to develop a sectoral strategic framework and directives on HIV/AIDS for schools and workplaces has been given to the education sector through the national multi-sectoral strategic framework on HIV/AIDS.

The Ministry's concerted efforts were expressed through the issuing of Education Circular No. 3 of 1993, which established the school HIV/AIDS education programme. The programme was later expanded to cover all education sector staff, through Circular No. 3 issued in 2000. Many different methods have been used to deliver HIV/AIDS information to sector staff, including issuing guidelines and directives, and conducting seminars.

However despite all of these measures, the interventions have been neither sufficient nor effective in addressing the problems resulting from the AIDS epidemic. The authors attribute this principally to the absence of a dedicated education sector policy upon which a strategic framework could be formulated. The mechanisms for the collaboration and exchange of information, the coordination of activities and accountability at sectoral level, which would have been outlined in such a policy, cannot be constructed on the basis of guidelines alone. Consequently, there is insufficient co-operation and even competition of priorities between NGOs, CBOs and the education sector.

5.1.1 Recommendations

Policy formulation should precede enactment of law and the subsequent preparation of circulars, regulations, guidelines and directives. It is impossible to realize effective and sustainable mainstream AIDS activities within the education sector without first creating a dedicated sectoral policy. The Ministry should therefore formulate a formal sector-specific policy on HIV/AIDS, which should form part of the current education and training policy, rather than being a separate and independent programme. Mainstreaming HIV/AIDS means including it in all key policy and strategy documents.

The section of the policy dealing with HIV/AIDS would provide the framework, direction and general principles for prevention, care and support of those infected and affected by the disease, including Ministry staff and those in affiliated institutions, and in mitigation of the impact of HIV/AIDS. Issues that would need to be addressed include:

- the creation of a code of conduct for teachers, dealing explicitly with HIV/AIDS;
- the processing of pensions and death gratuities;
- the management of infected and affected teachers, for example meeting transfer or reduced workload requests.

The policy should also cater for the interests of pupils and students, as well as trainees at teacher training colleges.

The main aim should be the creation of an environment that is conducive to the formulation of appropriate interventions, and which will in turn be effective in preventing and controlling HIV/AIDS and STI infections, protecting and supporting vulnerable groups, and mitigating the social and economic impact of HIV/AIDS. The policy would also prescribe the budgeting process, methods of raising funds, the mobilization of materials and human resources, and the identification of priority areas for HIV/AIDS prevention and control activities.

The development of such a policy would have to be participatory and interactive in nature, involving TACAIDS, the MoEC and its affiliated institutions, PORALG, the Ministry of Labour, Youth Development and Sports, the MoH, NGOs, CBOs, FBOs and any other MoEC stakeholders.

5.2 Leadership

Education sector leaders have the crucial responsibility of implementing HIV/AIDS activities, but there is little evidence of committed and sustained leadership on HIV/AIDS issues. Besides the problem of not perceiving the epidemic as an educational issue, the education sector has inadequate resources in terms of manpower, finance, equipment and supplies. For example, peer educators at MoEC headquarters and in schools have no IEC materials to use with clients. Leaders also lack the legal framework and means to effectively implement activities. Furthermore the education sector suffers from a general lack of supervision, monitoring and evaluation. Consequently under prevailing conditions HIV/AIDS programmes cannot be efficiently designed, implemented or revised.

5.2.1 Recommendations

Some education sector leaders are poorly informed about the framework for a multi-sectoral response to the HIV/AIDS epidemic and the importance of AIDS education interventions in their respective areas. This must be urgently remedied: education sector leaders must receive adequate training.

In order to implement activities effectively, education sector leaders must also have access to instructional support materials, both at Ministry headquarters and in schools. It is therefore advised that the MoEC ensures that peer educators are adequately equipped with IEC materials.

It was found that the responsibilities of MoEC peer educators are not reflected in job descriptions or taken into account when considering staff for promotion. As a result, the assignment is not taken seriously. It is advised that the MoEC gives token incentives and possibly awards peer educators with additional assignments in recognition of the extra work that they carry out.

The training and replacement of education sector staff has not responded to the impact of HIV/AIDS on the sector. If nothing is done about this, the sector risks facing a damaging

shortage of key personnel. To avoid this, it is advised that training and replacement, particularly of subject specialists, should reflect the impact of HIV/AIDS on the sector.

Concrete facts and figures are essential for effective leadership and advocacy. One of the greatest challenges is precisely the lack of reliable data about the impact of HIV/AIDS on teachers and pupils. This is largely because MoEC headquarters and the district education offices do not have an effective EMIS to monitor the impact of HIV/AIDS in the education sector. It is strongly advised that the current EMIS be made HIV/AIDS sensitive. The programme monitoring capacity should be increased, as should the capacity for collecting, storing, disseminating and retrieving information using electronic equipment. Such improvements will facilitate the formulation of sound training and replacement strategies and aid staff deployment. They will also enable comparisons to be made amongst different types of institutions (e.g. public and private schools, teacher training colleges etc.), studying absenteeism and measuring the effectiveness of interventions.

5.3 Advocacy

The mass media play a very important role for advocacy through educating, informing and entertaining the public. It is a very effective means of reaching many people at the same time and has been used extensively by senior leaders. However, the media used should be selected carefully and with reference to the target audience. With an illiterate population, for example, the written word (newspapers, flyers, circulars etc.) will not be very effective, whilst in poverty-ridden communities the spoken word (television, radio, etc.) will only have limited impact because of the relatively high cost of receiving equipment.

Seminars, conferences and workshops have also been used extensively as vehicles to deliver HIV/AIDS interventions, although they may be open to abuse. For example, Shellukindo et al. (2000) remark that sometimes these activities are not taken seriously by participants and have become income-generating activities for those involved in AIDS control and prevention.

Some religious leaders and education sector officials do not support advocacy for condom promotion and use in schools. They regard HIV/AIDS as God's punishment to sinners and promotion of condom use as encouraging people to commit adultery or to indulge in promiscuous activities. Shellukindo et al. (2000: 45) remind the readers and those opposed to condom use and promotion that, "If we cannot prevent people from breaking the sixth commandment (you shall not commit adultery) we should at least prevent them from breaking the fifth commandment (you shall not kill). Keeping silent about condoms is a sin because it means assisting the spread of illness and death."

5.3.1 Recommendations

In all cases, the effectiveness of the advocacy approaches described above have not been assessed, with regard to timing, the target group, the socioeconomic environment of the target group, etc. It is highly recommended that these approaches be evaluated in order to measure their efficacy and effectiveness.

Finally and most importantly, the MoEC should develop and implement ongoing plans for HIV/AIDS advocacy in the education sector, including outlining leadership roles and identifying role models.

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APPENDIX 1

A LIST OF PEOPLE INTERVIEWED

Name	Position	Institution
Mr. A. Mwakalinga	Director of Policy and Planning	MoEC
Mr. O. Mhaiki	Director of Basic Education	MoEC
Mr. M. Msongo	Director of Administration and Personnel	MoEC
Ms. R.P. Msoffe	Acting Director of School Inspection	MoEC
Mr. B. Buretta	Director of Secondary Education	MoEC
Dr. D.K. Ndagalla	Director of Cultural Development	MoEC
Dr. A.L. Temba	Director of Policy and Planning	TACAIDS
Dr. B. Fimbo	Head of IEC Unit	NACP
Mrs. M. Sitta	President	TTU
Ms. P.E. Olekambainei	Executive Secretary	TSC
Dr. F.C. Kigadye	Director	CSSC
Mr. Khatibu	Education Officer	BAKWATA
Mr. Mwaipopo	Education Secretary	TAPA
Mr. A. Chembere	Education Officer	Agha Khan Education Services
Mr. S. Maduhu	Regional Education Officer	Iringa Region
Mr. A. Midelo	District Development Director	Iringa Urban District
Mr. D. Feruzi	Mayor	Iringa Urban District
Mr. A.A. Kameka	District Education Officer	Iringa Urban District
Dr. M. Mpangachuma	District Medical Officer	Iringa Urban District
Mr. Mung'ong'o	District School Inspector	Iringa Urban District
Mr. Kihwili	District Teachers Union Secretary	Iringa Urban District
Mr. Mwachumbe	Headmaster	Lugalo Secondary School
Mrs. C.N. Mgonja	Headmistress	Iringa Girls Secondary School
Mr. W. Kyando	Head teacher	Mkimbizi Primary School
Ms. F. Abubakar	Head teacher	Mlandege A Primary School
Mr. A. Admini	Head teacher	Mlandege B Primary School
Mr. A. Ghemela	Ward Education Coordinator	Ilala Ward
Mr. V. Mvanda	Ward Education Coordinator	Mlandege Ward
Mr. C. Ferla	Director	SPW, Iringa Region
Mr. P. Njuyuwi	Director	IDYDC
Mr. J. Sizya	Programme Officer	INGONET
Ms. B. Massima	Programme Officer	TAHEA, Iringa Region
Mr. D. Kapufi	Programme Officer	IDYDC

APPENDIX 2

GROUPS OF PEOPLE WHO PARTICIPTED IN FOCUS GROUP DISCUSSIONS

Category or cadre	Number of FGDs	Number of participants
MoEC headquarters peer educators	1	8
MoEC headquarters middle cadre staff	1	9
MoEC headquarters low cadre staff – female	1	10
MoEC headquarters low cadre staff – male	1	10
Secondary school teachers	4	35
Primary school teachers	5	46
Secondary school students – female	3	29
Secondary school students – male	3	30
Primary school pupils – female	5	50
Primary school pupils – male	5	50

APPENDIX 3

TANZANIA RESEARCH AND RESULTS VALIDATION TEAMS

Data collection team	
Prof. Athanas Kauzeni	Team leader
Dr. Nesta Sekwao	Office of the CEO, MoEC
Dr. Letitia Sayi	ACU, MoEC
Ms. Hadija Maggid	Directorate of Policy and Planning, MoEC
Ms. Ruth Sam	Directorate of School Inspections, MoEC
Mr. Clarence Mwinuka	Directorate of Basic Education, MoEC
Ms. Cecilia Makinyika	School of Nursing, Muhimbili National Hospital
Dr. Vincent Mashinji	School of Medicine, Muhimbili National Hospital
Mr. Geoffrey Mandara	TSC
Mr. Clement Kihinga	Associate researcher

Results validation workshop participants	
Prof. Athanas Kauzeni	Team leader
Dr. Letitia Sayi	ACU, MoEC
Dr. Gabriel Rugalema	UNESCO/IIEP
Dr. Flora Kessy	Economic and Social Research Foundation
Mr. Clarence Mwinuka	Directorate of Basic Education, MoEC
Mr. Anthony Mtavangu	TTU
Ms. Emma Sundberg	Freelance consultant
Mr. Clement Kihinga	Associate researcher